BSAFE

INCIDENT CASE STUDY No.16

BRITANNIA COMMENTARY | JULY 2022

THE FOLLOWING COMMENTARY IS PART OF THE CASE STUDY MATERIAL AND HAS BEEN PREPARED TO CONSIDER SOME OF THE KEY ISSUES. THIS WILL SUPPORT REFLECTIVE LEARNING AND ENABLE DISCUSSION OF SOME OF THE CONTRIBUTORY FACTORS AND LESSONS LEARNED WITH PARTICULAR REFERENCE TO BEST PRACTICES.

HEAVY WEATHER LEADING TO A FATALITY

THE INCIDENT INVESTIGATION CARRIED OUT BY THE LOCAL PORT STATE AUTHORITIES IDENTIFIED A NUMBER OF FACTORS WHICH CONTRIBUTED TO THE INCIDENT AND THE CREW'S RESPONSE. THESE FACTORS AND THE LESSONS LEARNED ARE DISCUSSED BELOW.

LACK OF COMMUNICATIONS

The chief officer was known to be independent and to quite happily work by himself. On this occasion, and we have to speculate to a large extent, it may have been that as there was a particular issue on the forecastle, which was tackled personally by the chief officer as he wanted to fix it as quickly as possible. Therefore, he did not tell the captain or third officer what he was doing. This lack of communication was the start of a number of failings which ultimately led to the tragic incident which unfolded.

It is good practice to keep others informed on board when doing something out of the ordinary, or proceeding alone to a location, so that the full picture of what is happening on board is clear to all responsible parties at all times.

LACK OF MEANS OF CONTACT

The fact that the chief officer did not take any means of communication with him on deck was a major failing. As a result, when things went wrong, there was no way for anyone on the forecastle to easily summon help. If a radio had been available, it may have quickened the alert to the bridge, hastened the provision of assistance and stopped the confusion surrounding what had actually occurred. However, it is not known whether the sea that crashed onto the forecastle would have made any radio inoperable.

LACK OF RESTRICTED ACCESS

It is best practice to have a heavy weather policy in a vessel's Safety Management System. The policy should include guidelines on when access to the forecastle, main deck and poop deck should be restricted, while acknowledging that it can be difficult to give rigid environmental criteria when access should be restricted as there are many factors at play, including wind direction and speed, sea and swell directions and magnitude, freeboard and the vessel's stability.

RISK ASSESSMENT AND MITIGATIONS

The impression that the chief officer was keen to fix the issue with the water ingress into the forecastle and the damaged hatch cover is reinforced by the fact that no risk assessment was carried out. The chief officer may well have viewed the damage that occurred as a failing on his part and therefore he wanted to quickly "right the wrong". On this occasion a risk assessment would have helped to identify (a) the potential hazards and (b) the mitigations that should have been employed to reduce the risk to the repair party to ALARP (as low as reasonably practicable). If a risk assessment had been completed, the principal hazard, namely the inclement weather, should have been identified, along with the appropriate mitigations of changing the vessel's heading, and possibly speed, to reduce the possibility of seas and spray on deck for the period while personnel were on deck.

CONFUSION AS TO WHAT HAD OCCURRED

When a stressful event occurs, it is only natural that people will revert to speaking in their mother tongue as that feels more natural and is what they are most comfortable with. However, on this occasion this led to confusion as to exactly what had

HEAVY WEATHER LEADING TO A FATALITY

CONFUSION AS TO WHAT HAD OCCURRED (continued)

occurred. Although it is difficult to change such a natural reaction, it is recommended that, as part of on board safety training , this particular issue is highlighted to crew and, in the unfortunate event of a serious incident occurring, they are encouraged to try to stay calm and promptly pass on information clearly and concisely so that actions to help those affected can be instigated as quickly as possible.

PROBLEMS WITH THE INTERNAL TELEPHONES

The problem with the phone handsets coming loose in heavy weather and paralysing the telephone exchange could have been mitigated if clips had been placed on the telephones, so that the handsets did not fall off when the vessel encountered heavy weather.

INADEQUATE PREPARATIONS FOR HEAVY WEATHER

The bosun was the crew member who had closed and dogged the forecastle access hatch. However, he admitted that he had only tightened the wingnuts on the dogs hand tight and no lever of any type, such as the metal tube commonly found on the inside of weathertight doors to deck, was used to help tighten the dogs on the hatch. Furthermore, although an additional securing mechanism had been fitted, it had not been used on this occasion. If fitted, this additional securing measure alone may have prevented this tragic incident unfolding. It is unknown if this additional securing mechanism was not routinely being fitted. As this was not reported, we can only speculate. However, as fitting this mechanism required someone to go into the forecastle and climb up the access ladder, it may well have been that this particular task was considered a pain and may not have been completed after departure from each port. We frequently see inadequate preparations for heavy weather leading to serious incidents, often due to inexperienced crew. This includes a case where the forecastle store hatch was ripped off in similar circumstances to this incident, leading to heavy flooding and ultimately the loss of the vessel and fatalities.

LACK OF WATERTIGHT INTEGRITY

Although not a contributing factor to this incident, the fact that the vessel had been routinely sailing with the watertight doors leading from the underdeck passages to the forecastle spaces open was a concern. Any damage to the watertight integrity of the bow could have led to flooding into the underdeck passages and possibly into the cargo holds. All such doors should be kept closed while at sea and clear messages posted on both sides of the doors that they are only to be opened temporarily for access purposes and closed promptly thereafter.