SYNOPSIS

This accident was notified to the Marine Accident Investigation Branch (MAIB) by the Maritime Rescue Sub-Centre SOLENT at 0141 on Tuesday 28 July 1998. The investigation started later the same day and was undertaken by Mr A Rushton.

Pride of Le Havre is a 33,336 gross tonnage passenger/roro cargo vessel operating a regular ferry service between Portsmouth and Le Havre. She is registered in Portsmouth, UK and is managed by P&O European Ferries (Portsmouth) Limited The vessel is fitted with bow and stern doors and is capable of carrying 590 cars and 1600 passengers. Propulsion is by four diesel engines driving through two controllable pitch propellers. Two transverse thrust units are fitted forward.

The vessel completed loading at Le Havre at 2202, left the berth at 2211 and proceeded on passage for Portsmouth. At 2218 when passing the outer breakwater, the vessel suffered a "black out" with apparent loss of all main and auxiliary power. The main engines were not affected and the vessel retained manoeuvrability. Port Control was advised and tug assistance requested. The master was told of injuries to three engine room personnel and that a first aid party was required. Electrical power was restored at 2225 with the chief engineer reporting a fire in the engine control room. The crew alert was sounded and fire parties were sent to the engine room. The fire was reported out at 2238. Due to the serious nature of the injuries, medical help was sought from qualified passengers.

The vessel steamed south of the main approach channel while arrangements were made to return to port and for a medical team to board from the pilot boat. With two tugs attending, the vessel re-entered the harbour and berthed at 0024. The three casualties were then landed ashore by ambulance. Following a full assessment of the situation and the testing of all primary systems, the vessel sailed for Portsmouth at 0150. At 0712 the vessel arrived at Portsmouth where all passengers and vehicles were disembarked. The vessel was then taken out of service and moved to a lay-by berth to await examination and repair.

The explosion is considered to have been caused by a direct connection being made between two phases of the 660volt incoming supply. Contributory causes include the use of non-company issue test equipment and entangled test leads.

Recommendations are aimed at improving electrical safety by using fused test probes together with tighter company control over the use of non-company issue test equipment.