UK P&I CLUB

L P Bulletin

Friday 26 December 2008

Bulletin 616 - 12/08 - Man overboard fatality - Worldwide

The Australian Transport Safety Bureau (ATSB) recently published a report into a man overboard fatality. Given the likelihood of celebrations on board ship over the Christmas and New Year period, this bulletin explores the details of the safety investigation report, which found the crewmember had consumed alcohol and was fatigued due to a lack of sleep in the past twenty-four hours.

The full report can be downloaded from the ATSB website www.atsb.gov.au
Direct link: http://www.atsb.gov.au/publications/investigation_reports/2007/MAIR/mair246.aspx

The incident

The vessel was at sea and making way at the time of the incident. The crew had an evening barbeque and, despite a no alcohol policy, the master provided the crew with three cases of full-strength beer.

That evening the weather was pleasant and the ship was rolling gently up to about five or ten degrees to the southerly swell. By 0100 only an integrated rating (IR1) and the boatswain remained socialising. At 0300 they were met by the second integrated rating (IR2) who was conducting his rounds. The two IRs, who had been friends for many years, joked together for a few minutes before talking about the trip to Singapore and a possible stopover in Bali. IR2 suggested that they would be able to go swimming there. IR1 said, jokingly, 'Why wait? Let's go now!' and he pretended to vault over the ship's handrail.

At about 0310, as IR1 pretended to vault the rail, his movement was amplified by the ship's motion so that he overbalanced and fell over the port handrail and into the sea. Both IR2 and the boatswain saw IR1 overbalance and they reached out to grab him but were unable to prevent him falling overboard. After a search involving two ships and an aircraft, the missing seaman was never found.

▸ Analysis

Man overboard

It can be estimated that IR1 had consumed between ten and twelve cans of beer between about 1630 on 24 August and 0300 on 25 August. He was reportedly in good spirits when he jokingly pretended to vault over the handrail.

At about 0310, when he fell overboard, IR1 had only had about three hours of sleep in the previous 24 hours and he had not gone to bed in preparation for going on watch at 0400. An analysis of his work and rest hours suggests that he would probably have begun to experience the effects of fatigue.

At about 0230 the second mate thought that IR1 was a little unsteady on his feet when he passed through the wheelhouse. He was probably affected by fatigue and by his alcohol intake at that time. This, in turn, would have affected his judgement, resulting in his skylarking on the shelter

deck handrails in the first place, but also his ability to recover from overbalancing once he had started to fall over the railing.

Alcohol policy

It was the master's responsibility to enforce the management company's no alcohol policy and, while the ship was undertaking research voyages, he had apparently enforced it. However, for the voyage from Tauranga to Singapore, the master considered that it would be a pleasant trip without the hazards associated with the ship's normal operations. In violation of the company's 'no alcohol' policy, he purchased ten cases of beer for the voyage which he allowed the crew to drink at his discretion.

When the master provided the beer for the barbeque, he did not impose any limits on the number of cans that could be consumed by any individual crew member or a time at which they had to stop drinking. In fact, by providing 72 cans of beer for the barbeque, the master gave his tacit approval for the consumption of an excessive quantity of alcohol by some members of the crew. The master consumed about eight cans of beer himself before going to bed, a significant quantity of alcohol. Several other members of the crew also consumed a similar quantity.

The International Convention on Standards of Training, Certification and Watchkeeping for Seafarers, 1978, as amended 1995 (STCW95), details the obligations and requirements for safely maintaining watches on board a ship. Regulation VIII/1, 'Fitness for duty', includes the requirement that:

> '... the efficiency of all watchkeeping personnel is not impaired by fatigue and that duties are so organised that the first watch at the commencement of a voyage and subsequent relieving watches are sufficiently rested and otherwise fit for duty.'

Therefore, under STCW95, the master and the ship's officers have a 'duty of care' to ensure that the ship's watch-keepers are fit for duty. IR1 was scheduled to go on watch at 0400 but he had not rested after dinner. He had remained on the after deck drinking with other members of the crew. Neither the master nor the ships officers effectively monitored IR1 to ensure that he had stopped consuming alcohol and was adequately rested before going on watch.

While the safety management system included a 'no alcohol' policy, it was not consistently and effectively implemented on board the ship. Neither the master nor the ship's officers fulfilled their STCW95 'duty of care' obligations by ensuring that all of the crew were sober, adequately rested and fit for duty.

Use of the fast rescue craft

The ship had a muster list which detailed the personnel and their task allocation for launching the FRC. However, the crew launched the FRC very quickly after IR1 fell overboard and the boat was manned by the chief mate, the third engineer and IR2. It was lowered to the water by the master.

When IR1 fell overboard the master did not allocate tasks to the crew using the muster list as a guide. He chose to leave the second mate on the bridge while he lowered the FRC himself, a task which he did not practice at drills.

When the FRC was in the water, the chief mate, who did not usually operate the FRC, started its engine with the throttle set to run ahead even though the FRC had not yet been released from its hoisting wire. The sudden stop, when the boat's forward movement was arrested by the wire, caused IR2 to be thrown forward in the FRC where he broke his ankle.

While there was a need to respond to the situation very quickly, the hasty response of the crew bordered on panic. In their haste to launch the FRC, the master and crew undertook tasks that they had not regularly practiced. Furthermore, their near panic prevented them from effectively planning or executing their tasks.

For further information please contact:
Loss Prevention Department, Thomas Miller P&I Ltd
Tel: +44 20 7204 2307. Fax +44 20 7283 6517
Email: lossprevention.ukclub@thomasmiller.com