KISH P&I CLUB

موسسه متقابل کیش

KISH P & I LOSS PREVENTION CIRCULAR KPI-LP-08-2012

(Karin Schepers Grounding & Lessons to be Learnt)

Summary :

At 0536 on 3 August 2011, the container vessel Karin Schepers grounded on the Cornish coast while on passage from Cork, Ireland to Rotterdam, Netherlands. At 0323 the master

relieved the second officer as the officer of the watch, and he fell asleep a short time later. No lookout was posted, and with no one alert on the bridge the vessel continued for over 2 hours, crossing the Land's End Traffic Separation Scheme before grounding close to Pendeen Lighthouse, West Cornwall, England.

The vessel was undamaged, and the crew were able to refloat her on the next rising tide.

The master had been the 8-12 watch-keeper, and at midnight had handed over the watch to the second officer. However, the master returned to the bridge at regular intervals after midnight, sounding increasingly intoxicated until eventually he ordered the second officer from the bridge. Shortly after this, the master, alone on the bridge fell asleep.

When Karin Schepers was 2 miles from land, the coastguard at Falmouth Maritime Rescue Co-ordination Centre was alerted to its location and attempted, unsuccessfully, to contact the vessel. Lifeboats, a SAR helicopter and a cliff rescue team were all mobilised before the vessel grounded. The master eventually responded to the coastguard after the vessel was aground and advised them that the crew were all safe and that the vessel would be refloated by de-ballasting. After 50 minutes being aground, Karin Schepers refloated and resumed passage under her own power.

Additional safety barriers, which could have helped to mitigate the risk posed by the master falling asleep, were not in place; there was no lookout on the bridge throughout the night, and the bridge navigational watch alarm system was not switched on. The audits of the vessel's safety management system had failed to detect that these important safety requirements were being ignored on board or that measures designed to prevent the unsafe watch-keeping practices on their vessels were ineffective.

Narrative:

Karin Schepers arrived in Cork from Rotterdam at 0720 on 1 August 2011. The vessel was operating on a regular feeder container liner service between Irish ports and Rotterdam.

The vessel shifted berth twice during the day and ceased cargo operations at 1645.

She remained alongside overnight, during which time the master, who did not keep a watch in port, had an unbroken night sleep.

Cargo operations resumed at 0900 on 2 August and completed at 1800. A pilot boarded at 1950 and the vessel sailed out at 2000 bound for Rotterdam. The master and chief officer were on the bridge with the pilot, who steered the vessel out of harbour using the autopilot. The pilot disembarked at 2115.

At 2120, Karin Schepers began her sea passage; the course was set to 135º on autopilot towards the Land's End Traffic Separation Scheme (TSS). The master was the 8-12 officer of the watch (OOW).

The chief officer, who was the 4-8 OOW, had remained on the bridge following his watch in order to compile a list of the dangerous cargo the vessel had loaded. This information was required when reporting to the coastguard on entry to the various TSS the vessel would encounter during the passage.

Just before midnight, the second officer came to the bridge to take over as the 12-4 OOW. The chief officer completed the dangerous cargo list and left the bridge.

The master handed over the watch to the second officer and left the bridge. No lookout was posted and the bridge navigational watch alarm system was not switched on.

At 0022 the master returned to the bridge and turned on a music compact disc player. He sat on one of the bridge chairs in front of the radars and the second officer occupied the other chair. The two men had a general discussion, in English.

KISH P&I CLUB

Over the course of the next 2 hours the master left the bridge at intervals but returned each time after about 10 minutes.

At 0323 the master ordered the second officer to leave the bridge.

At 0426 Karin Schepers reached her planned alteration of course position at the entrance to the south-bound lane of the TSS. However, the vessel did not alter course and continued on a heading of 135º, at 16.6 knots, as she crossed the north-bound lane of the TSS, passing within 2 miles of a vessel in that lane at 0456 .

At 0525 Karin Schepers was 2 miles from land when an unidentified vessel called her on VHF radio to advise her to check her position. No response was made to this call. Alerted by this call, the coastguard at Falmouth MRCC made a number of attempts to contact Karin Schepers on VHF radio, Medium Frequency radio and satellite telephone. These calls were audible on the bridge of the vessel, but the master did not respond.

Karin Schepers began to vibrate heavily as she entered shallow water, the satellite telephone continued to ring, and numerous bridge alarms sounded as the vessel grounded at 0536.

At 0538 the master woke up and the propeller pitch was set to zero. The chief officer arrived on the bridge, asked the master what had happened, and was told “nothing”.

Environmental conditions :

At the time of the accident the wind was light airs with a calm sea.

Morning twilight began at 0520 and sunrise occurred at 0654 (UTC+2).

The tidal stream off Land’s End at the time of the grounding was northerly at 2 knots.

Previous accidents :

On 22 March 2009, Karin Schepers grounded in Danish waters while on passage from Finland to the UK. The Danish Maritime Authority (DMA) investigated the accident and published a report, which concluded that the grounding of KARIN SCHEPERS was caused by the following:

• The chief officer was incapacitated due to intoxication.

• The chief officer fell asleep during his watch.

• There was no look out on the bridge.

• The Bridge Navigational Watch Alarm System was off.

• No crewmembers reacted on the various attempts to draw attention to the dangerous path the ship was taking.

Probable Causes in the recent Grounding :

A) Fatigue:

Master fell asleep after he had ordered the second officer to leave the bridge. It is probable that he was sedated, which would have contributed to his fatigue.

Analysis of the master’s rest periods shows that there was a high risk of a fatigue problem despite having slept well for the entire previous night, when the vessel was alongside in Cork. He was aware that Karin Schepers would sail out that evening, but did not take the opportunity to rest during the day. He remained on the bridge at midnight, at the end of his watch, even though Karin Schepers was in open water and the second officer was a qualified OOW who was familiar with the vessel.

The effects of fatigue include slow reactions, slips, and lapses in decision-making.

Any type of intoxication exacerbates these effects. VDR records indicate that he became progressively more tired and displayed more signs of intoxication, ultimately becoming physically abusive to the second officer before ordering him down & consequently falling asleep; alone, on the bridge.

After that second officer had been ordered from the bridge by the master, he did not seek advice from another senior officer on board before going to bed, although he was quite sure that the master is not fit to follow the watch-keeping duties. The fact that the second officer did not do this suggests a lack of an effective crew resource management structure on board the vessel.

B) Look-out :

No lookout was posted when Karin Schepers entered and departed port, or during the hours of darkness. This appeared to be the master's normal operating practice. The requirement to have a lookout posted during the hours of darkness, in addition to the OOW, is widely promulgated and was included as an owner's instruction to the master in the vessel's Safety Management System (SMS). By failing to require a look-out to be posted; the safety of the vessel, her crew, and the environment were placed at risk.

The fact that the owner was unaware that lookout was not routinely used on board indicates weakness in the owner's ability to monitor the on-board application of the vessel's SMS. The effectiveness of a SMS relies on a robust audit procedure in which the owner actively engages to ensure company procedures are being followed.

Where the presence of a company representative is likely to alter the normal operating methods employed on board, consideration should be given to the routine examination of on-board records, including VDR recordings and to audit compliance with the SMS.

C) Bridge Navigational Watch alarm System :

The BNWAS is a system designed to ensure that the OOW remains alert by activating an alarm sequence at set intervals. This sequence will usually consist of a flashing light, followed by an audible alarm that requires acknowledgement on the bridge in order to reset the system. In the event that this went unacknowledged, an audible alarm would sound in selected cabins and, if this also went unacknowledged, the general alarm would be activated, alerting the entire crew.

A BNWAS was fitted on Karin Schepers but it was not turned on at the time of the accident, and evidence indicates that it had not been used for several months.

Use of the BNWAS was routinely not required by the master. By deciding not to use this important safety device; the vessel, crew and environment were placed at an increased level of risk in the event that the OOW became incapacitated. The importance of the BNWAS as a safety barrier has been recognised by the IMO, which introduced mandatory carriage requirements for the equipment, on a rolling programme, from 1 January 2011.

The failure to use the BNWAS is another indication that the vessel's SMS was ineffective. It is important that audits are robust and of sufficient scope to provide evidence that companies' SMS procedures are being complied with at all times.

Lessons to be Learnt:

1- The SMS procedures as well as international requirements were not followed properly. Especially the hand-over procedure was not followed as per the Bridge Procedure Guide and other best management practices.
2- Look-out as a very vital part of watch-keeping was not maintained. The presence of a watch-man as an aid to the OOW could have avoided the incident.
3- The equipments required by the regulations were not properly used and intentionally neglected.
4- The company management & audit as a supervision tool were not carried out as appropriate; focus areas were not looked into nor any practical measures were taken to avoid recurrence of the same types of incidents. Having had a similar grounding accident on the very ship with the nearly the same root causes renders very important parts of the SMS inefficient.

KISH P&I CLUB

KPI Loss Prevention Team

June 2012