Ship Type: All Trade Area: All

Bulletin 422 - 07/05 - Fatal Man Overboard Rescue Attempt - Worldwide

The case described below highlights the need for shipowners to carry out proper risk assessments so that the master and his officers have guidance on how to devise and execute an appropriate plan with regard to the rescue of a person in the water when weather conditions do not permit the launching of a rescue craft.

The vessel involved was a large high-sided ferry in rough seas with wave heights of 4.0 metres and a 1.5 metre swell. Shortly after completing an alteration of course, giving way to another vessel and causing a heel of four to five degrees and increasing the roll, passengers raised the alarm after noticing a passenger in the water. The ferry launched a lifebuoy, commenced a Williamson turn, broadcast a PAN PAN and posted lookouts, etc as per company procedures and operational manuals. Contact was made with the other vessel in the vicinity which slowed and joined the search and by the time the casualty was spotted, confirmed that its rescue craft was ready for launching and crew donning immersion suits. The casualty was surprisingly found to be alive and in good condition, due to his build and strong swimming ability.

Until the casualty was spotted, discussions on the bridge of the ferry were solely concerned with conducting the search and no consideration was given as to how the casualty was to be rescued and no preparations in that respect were made. Once spotted, the master of the ferry decided to try to rescue the casualty by recovering him to the ferry. The master concluded that the weather conditions were such that it was not possible to launch either of the rescue boats and he considered the only viable option was to recover the casualty through the bunker door on the port side of the vessel. He proceeded to carry out his rescue plan by manoeuvring the ferry so as to bring her as close to the casualty as possible and as quickly as possible.

In the event, the vessel left the casualty to starboard and so the crew had to perform the rescue through the pilot door, which was 10 feet above the waterline, was only wide enough for one man and was also above the rubbing strake. It was decided a crewmember would have to don an immersion suit and perform the rescue on a pilot ladder. The master put the engines astern to take some way off the vessel but this brought the casualty towards the starboard bow. The master shut down the bow thrusters with the result that the vessel developed a swing to starboard. The casualty disappeared from view under the flare of the bow and came into view again on the port side; face down in the water and appearing lifeless. In the condition that the casualty was now in, the attempt to rescue him through the pilot door was abandoned and the master of the other vessel on scene decided that he was no longer prepared to risk his crew by launching a fast rescue craft. The casualty was finally rescued by helicopter but confirmed deceased.

This case was governed by the Athens Convention and notwithstanding the fact that the casualty was in the sea rather than onboard when he met his death, the parties involved agreed that he died during the course of carriage within the meaning of the Convention and that Convention therefore applied and the following was found:

- The bridge team was negligent in failing to give any consideration as to how the casualty was to be rescued.
- The shipping line was found to be negligent in that the master, officers and crew onboard had received no advice, guidance or training with regard to the rescue of a man overboard in such circumstances.
- It should have been obvious to the master that the fast rescue boat of the other vessel was in a position to rescue the casualty much more quickly and with far less danger to him than the planned

retrieval to the ferry. All that was required was for the master of the ferry to request the other vessel to go ahead and launch. As the on-scene co-ordinator it was for the master of the ferry to request this launch and he was negligent in failing to do so.

- The master was negligent in failing to prepare a careful and detailed rescue plan or to have such a plan available. The rescue plan adopted by the master had no hope of success.

- The master was negligent in deciding to attempt retrieval of the casualty through the bunker door in the sea and weather conditions then prevailing, and with the obvious real risk of waves entering and destabilising the vessel.

- The master was negligent in his manoeuvring of the vessel in making his final approach to the casualty. Instead of adopting the standard method of approaching a man in the water by manoeuvring his vessel an appropriate distance upwind; stabilising it and then making leeway down towards the casualty, he went dangerously close too quickly and had the casualty alongside whilst the vessel still had way on, making it necessary to go astern. That led to the need to stop the bow thrusters and subsequently control of the bow was temporarily lost and it swung dangerously close to and above the casualty. The direct consequence of those negligent manoeuvres was that the casualty was faced with a significant change in the sea conditions that he had to cope with and, as a result, he drowned.

- The casualty's condition when first spotted was such that he would have survived for long enough to be rescued by either the other vessel's rescue craft or the helicopter. His death by drowning was caused by the change in conditions with which he was faced as the result of the ferry master's decision to try and retrieve him to the ferry and the manner in which he put that decision into effect.

Please refer to [2005]2 Lloyd's Rep.13 for the full report.

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