

SUMMARY

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Report RS 2007:04es

Incident in which passenger vessel St. Erik collided with a quay in Gothenburg, O county, on 14 July 2006

Case S-92/06

SHK investigates accidents and incidents with regard to safety. The sole objective of the investigations is the prevention of similar occurrences in the future. It is not the purpose of this activity to apportion blame or liability.

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In case of discrepancies between the English and the Swedish texts, the Swedish text is to be considered the authoritative version.





The Swedish Maritime Administration SE-601 78 NORRKÖPING, Sweden

Report RS 2007:04es

The Swedish Accident Investigation Board has investigated the incident in which passenger vessel St. Erik collided with a quay in Gothenburg, O county, on 14 July 2006.

In accordance with section 14 of the Ordinance on the Investigation of Accidents (1990:717) the Board herewith submits a report on the investigation.

The Board will be grateful to receive, by 04.04.08 at the latest, particulars of how the recommendations included in this report are being followed up.

Christina Striby

Per Lindemalm

Ylva Bexell

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Report finalised 4 October 2007

Sex, age, period of time as

captain

Vessel; Type, registration Motor passenger vessel St. Erik Signal letters **SGFI** Certificate All that were necessary Registered owner/Operator Strömma Turism & Sjöfart AB Nationality/Flag Swedish/Sweden Classification society The Swedish Maritime Administration Time of occurrence 14 July 2007, at about 10:00 in daylight Note: All times are given in Swedish daylight saving time (UTC + 2 hours) The river Göta Älv, Göteborg, O county Place National voyage/Pleasure cruise Type of voyage/Business Surface and weather Calm, good visibility conditions Persons on board: crew members 5 92 passengers Injuries to persons Minor injuries, approx. 11 persons Damage to vessel Limited hull damage Damage to cargo None Other damage (to the None environment) Captain:

The Swedish Accident Investigation Board (SHK) was notified on 14 July 2006 of an incident in which passenger vessel St. Erik collided with a quay in Gothenburg that same day at about 10:00.

Male, 46 years, 9 years as captain of this

The incident has been investigated by SHK represented by Christina Striby, Chairperson, Ylva Bexell, Chief nautical investigator and Per Lindemalm, Maritime technical investigator.

vessel

SHK was assisted by Lena Kecklund, chief human factors investigator (MTO).

The investigation was followed by Sten Anderson, Swedish Maritime Administration.

Summary

Soon after departure from its normal berth at Lilla Bommen in Gothenburg, on a voyage to Marstrand, passenger vessel St. Erik was in the process of overtaking the larger vessel Stena Danica on the river Göta Älv. The master of the St. Erik saw an oncoming vessel in the waterway and realised that it would become tight if Stena Danica went any further to starboard in the main channel. He reduced engine revolutions and declutched the machinery from the propeller shaft, switching to reverse. The engine then stopped. He tried several times to restart it, but without success.

At a speed of about six knots the bow of the St. Erik collided with a quay that projected out from the northern shore of the waterway. Passengers on the upper deck were thrown around. About a dozen of them were injured and were taken to hospital. Some crew members were also injured. However no-one was seriously injured. The bow of the vessel was considerably crushed inwards and loose material on board thrown about. China and glass broke. The possibility of the engine cutting out if the vessel was put into revers while still moving forward was a known problem. The same thing had happened several times before and had also been reported to the shipping company in the form of occurrence reports.

According to §2 of the second paragraph in the Accident Investigation Act (1990:712) maritime incidents must also be investigated if the incidents mean that there is a serious risk of an accident, or if an incident indicates important deficiencies from the safety viewpoint. SHK decided therefore to investigate the event.

The reason for the incident was that the manoeuvring problems of the vessel had not been resolved. This in turn was because the system employed by the vessel's owner for safety management (ISM) was not complete in its design, not established at all levels in the company and not complied with.

A contributory factor was that the Maritime Inspectorate continued to issue certificates to the shipping company despite having found that deviations from the safety organisation system had not been resolved.

Recommendations

SHK recommends that the Swedish Maritime Administration:

- considers preparing an overall functional requirement for machinery installations in older passenger vessels (RS 2007:04es R1),
- prepares internal tools for risk analysis and human factors analysis for the inspectors' assessment of vessels that are not satisfactorily covered by the existing regulations (RS 2007:04es R2),
- rewrites the general advice concerning §4 of the Swedish Maritime Administration regulations (SJÖFS 2002:8) so that the intentions of the general advice become undisputable (RS 2007:04es R3),
- reviews and possibly produces internal guidelines for ISM certification in order to ensure that Documents of Compliance are issued for companies that have real possibilities of meeting the requirements of the ISM code (RS 2007:04es R4), and
- intensifies its efforts to raise the level of knowledge in respect of the ISM code in the branch, particularly at company management level (RS 2007:04es R5).