



भारत सरकार / GOVERNMENT OF INDIA
पत्तन, पोत परिवहन और जलमार्ग मंत्रालय
MINISTRY OF PORTS, SHIPPING AND WATERWAYS
समुद्रीय प्रशासन महानिदेशालय, मुंबई
DIRECTORATE GENERAL OF MARITIME ADMINISTRATION, MUMBAI

F.No.20-11011/16/2023-TRG-DGS (C.No.25023)

Date: 29.09.2026

SHOW CAUSE NOTICE

Subject: Show Cause Notice for prima facie major deficiencies in enforcement of the ban on alcohol, hostel supervision, security and access control following the fatal incident at T.S. Chanakya, Indian Maritime University, Navi Mumbai Campus on 28.05.2026 – Reg.

WHEREAS, T.S. Chanakya, Indian Maritime University, Navi Mumbai Campus (MTI No. 208053) (hereinafter the “Institute” or “MTI”), located at Karave, Nerul, Navi Mumbai, Maharashtra – 400 706, has been approved by the Directorate General of Maritime Administration (DGMA).

2. WHEREAS, in terms of Paras 1.4.1 and 1.4.2 of DGS Order No. 07 of 2016 (hereinafter the “Order”), which apply to all Institutes including Government institutes, the Institute is bound by the Order and the conditions of its approval.

3. WHEREAS, Para 1.15 of the Order, “Ban on Alcohol, Tobacco and Drugs”, requires the Institute to have a policy thereon and to strictly enforce abstinence therefrom, except for medicinal drugs prescribed for a current ailment, and provides that infringement shall be a serious misconduct by the candidate and by the Institute.

4. WHEREAS, Para 3.2 of the Order requires designated persons to be on duty on the campus at all times during the course period to ensure the welfare, discipline and safety of candidates and the security of the Institute, the person on duty being in-charge of discipline.

5. WHEREAS, pursuant to D.O. No. 20-11011/16/2023-TRG-DGS dated 03.06.2026, the Mercantile Marine Department (MMD), Mumbai, conducted a fact-finding inquiry into the incident of 28.05.2026 and submitted its report dated 10.09.2026 (hereinafter the “Report”), which is relied upon and enclosed.

6. WHEREAS, as recorded in the Report, Cadet Somnath Singh Shivam (hereinafter the “deceased”), a First-Year B.Sc. (Nautical Science) cadet, who was accommodated in Hostel No. 2 and was also performing Quartermaster duties, is stated by his roommate to have gone outside the campus after dinner on 27.05.2026 and returned at about 23:00 hrs. Between about 01:30 hrs and 03:30 hrs on 28.05.2026, he and three other cadets consumed alcohol in a hostel room at an informal farewell gathering. According to the duty warden, hostel rounds were conducted between 22:30 hrs and 23:00 hrs and at about 04:00 hrs, and nothing unusual was observed.

7. WHEREAS, the Report further records that at about 06:03 hrs on 28.05.2026 a cadet found the deceased lying injured at the rear of Hostel No. 2 and informed the security guard, who informed the duty warden at about 06:07 hrs. The deceased was taken in the Institute's emergency vehicle to D.Y. Patil Hospital, where he succumbed to his injuries. The Report also records that no material linking the incident to ragging, bullying, assault or foul play emerged.
8. WHEREAS, the Report finds that the said consumption of alcohol was in violation of institutional rules, records the statement of the roommate of the deceased that it had been procured from outside the campus, and records the confirmation of the duty warden that cigarettes and alcohol had earlier entered the hostel through a broken washroom window. That such consumption went undetected during the night, notwithstanding the Institute's prior knowledge that prohibited items had entered the hostel, prima facie indicates that abstinence from alcohol was not strictly enforced as required under Para 1.15, and raises a question as to the adequacy of the night supervision arrangements under Para 3.2 of the Order.
9. WHEREAS, the Report finds that the rear of Hostel No. 2, where the deceased was found, was not covered by CCTV surveillance, and that unauthorised access routes existed through hostel windows and the boundary wall, through which cadets were able to leave and re-enter the campus. Such unsecured routes permit the undetected movement of cadets and entry of prohibited items, and prima facie indicate a lapse in maintaining the security of the Institute contemplated under Para 3.2 of the Order.
10. And WHEREAS an anonymous representation has additionally alleged that another cadet had fallen from a hostel window in 2024 and sustained injuries, deficiencies relating to hostel maintenance, food hygiene, emergency handling, grievance redressal and protection of complainants. These allegations are not treated as established facts at this stage; however, they require a specific and documented response from the Institute;
11. WHEREAS, the witness statements in the said report confirmed that hostel windows had been used to access the terrace, and the statement of the roommate of the deceased that cadets could climb through them to the roof. The Report finds that the deceased had previously engaged in this unsafe practice. No risk assessment of fall hazards and roof access in the hostels, or any measure taken to stop the practice before 28.05.2026, has been placed on record. As the duty warden, being the person in-charge of discipline under Para 3.2 of the Order, had information of this practice, the absence of such assessment or measures prima facie indicates that a hazard known to the Institute was not addressed.
12. WHEREAS, the Report records that no witness observed the occurrence, that its precise circumstances remain unestablished pending the police investigation and post-mortem report, and that the role of alcohol cannot be determined on witness testimony alone. The deficiencies herein are accordingly examined as lapses in their own right, and not on the basis that any of them caused the death of the cadet.
13. WHEREAS, Para 5.3.1 of the Order provides that major deficiencies include, inter alia, any other significant lapse from the guidelines (Para 5.3.1.7); Para 5.5.1 provides that major

deficiencies may lead to temporary or permanent withdrawal of approval of the course or of the Institute, as set out in Paras 5.5.2 to 5.5.5; and Para 5.6 provides for a show cause notice before any such withdrawal. Further, DGS Circular No. 23 of 2020 requires the activities of Maritime Training Institutes to be continuously monitored through a Quality Standards System, including internal audits, identification of deficiencies, corrective action and root-cause analysis, and provides that any deficiency therein shall be treated as a major non-conformity.

14. WHEREAS, the lapses in paragraphs 8 to 10 above, taken together, prima facie amount to non-compliance with Paras 1.15 and 3.2 of the Order and to a significant lapse from the guidelines under Para 5.3.1.7, and thus appear to constitute a major deficiency warranting action under Para 5.5 of the Order.

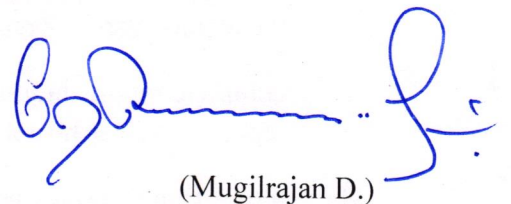
NOW, THEREFORE,

15. The MTI is hereby called upon to show cause, within 15 (Fifteen) days from the date of receipt of this Notice, as to why appropriate regulatory action should not be taken against it under the applicable provisions of DGS Order No. 07 of 2016, DGS Circular No. 23 of 2020, and other applicable regulatory requirements, including, but not limited to:

- i. complete chronology of the incident and emergency response, including calls made, officials informed, vehicles used, hospital records and officials present;
- ii. campus and hostel CCTV plan, camera locations, coverage, identified blind spots, recording-retention policy and reasons for absence of CCTV coverage behind Hostel No. 2;
- iii. warden and security duty rosters, attendance records, patrol registers and other records for 27–28 May 2026, together with evidence of round-the-clock hostel supervision;
- iv. details of all unsecured windows, broken windows, boundary gaps, roof-access routes and restricted-area openings, including the date on which each deficiency became known and the action taken for rectification;
- v. complete report, inquiry, risk assessment and corrective/preventive action concerning the reported similar hostel fall incident in 2024;
- vi. the Institute's policy regarding alcohol, tobacco and drugs,
- vii. an explanation of how alcohol reportedly entered the campus/hostel, supported by gate registers, visitor records, parcel records, vehicle-entry records, search procedures, security instructions and disciplinary records;
- viii. details of the medical room/sick bay, first-aid facilities, stretchers, trained personnel and ambulance or assured round-the-clock medical transport available on 28.05.2026;
- ix. complaint, maintenance and repair records concerning the alleged missing/broken window frame in DS3 and other relevant hostel maintenance deficiencies;

- x. food-safety, mess and kitchen inspection records, including complaints received and action taken in relation to food hygiene;
 - xi. details of the grievance-redressal mechanism available to cadets, including arrangements for confidential reporting, escalation and protection against retaliation;
 - xii. records of internal inspections, safety reviews, hostel inspections or committee meetings concerning hostel safety, access control, CCTV surveillance, security, student discipline or emergency arrangements during the relevant period; and
 - xiii. a point-wise Action Taken Report on every recommendation contained in the MMD fact-finding report, indicating the responsible officer, action taken, completion date and documentary proof.
16. The Institute shall ensure that no cadet, employee or witness suffers retaliation, intimidation, academic disadvantage or placement-related prejudice for furnishing information or participating in any inquiry relating to these matters.
17. The Institute shall also furnish all relevant policies, procedures, registers, records and reports in support of its reply, together with a time-bound corrective action plan indicating the measures completed and pending, the officers responsible and the target dates.
18. The Institute may request a personal hearing along with its reply. Any request for extension of time shall be made, with reasons, before expiry of the stipulated period.
19. If the Institute fails to reply within the stipulated period, or to appear for a personal hearing if called upon, the matter shall be decided on the material on record without further reference to it.
20. The observations in this Notice are prima facie and do not determine any civil or criminal liability. The final decision, if any, shall be taken after due consideration of the reply and the records on file. This Notice is without prejudice to any other action under the applicable laws, rules, orders and circulars.

This issues with the approval of the Competent Authority.



(Mugilrajan D.)

Deputy Director General (Training & Technical)
Directorate General of Maritime Administration (DGMA), Mumbai

To
The Campus Director (I/C),
T.S. Chanakya, Indian Maritime University – Navi Mumbai Campus (MTI No. 208053),
Karave, Nerul, Navi Mumbai, Maharashtra – 400 706.
Email: director.navimumbai@imu.ac.in
Tel.: +91-22-27702343

Encl.: Fact-finding report of the Mercantile Marine Department, Mumbai, dated 10.09.2026, in respect of the incident dated 28.05.2026 at T.S. Chanakya, Indian Maritime University, Navi Mumbai Campus.

Copy to:

1. The Vice-Chancellor, Indian Maritime University, Chennai – for information and necessary action.
2. The Principal Officer, Mercantile Marine Department, Mumbai.

**FACT FINDING REPORT INTO THE INCIDENT OF DEATH OF CADET
SOMNATH SINGH SHIVAM, FIRST YEAR B.SC. NAUTICAL SCIENCE
STUDENT OF T.S. CHANAKYA, INDIAN MARITIME UNIVERSITY, NAVI
MUMBAI CAMPUS**



Submitted in compliance with DGS D.O. No.20-11011/16/2023-TRG-DGS dated 03th June 2026

By

Mercantile Marine Department, Mumbai

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1. Background

This report is submitted in compliance with the directions contained in D.O. No.20-11011/16/2023-TRG-DGS dated 03 June 2026 issued by the Directorate General of Shipping, seeking a detailed factual report regarding the death of Cadet Somnath Singh Shivam, First Year B.Sc. Nautical Science Cadet, T.S. Chanakya, IMU Navi Mumbai Campus.

The Directorate requested verification of the following aspects:

- (i) Circumstances leading to the death of the cadet.
- (ii) Chronology of events.
- (iii) Immediate response of the institute authorities.
- (iv) Verification of allegations relating to discipline, ragging, alcohol or prohibited substances.
- (v) Adequacy of hostel security and access control measures.
- (vi) Details of any internal inquiry conducted by the institute.

2. Sources of Information

The report is based upon the following:

1. Consolidated voice recording of ten witnesses.
2. Institutional records made available during the inquiry.
3. Information furnished by the institute.
4. Institute press release.
5. Panchnama
6. Post-Mortem Memorandum (medical findings to be correlated with final report upon complete verification).

3. Particulars of the Deceased & Brief Facts

Name: Somnath Singh Shivam

Course: First Year B.Sc. Nautical Science Student

Hostel: Hostel No.2

Additional Responsibility: Quartermaster

Cadet Somnath Singh Shivam, a First-Year B.Sc. Nautical Science student, sustained severe injuries after falling from the hostel building during the early hours of 28th May 2026. He was immediately shifted to D.Y. Patil Hospital but succumbed to his injuries despite emergency treatment.

4. Chronology of Events

4.1 Activities Prior to the Incident

Cadet Anshul Baloda stated that on 24th May 2026 he accompanied the deceased for shopping and a temple visit. Both returned to the institute during the evening. He stated that throughout the study leave period before the examinations, the deceased remained cheerful, interacted normally with fellow cadets and displayed no abnormal behaviour.

Deceased roommate cadet Sreyan Saha, similarly stated that the deceased continued his normal routine of studies, interaction with friends and examination preparation and exhibited no signs of emotional distress or behavioural change.

4.2 Events on 27th May 2026

The duty warden stated that the deceased performed Quartermaster duties in the Warden's Office until approximately 22:00 hrs, after which he was instructed to return to his hostel room and continue his examination preparation.

Cadet Sreyan Saha stated that the deceased had gone outside the campus after dinner and returned to the hostel at approximately 23:00 hrs.

4.3 Gathering during the Night of 27/28th May 2026

At approximately 01:30 hrs, the deceased Cadet Anshul Baloda, Cadet Sreyan Saha and Cadet Tanmay Patel gathered in the hostel room for an informal farewell as Cadet Anshul Baloda was proceeding home after completion of examinations. All witnesses consistently stated that one bottle of whisky was consumed by the four cadets along with snacks between approximately 01:30 hrs and 03:30 hrs.

4.3.1 The witnesses uniformly stated that:

- no quarrel or argument occurred,
- no ragging or harassment took place,
- no emotionally disturbing conversation occurred;
- no prohibited drugs were consumed.

4.3.2 Cadet Anshul Baloda stated that the deceased remained cheerful, fully conscious and behaved normally throughout the gathering. Cadet Sreyan Saha stated that he became unwell after consuming alcohol, vomited through the hostel window and

thereafter went to sleep. At the time he slept, the deceased remained seated on his bed while Cadet Anshul Baloda was still present in the room. Cadet Anshul Baloda subsequently left the room after assisting another cadet to his room and stated that he observed no indication that the deceased intended to cause harm to himself.

5. Discovery of the Incident

The duty warden stated that hostel rounds were conducted between 22:30 hrs and 23:00 hrs and again at approximately 04:00 hrs. Nothing unusual was observed during either inspection. Around 06:03 hrs, Cadet Harsh Raj noticed an injured person lying behind Hostel No.2 and informed duty security guard Mr. Shankar. At approximately 06:07 hrs on 28th May 2026, the duty warden received a telephone call from a security guard informing him that a cadet had fallen from the hostel building. The duty warden immediately proceeded to the location and found the deceased lying on the rear side of Hostel No.2 with severe head injuries and active bleeding.

6. Emergency Response by the Institute

The evidence indicates that upon receiving information regarding the injured cadet, the security guard immediately informed the duty warden, who promptly reached the scene. Efforts were made to contact an ambulance, and when immediate ambulance assistance was unavailable, the institute's emergency vehicle was arranged without delay. The cadet was shifted to D.Y. Patil Hospital, where emergency treatment was initiated. The warden's informed senior institute officials and the cadet's family and thereafter arranged additional cadets for blood donation if required.

Hospital authorities informed the duty warden that the cadet had sustained severe head injuries with internal bleeding and suffered repeated cardiac arrests despite continuous resuscitative efforts. The cadet Somnath was subsequently declared deceased.

7. Circumstances Leading to the Incident

7.1 Statements also indicate that hostel windows had previously been used to access the terrace or restricted areas of the building. Somnath's roommate specifically stated that he had personally seen the deceased climb towards the terrace through the hostel windows on earlier occasions and had cautioned him about the danger involved.

7.2 None of the witnesses actually observed the fall. Therefore, the precise circumstances leading to the incident remain unestablished on the basis of oral evidence alone. While some witnesses expressed the opinion that the deceased might have accidentally fallen while attempting to access the terrace.

7.3 The police informed the duty warden that the injuries were consistent with a fall or jump from the hostel building. However, no witness were reported to have seen the occurrence.

8. Verification of Allegations Relating to Ragging and Discipline

8.1 Cadet Anshul Baloda stated that the institute maintained a disciplined and regimented environment. He stated that seniors occasionally imposed physical punishments such as kneeling, push-ups and planks; however, he did not consider these acts to constitute ragging or physical assault. He further stated that complaints made by certain first-year B.Sc. cadets had earlier resulted in disciplinary action against one third-year cadet leader.

8.2 No witness stated that the deceased had been subjected to ragging, bullying, intimidation or harassment immediately prior to the incident. No material connecting ragging with the present incident emerged during the inquiry.

9. Verification Regarding Alcohol or Prohibited Substances

Independent witness statements establish that one bottle of whisky was consumed inside the hostel room during the night preceding the incident. The roommate also stated that the alcohol had been procured from outside the campus. All witnesses denied consumption of narcotic drugs or any other prohibited substance.

10. Examination of Hostel Security and Access Control

The inquiry revealed the following:

- (a) The rear side of Hostel No.2 was not covered by CCTV surveillance.
- (b) The roommate stated that students were able to leave and re-enter the campus through an unsecured hostel window and a gap in the boundary wall.
- (c) The duty warden confirmed that cigarettes and alcohol had previously entered through a broken washroom window. The opening has since been secured.
- (d) The roommate further stated that before installation of safety grills, students could climb through hostel windows and access the hostel roof. He stated that he had personally seen the deceased do so on several occasions and had cautioned him against the practice.
- (e) The duty warden stated that he had heard similar information from cadets but had never personally witnessed such conduct.

11. Previous Similar Incident

The duty warden recalled that during the year 2024 another cadet had fallen from a hostel window, sustained injuries and survived. According to the duty warden, the present case is the first fatal incident of this nature during his tenure.

12. Findings

On the basis of material presently available, the following findings emerge:

1. No witness observed the actual occurrence.
2. No evidence presently indicates assault or foul play involving other cadets.
3. Witnesses consistently described the deceased as cheerful, academically competent and emotionally stable.
4. Alcohol was consumed within the hostel in violation of institutional rules.
5. Unauthorised access routes existed through hostel windows and the boundary wall.
6. CCTV surveillance did not cover the location where the cadet was found.
7. Witnesses confirmed that the deceased had previously engaged in the unsafe practice of climbing to the roof through hostel windows.
8. The exact manner in which the deceased came out of the hostel window has not been established during the inquiry and remains under investigation by the police.

13. Observations

The available medical record indicates that Somnath succumbed to multiple traumatic injuries sustained after the fall. The inquiry has not revealed any material linking the incident to ragging, bullying or interpersonal conflict.

However, the inquiry has identified deficiencies in hostel security, surveillance, access control and enforcement of institutional discipline, particularly with regard to unauthorised movement and entry of alcohol into the hostel premises.

These deficiencies require immediate corrective measures irrespective of the outcome of the criminal investigation.

14. Recommendations:

The following measures are recommended:

1. Installation of CCTV cameras covering all hostel blind spots.
2. Permanent sealing of all unauthorised access routes.
3. Strengthening of hostel access control and night surveillance.
4. Electronic monitoring of security patrols.
5. Regular inspections to prevent entry of alcohol and prohibited substances.
6. Structural measures to prevent access to roofs through hostel windows.
7. Periodic safety awareness programmes for cadets.
8. Strengthening of counselling and student welfare mechanisms.
9. Continued strict implementation of anti-ragging regulations.
10. Full cooperation with the ongoing police investigation and implementation of any further recommendations arising therefrom.

15. Conclusion

On the basis of the material presently available, this inquiry concludes that the institute authorities responded promptly and appropriately after the injured cadet was discovered. There is no evidence to indicate any deliberate delay in providing medical assistance or any attempt to suppress or conceal the occurrence.

The inquiry has however identified deficiencies in hostel discipline and security, particularly with regard to the prevention of unauthorised entry of alcohol into the campus and surveillance of vulnerable portions of the hostel premises. These deficiencies require immediate corrective measures to enhance student safety and strengthen institutional controls.

The inquiry has not found evidence supporting allegations of ragging, assault, or other forms of foul play in connection with the death of the cadet. Likewise, while alcohol consumption by the deceased and his companions has been established, its precise role in the occurrence of the incident cannot be determined solely on the basis of witness testimony and must be assessed in conjunction with medical and forensic evidence.

In view of the absence of any eyewitness to the fall, the inquiry is unable to reach a definitive conclusion regarding the exact circumstances that led to the incident. The findings contained in this report are therefore preliminary in nature and should be read together with the final findings of the investigating police authorities, supplemented by medical forensic evidence of Post-Mortem report which is yet to be received from the authorities.

 10/09/2026
Name: Capt. Santoshkumar Darokar
Designation: Principal Officer-cum-Joint DG(Tech)

 10/09/2026
Name: Kiran Chempakasseryasidharan
Designation: Engineer & Ship Surveyor-cum-DDG(Tech)