

It could never happen to me – could it?

How confident are you that you *really* do know how well the Safety Management System is working on board your ships?

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As year 2006 opened I was optimistically looking forward to another year when ships would continue to become safer and our seas cleaner. Alas, the first document I read in 2006 was the report which had just been published by the United States Coast Guard of the Investigation into the Explosion and Sinking of the Chemical Tanker ‘*Bow Mariner*’ in the Atlantic Ocean on February 28, 2004 with Loss of Life and Pollution.¹ This brought great sadness at a number of levels; utter sadness at the loss of life of another 21 seamen and their ship. Sadness at the pollution. Sadness, frustration and maybe even anger in the knowledge that that the incident could almost certainly have been prevented. Sadness that the safety management system which should have been in place to protect the seafarers, their ship and the environment was not being implemented properly and, as a consequence, let them down. Sadness that no-one seems to have picked up that things were going seriously wrong on board ‘*Bow Mariner*’ before the bubble finally burst. But there was another level of sadness – that the reputations of two highly respected names in the ship owning and ship management world were seriously damaged as a result of the report which exposed a safety management system which was not being managed.

I will return to some of the findings in the *Bow Mariner* USCG Report later in this article - but before doing so I will say that whilst I was saddened that this ship was owned and operated by highly respected organisations – I was not particularly surprised. The fact that I was not surprised is cause for concern. I am not now talking about the specific ship owner or ship manager involved in the *Bow Mariner* but rather to a phenomenon I am encountering generally and far too frequently. I am regularly involved in investigating casualties, cargo damage and personal injury incidents where it becomes apparent that the office ashore believes that the SMS is working perfectly well but, in fact, there are serious problems in the actual working of the systems on board. The phenomena has manifested itself within large, very well known, and highly respected, organisations as well as much smaller ship operators. It has appeared in older ‘traditional’ companies as well as new players in the market.

In research I undertook in the period from year 2000 to 2002² it became quite apparent that often the perceptions of whether ISM was working varied considerably between those working on board ship and those working in the office ashore. When I saw this tendency clearly reflected in many of the investigations I have been involved in I was obliged to explore certain issues in more detail. Invariably, a good set of Procedures Manuals existed, Internal Audits had been undertaken, on paper at least,

¹ The full report can be accessed as a pdf document at <http://www.uscg.mil>

² Published as ‘Cracking the Code – The relevance of the ISM Code and its impact on shipping practices’ – The Nautical Institute 2003 – ISBN 1 8700 77636

and often impeccable records had been maintained, with all the correct boxes neatly ticked – and glowing reports were prepared for the annual meeting of the Company directors. However, in spite of all that the people on board were not actually following the procedures of the SMS. Instead of it being a useful management tool, the SMS was perceived to be an unnecessary and unwanted burden which was creating a considerable amount of extra work with little or no tangible benefit. The problem was often much more than a simple matter of communication it would frequently point towards a lack of leadership and of team work on the ship and ashore.

When I have investigated the problems I am sometimes led to fairly clear cases of inadequate leadership, poor management and similar matters which have led to behavioural and motivational problems. Sometimes though the explanation has been quite surprising. One such surprise was rooted in either self preservation or pride – depending upon the severity of the problem. What I have observed, on a number of occasions now, is a Designated Person (D.P.) for the Company being fiercely protective of his or her SMS. Usually the particular individual D.P. had been personally involved in the writing of the Procedure Manuals. Often a considerable amount of money had been invested in setting up the original SMS and in maintaining it on an annual basis. Unfortunately, it happens that the D.P. can lose objectivity when assessing the performance of his / her ‘baby’. It can be very, very difficult to accept sometimes that there may be quite serious flaws in the System; that the system is not providing any payback and is basically an inappropriate or inadequate system.

For a number of years now we have banded around little phrases like ‘no-blame culture’ and, more recently, ‘fair’ or ‘just’ culture – usually directed at those on board the ship trying to encourage them to overcome what is probably a very natural self preservation instinct and confess, or rather report, their non-conformities, hazardous occurrences and near misses – all in the belief, and I believe in this implicitly, that we can learn very important lessons from such incidents and thus take remedial action before a full scale accident occurs. However, what about the Designated Person – or indeed the line managers – do they believe what they say about ‘no-blame culture’? Do they really live and work in such a culture? How comfortably are they, really, to approach the Chief Executive and the Board and declare that the Safety Management System they spent two years developing at a cost of \$80,000 in external consultants fees actually doesn’t work! That what is required is a new, simplified system with much less paperwork and a greater investment in bringing the Masters, Officers and all Crew members into active, participatory, roles within the SMS. I am sure there will be some good Chief Executives who will be prepared to listen – although no-doubt would expect a clear explanation of why the present system was not working as it was intended, a cost benefit analysis and a clear plan and budget for the development of a new system. Certainly they would see the folly of also losing an individual who has gone along what was a very expensive learning curve – his or her mistakes have been made but valuable lessons have been learnt. Now is the time to accept what has happened and move forward; it is definitely not the time to shoot oneself in the foot! However, I can also very well imagine a very different scenario where the situation would be swiftly dealt with by replacing the no doubt allegedly ‘incompetent’ D.P. with another who can make the existing system work. Such a reaction will almost certainly lead to further inefficiencies, losses and possibly loss of lives, personal injuries, pollution, loss of ships, damage to cargo and other losses for which the ship operator may not be insured.

A related issue which had puzzled me when I investigated many of these incidents was how the ships, and indeed the office ashore, had managed to continue with the deficiencies in their SMS being undetected. Surely the Flag State Administration or Recognised Organisation auditors and inspectors would have picked these things up during external audits? Surely Port State Control Inspectors would detect that the Systems were not working properly when they attended the vessels? The reality is that the audits and inspections tend to be somewhat superficial and often restricted to ensuring that certain paperwork has been completed properly. They are also, because of the limited time available, sample audits. It would appear that enough can be done to make sure that the paperwork is sufficiently in order to ensure that the office receives its Document of Compliance (DOC) and the ship its Safety Management Certificate (SMC). Enough can be done to convince the PSC inspector that he / she does not need to delve any deeper into the working of the systems. However, lying beneath the façade there lurks an inefficient and inappropriate system which may be managing the paperwork but is not managing safety.

Returning now to the report on the Bow Mariner I will flag up where there were probable weakness in the SMS, what went wrong, why it probably went wrong and what could perhaps have been done to detect the problems before it became such a tragic accident. However, it is also important to recognise that in undertaking this analysis my knowledge of what was going on, on board Bow Mariner and in the offices of the managers, is limited to that set out in the USCG Report. Where I speculate I will say so.

The Bow Mariner was lost off the Atlantic Coast of the USA on 28 February 2004, after a huge explosion tore through the vessel. The explosion caused catastrophic structural damage and led to immediate flooding of nearly the entire cargo area.

The ship sank after an hour and half with the loss of 21 lives and spilling ethyl alcohol and a mixture of fuel oils and slops into the U.S. Exclusive Economic Zone.

The managing operators had in place what I believe would have been a sophisticated Safety, Quality and Environmental Management System (SQEMS). The DOC had been revalidated very recently following a revalidation audit and a new SMC had been issued only a month before the tragedy. I am speculating but I am little doubt that the management system manuals would have been very well written, although possibly voluminous, but would have satisfied the requirements of the ISM Code – if the procedures had been followed.

However, the USCG report provides a catalogue of non-conformities and failures of the system. There appears to have been a serious cultural and management problem on board between the Greek Master and senior officers and the Filipino junior officers and crew. There appears to have been little or no effective management or leadership on board with the junior officers and crew being almost excluded from the onboard team and without any identifiable or clear role within the safety management system. Clear and explicit procedures were being flouted or ignored completely with an apparent total disregard for even the most basic level of safety. Fraudulent paperwork appears to have been completed confirming that certain things had been done – when in fact they had not been done – one specific, and tragically relevant, example came to

light – that emergency and lifeboat drill were recorded as having been carried out whereas no such drills had taken place.

I cannot do justice to the USCG report in this article and I would urge everyone to study its contents thoroughly and ask yourself whether you really are satisfied that the SMS on board your ships really is working as it was intended to work. Now is the time to check – do not wait until the accident happens and more lives are lost or the environment or property is damaged. Once an incident happens your systems will be put under the microscope and will be subjected to the most intense scrutiny and interrogation. This could be expensive not only in terms of lives lost but also in financial terms and with the potential to cause serious damage to your company reputation.