

SYNOPSIS

Maersk Newport sailed from Le Havre for Algeciras just after midnight on 10 November 2008 in force 4 to 5 winds. Overnight the weather deteriorated and the ship's speed was reduced. By 1200 the wind had further increased to force 8 to 9 with rough seas. At 1250 the bow thruster room bilge alarm sounded and a number of holes were found in the port side of the bow thruster room shell plating through which water was pouring. The port anchor chain lashing was found to have released and the anchor had fallen, against the windlass brake tension, into the water. As the ship continued to pitch in the heavy seas, the anchor impacted against the hull, causing the damage. It was later found that five adjacent compartments had also flooded.

Despite the forecasted poor weather conditions no specific heavy weather checks had been carried out. By the time they were considered necessary it was too dangerous for personnel to go on to the deck, so the anchor securing arrangements were not verified. The port anchor chain lashing arrangement failed because neither it, nor the windlass brake, was sufficiently tightened and the hawse pipe cover was not fitted.

The vessel continued her passage and arrived at Algeciras on 13 November for cargo operations and repair. Repairs were arranged by the technical superintendent with little input from the ship's crew. Unbeknown to the crew, oxy/acetylene metal cutting by shore contractors had been arranged for when the ship was alongside and engaged in cargo operations. At about 0055 on 15 November, the contractor's safety watchman left the forecastle and, by 0110, a fire had developed in the vicinity of the port windlass winch mooring rope and a bank of 15 acetylene bottles. One oxygen and two acetylene bottles exploded in the fire, which was extinguished at 0546. There were no injuries. Damage was restricted to the forecastle area. The cause of the fire is likely to have been a discarded cigarette which ignited contractors' clothing in the vicinity of the mooring rope and acetylene hoses.

Because of poor communications, no shipboard Permit to Work control measures were in place for the planned hot work, and the contractor's safety watchman had no emergency communication link with the crew. He left his safety station without the knowledge of the foreman, so the fire was not discovered for about 15 minutes. The gas cutting assemblies were not leak tested and the "in use" gas bottles were co-located with the remaining bottles increasing the risk of fire spread.

Neither accident was reported to the Marine Accident Investigation Branch (MAIB) or to the management company's Designated Person Ashore (DPA).

Recommendations have been made to A.P. Møller Maersk which include a review of internal and external communication procedures, control of contractors, hot work arrangements and accident reporting procedures. The company has also been recommended to issue instructions on preserving voyage data recorder information for accident investigation purposes.

The repair contractor has been recommended to ensure that no flammable material is left near gas bottles, its workers are equipped with Very High Frequency (VHF) radios, a safety watchman is always available, that gas connection leak tests are carried out and, where feasible, "in use" bottles are separated from those in the storage area.