

## SYNOPSIS



On 29 September 2007, three seamen on board the ERRV *Viking Islay* lost their lives as a consequence of entering an enclosed space. The ERRV *Viking Islay* was working in the North Sea conducting rig support operations when two of the vessel's seamen went forward with the intention of securing a rattling anchor chain within the chain locker. One of the seamen entered the chain locker and collapsed. It is probable that the other seaman, realising that help was urgently required, raised the alarm with the duty watchkeeping rating on the bridge before he, too, entered the chain locker in an attempt to help his companion. He also collapsed.

During the consequent rescue efforts, the first rescuer found he was unable to enter the chain locker wearing a BA, and he therefore donned an EEBD. He entered the space, but at some point the hood of the EEBD was removed, or became dislodged and this rating also collapsed.

All three seamen died as a result of an oxygen deficient atmosphere within the chain locker.

The MAIB's investigation has concluded:

- The oxygen deficient atmosphere within the chain locker was caused by natural on-going corrosion of the steel structure and anchor chain within the space.
- The crew of *Viking Islay* failed to recognise the chain locker was a potentially dangerous enclosed/confined space, or the likelihood that the atmosphere within the space could become oxygen deficient over time. Consequently, well established permit to work measures were not considered before the space was entered.
- Training and subsequent drills in the use of EEBDs had not been sufficient to ensure the limitations of the equipment were recognised in an emergency.
- The ship manager's company policy on entry into enclosed spaces was not clear and did not take into account scenarios that could require crews to enter confined spaces while at sea. A further consequence of this was that gas monitoring equipment supplied to the vessel was unsuitable for ensuring safe entry into enclosed spaces.
- The audit regime employed by the ship's managers to ensure compliance with its SMS failed to detect deficiencies in training, equipment and safety culture on board *Viking Islay*.

The ship manager has taken action to address many of the safety issues identified during the investigation. However, recommendations have been made to Vroon Offshore Ltd and the Maritime and Coastguard Agency on the promulgation of additional information to highlight limitations on the use of EEBDs and improvements in the training given to mariners in the use of this type of equipment.