SYNOPSIS

This accident was notified to the Marine Accident Investigation Branch (MAIB) by P&O Stena Line by telephone on Thursday 12 November 1998. The investigation started on Monday 14 November and was undertaken by Mr A Rushton.

P&OSL Kent is a 20,446 gross tonnage passenger/roro cargo/ferry operating a regular ferry service between Dover and Calais. She is registered in Dover, UK and is managed by P&O Stena Line Ship Management Limited, UK. The vessel is fitted with bow and stern doors and is capable of carrying 525 cars and 1825 passengers.

The vessel completed loading at Calais at 1724, left the berth at 1735 and proceeded on passage for Dover. After full away was rung, the engine room staff gathered in the engine control room for a cup of tea. At about 1800, a third engineer left the control room to work in the generator room, followed shortly afterwards by the fourth engineer. On approaching watertight door No 6, the fourth engineer found the donkeyman trapped vertically in the door. He released the man, and summoned help.

At 1806 the engine room reported to the bridge that a motorman had collapsed unconscious in the engine room and that assistance from the first aid team was required. Meanwhile, in the engine room, resuscitation procedures were being carried out on the donkeyman by the engine room staff. The chief engineer was informed and, in turn, informed the master. Once the seriousness of the situation became known, the vessel's speed was increased and discussions held on the advisability of helicopter evacuation. Passenger medical assistance was sought and a doctor and two nurses attended at 1815. Resuscitation procedures continued until, at 1830, the doctor stated the donkeyman was dead.

Only later did it become known that the donkeyman had been trapped in the watertight door. Apart from the fourth engineer, everybody had only seen the donkeyman lying on the floorplates. The operation of the watertight door was checked and confirmed as being in working order. At the time of the accident the watertight door system was in "Local Control" mode. (closed but could open, and would stay open in position selected by control handle ie not automatic closure).

The watertight door system fully complied with the regulations, and was regularly maintained. All crew members using the doors were trained in their correct usage.

The cause of the accident was a failure on the part of the donkeyman to follow the correct operating procedure for power operated watertight doors. Contributory causes were a possible trip at the doorway, hitting his head on the steelwork and falling forward onto the operating handle causing the door to close, carrying bag of salt on his shoulder, and not fully opening the door before attempting to pass through.

Recommendations are aimed at re-assessing the recommended door operation procedure when using "Local Control" mode on a type "B" watertight door.