



PEOPLE P 002
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SIGNALS EXPERIENCES

Case studies for North of England Members

Heavy weather injury

A 36,000 GT container ship set sail from port at 1600 hours. By the following morning the ship was slow steaming in heavy weather and shipping water forward. The chief officer went forward to close some ventilators on the focsle, but was injured when a large wave broke over the bow.

What happened?

At 0600 hours the bilge alarm for the bow thruster space was activated. The master, who was on the bridge with the chief officer, called the chief engineer to the bridge to discuss the reason for the alarm. They were both concerned that the ship may have either hit something or suffered damage to a vent or sounding pipe. The master considered it too dangerous for anyone to attempt to access the forward part of the ship and with the bilge pumped out and the alarm reset they decided to further slow down and monitor the situation.

The chief officer remained uncommitted during the discussions on the bridge as he suspected that the reason for the alarm was that water was leaking through the bow thruster space ventilators, which he knew he had left open. He had reported all secure for sea to the master and intended to close the bow thruster ventilator flaps after his watch the previous evening but as the weather then was good and he was tired he went to bed deciding to close them the next morning.

It appears that he may not have been aware of the weather forecast and neither was the weather discussed with the master so by next morning the weather had deteriorated sufficiently to cause concern and for the ship to slow down.

Despite the master stating that it was too dangerous to send someone forward the chief officer decided to go to the focsle himself and close the vents rather than admit what had happened. He made his way forward using the underdeck passageway and went out onto the after end of the focsle to close the ventilators.

While he was closing the ventilator flaps a particularly large wave broke over the focsle. The chief officer was knocked over by the force of water and his leg was caught in a deck fitting and broken. He managed to get to the focsle intercom to raise the alarm and he was then rescued by the ship's emergency party.



What lessons can we learn?

Passage planning

The weather can kill! An absolutely fundamental element of passage planning is to assess the risk involved in a particular voyage and one hazard that will always be present is the weather. The master should have taken account of the weather reports when planning the passage of the ship so as to avoid the heavy weather if possible.

The monitoring of weather forecasts is a shared responsibility of all bridge team members. Part of the monitoring process once a voyage is under way is to continue to receive updated weather information and adjust the passage plan accordingly. Rather than be forced to slow down in bad weather it would be better to change the passage plan to avoid bad weather and so avoid subjecting the crew to additional risks and the ship to additional stresses.

Not following procedures

The safety management system will have a procedure for securing the ship for sea and access to the decks during heavy weather. Those procedures will be based on risk assessments that the ship operator is obliged to carry out for all hazards that are reasonably foreseeable.

Securing the ship for sea is a fundamental and basic element of the practice of good seamanship. It must be done prior to sailing and must not be postponed or overlooked. This should routinely include the stowing of loose equipment and mooring ropes, placing extra lashing on anchor cables if necessary, and closing ventilators in exposed positions.

WHAT DO THE REGULATIONS SAY? 

It is foolhardy, unless it is an emergency situation, to access the decks when a ship is encountering heavy weather. The master is responsible for the informal risk assessment of the actual heavy weather encountered and the decision on safe shipboard access under the particular circumstances. In this incident the chief officer by-passed these two safety procedures and his actions and the consequences demonstrate that vital safety procedures must be followed to reduce risk. An essential element of a successful safety culture is for all persons on board to understand the importance of following safety procedures.

Teamwork

Good teamwork demands that team leaders take their responsibilities seriously and that they are aware of the strengths and weaknesses of the other team leaders and members. There can be situations where key members find it difficult to 'lose face' to an extent that they overlook the fact that pursuing a course of action may endanger themselves or other members of the crew team.

The master (as team leader) should have a high awareness of the strengths and weaknesses of his team. During formal rounds of the ship or informal 'walkabouts' the master should become aware of how well the safety culture on board is working – perhaps there were signs that the chief officer was by-passing procedures that the master could have noticed.

Which regulations provide guidance?

ISM

Section 7 – Development of Plans for Shipboard Operations – requires that the Company establish procedures for the preparation of plans and instructions, including checklists for key shipboard operations. The securing of a ship for sea at the beginning of a voyage would be such a key operation.

ICS

The Bridge Procedures Guide published by the International Chamber of Shipping provides detailed guidance for bridge operations. Part B of the Guide includes a checklist – B2 Preparation for sea – which requires a report that all hull openings are secured and watertight or weathertight as appropriate.

Your experiences

If you have had an experience that would be useful to share as a Signals Experience on an anonymous basis please contact the Risk Management Department and let us know.

Previous experiences

Previous Signal Experiences can be viewed and downloaded from the Risk Management pages of the North of England website.

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