MAIB

MARINE ACCIDENT INVESTIGATION BRANCH

FLYER TO SHIPPING INDUSTRY

SPRUCE: INTER-DEPARTMENTAL FLEXIBILITY – ENSURE THE CREW ARE PROPERLY TRAINED

At 1718 UTC, on 06 March 2006, the cook of the LASH vessel *Spruce* sustained serious injuries to his left leg and left pelvis as the result of a fall of 6m from the ship's deck into the empty barge hold. These injuries required several operations and it was 6 weeks before he was fit enough to be repatriated. It was estimated that it would be an additional 6 months before he would be fit to return to work onboard ship.

The incident occurred at mooring standby while some of the crew were recovering the portable gangway prior to letting go. The cook was assisting in this operation, after which he had been tasked to assist with unmooring operations on the forecastle even though he was not trained for working on deck and he had little experience of doing so.

The operation to recover the gangway was labour intensive; five members of crew were used to manhandle the gangway up the side of the vessel to the main deck where the stowage position was located. The vessel was originally fitted with a method of retrieval for a fixed gangway, but this had been cropped and removed a number of years previously for an unknown reason.

The deck personnel required by the vessel's Minimum Safe Manning Certificate (SMC) (master, 3 officers and 3 deck ratings) were insufficient for mooring operations, gangway handling and other tasks. It was necessary for the cook and the steward (who were not included on the SMC) and motormen to assist on deck at times of peak workload. The flag administration was unaware of this fact when it determined the level of minimum safe manning on *Spruce*.

Inter-Departmental Flexibility is a manning concept that is recognised by some individual flags but which is not defined by the International Maritime Organisation in its Standards of Training, Certification and Watchkeeping (STCW) Code.

Safety Issues:

- Where a form of Inter-Departmental Flexibility is operated, the flag administration should be made aware and full relevant training must have been given to all the personnel involved. Personnel who are insufficiently trained are a burden on their colleagues and a danger to themselves and all involved.
- The accident could have been prevented had the Company ISM system been operating effectively. It is highly probable that a number of very similar near miss incidents will have occurred previously but the senior officers, the safety committee and the company were not fully aware of the risks.
- Whenever changes are made that affect the vessel's working procedures, as in this case when the fitted gangway retrieval system was removed, a new assessment should be conducted to ensure unacceptable risk has not been created.
- This accident highlights the essential need for flag administrations to be aware of operational idiosyncrasies and any special requirements when determining the levels of minimum manning to be included on the Safe Manning Certificate.

Further details on the accident and the subsequent investigation can be found in the MAIB's investigation report, which is posted on its website:

www.maib.gov.uk

Alternatively, a copy of the report will be sent on request, free of charge.

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