Marine Safety Investigation Unit

Transport Malta

SAFETY INVESTIGATION REPORT

201108/001 REPORT NO.: 08/2012 July 2012

MV KAIE
Fatality of crew member
In position 57° 48' 40"N 009° 50' 40"E
05 August 2011

SUMMARY

At 2225 on 05 August 2011, an able seaman (AB) fell down the staircase in the accommodation of the Maltese registered general cargo *Kaie*, while navigating the Skagerrak Strait. He was given first aid by the crew members, but eventually passed away the following day.

The investigation identified that the AB almost certainly fell down the staircase because he was under the influence of alcohol. It was also established that the 'no alcohol' policy was not consistently and effectively implemented on board the ship.

The analysis of the available information suggested lack of manifestation of a safety climate on board the ship, which did not reflect the spirit of the company's safety policy as intended to be implemented on board the ship.

The company has transmitted a circular on the subject matter on all vessels under its management and ensured that the matter was discussed with all the masters and crew members. One recommendation has been made to the ISM managers.

MV *Kaie*

FACTUAL INFORMATION

Vessel, crew, and environment

Kaie, is a 2374t general cargo vessel, was built by Ferus Smit, Foxhol, Netherlands in 1990 and is registered in Malta. She was owned by Hansa Shipping Ltd., managed by Hansa Ship Management OU, and classed with Germanischer Lloyd. The vessel had an overall length of 88.25 m and a beam of 13.17 m.

Kaie had one hold and two hatch covers, was ice-classed and engaged in international trade. At the time of the accident, she had a crew of eight, being Russian, Estonian, and Ukrainian nationals. The vessel was manned in accordance with the Minimum Safe Manning certificate. The working language on board was English although safety management system documents were available to crew members in Russian and English.

The deceased crew member was a 47 year old Russian national. He held an able seamen certificate issued by the Estonian authorities. He had also successfully completed the necessary courses of the basic safety training in accordance with the relevant sections of the STCW Convention. Since 2007, the AB had sailed on five ships prior to joining *Kaie* on 28 May 2011. The crew member was signed on as an AB / welder for a period of 4 ± 1 month. He was assigned the 0400 – 0800 and 1600 – 2000 watches in the bridge management team.

The accident happened at about 2225. The weather conditions were overcast with moderate swell. Visibility was also moderate at about five nautical miles. Outside air temperature was 18°C.

Narrative

On 04 August 2011, at about 2100, *Kaie* left the port of Wismar, Germany in ballast bound for Espevik in Norway. Until the time of the accident, the voyage was uneventful. During the night of 05 August, one of the engineer officers was woken up by a loud thud. The noise came from outside his cabin on the starboard side of the crew accommodation under the staircase leading from the boat deck. Upon investigating, he found one of the ABs lying down across the alleyway.

Seeing this, the engineer walked the length of the alleyway and approached the bosun and one other crew member and requested the bosun to follow him. The engineer led the way through the alleyway to where the AB was lying on the deck on his right side (figure 1). It was evident that the crew member was seriously injured. He was immediately assisted by two of the crew members while the other called the chief officer. They were later joined by the master who left the bridge after he was relieved by the chief officer.

The master assessed the situation. The injured crew member was unresponsive to calls from his colleagues. There was a strong smell of alcohol to the extent that the crew members were unaware whether or not the AB was unresponsive due to the fall or the effect of the alcohol.

The injured crew member was carefully transferred to another part of the alleyway (figure 2).

Figure 1: The AB was found lying down at the bottom of this staircase

The master requested that the injured crew member remains monitored. Being assured

by the other crew members that AB will be feeling better after the night, the master decided not to radio for medical assistance. In this respect, the vessel continued on her voyage.

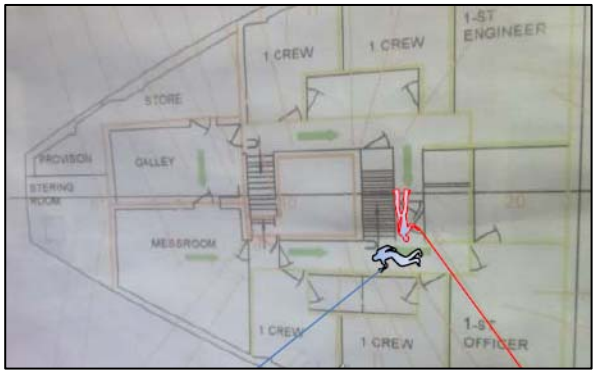

Figure 2: The blue figure indicates the position in which the AB was found lying down at the bottom of this staircase. The red figure shows the area where he was initially transferred

The crew members took turns to stay at the side of the crew member. During the day, *i.e.* hours after the accident, the smell of alcohol remained very strong. It became evident that the crew member would not be fit for duty. Until 0600, his pulse remained stable and his pupils responded well to light. However, at about 1000, the crew member's medical condition took a turn for the worse and he eventually passed away.

Autopsy report

The autopsy carried out in Norway revealed that the crew member sustained head injuries as a result of a fall (blunt trauma). It was also concluded that the crew member was suffering from alcohol intoxication at the time of death.

ANALYSIS

Fall inside the accommodation

The fall of the crew member was not witnessed by any of the crew members. However, the way he was found at the bottom of the staircase and the noise which was heard by one of the crew members just outside his cabin, left no doubt that the crew member had fallen down the staircase. It is probable that the crew member had just returned from the open deck where he had been smoking.

'No alcohol' policy

At the time of the accident, the ISM managers implemented a strict 'no alcohol' policy on board *Kaie*. Consequently, the vessel was operated as a 'dry ship' with no alcohol consumption permitted on board.

The company's main concern was safety related and by enforcing the (drug) alcohol policy, it wanted to ensure that all crew members will be able to respond to any emergency and at any time. It was the master's responsibility to enforce the company's policy. Moreover, all crew members signed a declaration in this respect and were therefore aware that a breach of the alcohol policy at any time on board would have led to immediate dismissal.

Although it was the master's responsibility to enforce the 'no alcohol' policy, it does not appear that this was being done in an effective way. On several other occasions the AB was noticed to be intoxicated and smelt of alcohol. The crew members claimed that alcohol was inaccessible on board because of the 'no alcohol' policy; however, it was recalled that the crew member used to go ashore on his bicycle. On at least one occasion, his breath smelt of alcohol.

It was not excluded that since no alcohol was available on board, the crew member had access to alcohol ashore at the vessel's last port of call. The fact that the accident happened in open seas was also indicative that the alcohol was consumed on board, possibly inside the cabin. Thus, whilst the safety management system included a 'no alcohol' policy, it was not consistently and effectively implemented on board the ship.

This also implied that neither the master nor the ship's officers fulfilled their obligations to ensure that all crew members were fit for duty at all times.

The staircase

An inspection of the staircase where the accident happened did not reveal any structural defects that could have contributed to the fall in a direct or indirect way.

Figure 3: The lower horizontal part of the door frame

It was not excluded, however, that the crew member could have tripped in the lower horizontal part of the door frame (figure 3). It was also considered possible that the rolling of the ship in the swell may have also contributed to the fall.

Shore medical assistance

The master arranged for several of the crew members to attend the injured AB on a roster basis, until he would have been in a position to resume his duties. Reassured by the crew members that the AB would feel well again, the master did not seek shore medical assistance. On the basis of the preliminary examination of the AB by the crew members, it did not transpire that medical assistance was necessary.

It is acknowledge that the crew members neither had the skill nor the knowledge to assess the medical condition of the injured AB although first aid was administered. The indication of alcohol abuse seemed to have 'diverted' the attention of the crew members to the issue of intoxication from the internal physical injuries sustained following the fall down the staircase. It was expected that after some hours of rest, the effects of alcohol would have subsided. To this extent, it was not deemed necessary to radio for medical help immediately after the accident.

The master's leadership style

The influential role that any master has on board a ship cannot be overstressed. The master's (important) role on board has two components; a managerial one and leadership – and there is a clear distinction between the two.

As far as management is concerned, the master was responsible to ensure that the needs of the ship (and eventually the entire organisation) are met. However, the human component is led, and this was where his leadership skills had to be influential.

In his capacity of a leader, the master had the potential to influence the organisation on board the ship. The influence, which the master can have on board, enables him to create cultures. In so doing, however, there needs to be a general focus on the greater organisation and its goals enshrined in the safety management system.

The issue of alcohol was not limited to this one particular case only, which eventually resulted in the death of the crew member. (One crew member recalled that on one occasion, the master ordered that the crew member is relieved of his duty on the deck after it was suspected that he was intoxicated. The master had joined the ship on 03 May 2011, *i.e.* several weeks before the AB).

It did seem that the master was aware that there was a problem with the enforcement of the company's 'no alcohol' policy. It

was precisely on this basis of this matter that one had to review the master's leadership approach on board *Kaie*.

Further to being responsible to enforce the company's 'no alcohol' policy, the master had to articulate that policy, especially if there was a clear indication that it was not being respected. It was in actual fact a value, which he had to ascertain that all crew members believed in – even by virtue of the potential hazards which this could have created on board.

Since the issue of alcohol was not a one-off case, the crew member (for whatever reason – medical or otherwise), did not subscribe to the company's policy. There was, however, no evidence, which suggested that the matter was being eloquently addressed on board.

It has to be remarked, however, that the master did not have the necessary knowledge and skills to address potential psychological complex issues similar to this one. It was therefore here that company's support would have become crucial.

The company was unaware that this was actually the second incident of alcohol abuse since the first occurrence was not reported to the managers ashore[1]. Therefore, this situation not only led to lack of enforcement, but it had also deprived the company from providing the necessary support to the master.

Leadership and safety management system

The master's leadership style and effectiveness is amalgamated with the safety management system and have to be seen from a holistic perspective. This is so because the master's leadership played a vital role in meeting the strategic needs of the organisation. This being the case, it has to be remarked that safety management is part of the strategic policy of any shipping organisation.

The strategic management influenced the organisational climate and therefore shaped the (social) environment on board the ship. The link to safety climate and strategic management (and therefore safety management) was the social environment.

The safety climate on board depends on the social environment and whilst the company strived to ensure that safety was a value, certain decisions on board may have contradicted the company's safety philosophy. The decision of the master to hold to the situation described above was one such manifestation[2].

In view of the (individual) approaches taken on board in addressing this situation, it may be stated that there was a lack of tangible manifestation of an underlying safety climate.

CONCLUSIONS

1. The crew member may have tripped in the lower horizontal part of the door frame, falling down the staircase after returning from the open deck where he had been smoking;
2. It is probable that the rolling of the ship in moderate swell could have contributed to the fall of the crew member;
3. The master did not effectively enforce the company's 'no alcohol' policy;

[1] The company had also researched the history of the crew member (since this was his first contract). However, no records of alcohol abuse were identified.

[2] This does not necessarily mean that the crew members are exonerated from the task. It has to be remarked that evidence does not indicate that crew members discussed any possible actions with the master.

4. The crew member had access to alcohol ashore at the vessel's last port of call;
5. The lack of commitment towards the company's 'no alcohol' policy matter was not being eloquently addressed on board the ship;
6. The company was inhibited from providing the necessary support to the master in his role as an enforcer of the company's 'no alcohol' policy;

SAFETY ACTIONS TAKEN DURING THE COURSE OF THE SAFETY INVESTIGATION[3]

An internal memorandum has been circulated on board all ships under the management of Hansa Ship Management OU. All serving masters have been requested to raise and discuss the matter with their respective crew members.

RECOMMENDATIONS

Hansa Ship Management OU is recommended to:

08/2012_R1 ensure that the Alcohol and Drug Policy is consistently and effectively implemented and continuously monitored by company senior management and vessels' management.

[3] **Safety actions and recommendations should not create a presumption of blame and/or liability.**

SHIP PARTICULARS

Vessel Name:	*Kaie*
Flag:	Malta
Classification Society:	Germanischer Lloyd
IMO Number:	8906298
Type:	General Cargo
Registered Owner:	Hansa Shipping Ltd.
Managers:	Hansa Ship Management OU, Estonia
Construction:	Steel
Length Overall:	88.25 metres
Registered Length:	86.33 metres
Gross Tonnage:	2,374
Minimum Safe Manning:	8
Authorised Cargo:	In ballast

VOYAGE PARTICULARS

Port of Departure:	Wismar
Port of Arrival:	Espevik
Type of Voyage:	International
Cargo Information:	In ballast
Manning:	8

MARINE OCCURRENCE INFORMATION

Date and Time:	05 August 2011 at 2225
Classification of Occurrence:	Very Serious
Location of occurrence:	Skagerrak Strait
Place on board	Accommodation space
Injuries / fatalities:	One fatality
Damage/environmental impact:	None
Ship Operation:	In passage
Voyage Segment:	Mid-water
External & Internal Environment:	Overcast with moderate swell. Artificial lighting inside.
Persons on board:	8