MANCHESTER CRUISING ASSOCIATION

A Coroner's Reflections on Disasters

13 January 2005 Richard Sturt

Richard, who lives near the coast in Kent, was the East Kent Coroner and Prosecutor in maritime matters and it was our privilege and pleasure to have him share his experience and views with us.

He began by giving us his definition of a disaster – an accident leading to considerable loss of life – and by giving us a quote from Gladstone (roughly) – "Show me the manner in which a nation deals with its dead and I will show you how well it deals with society".

We should, in a well-ordered society, learn and benefit from such unfortunate occurrences. Sadly, we seldom develop and/or implement preventative and management measures until accidents of this scale happen. He did contrast this state of affairs with the air transport industry where near-misses are reported and taken very seriously – this from his previous experience as a director of the Air Traffic Control Authority.

Richard gave us five examples of major disasters:

- In 1878, the collier, Bywell Castle, going downstream from Gallions Reach, on the Thames, with a pilot on board was in collision with the paddle steamer, Princess Alice, carrying 700 passengers back upstream from a pleasure trip to Sheerness. The accident occurred as a result of a combination of the effect of a cross-current and a subsequent misunderstanding between the vessels. The Princess Alice sank with the loss of 640 lives.

- This illustrated a major point in such cases – that any accident on the water is always more serious than anything similar on land. In this case lives were lost because very few people could swim, there was insufficient life-saving equipment, women would be wearing long, encumbering dresses and, furthermore, the Thames would be much like a moving cess-pool.
- In 1971, Richard himself heard the collision between the Paracas and the Texaco Caribbean in the English Channel near Dover. This was a result of no clear decision of what course to take and, possibly, poor watch-keeping. Both vessels sank and during the clearing-up and salvage operations, in spite of extensive warning indications, several vessels piled into the wrecks with further loss of life. Sound familiar??

The result was the installation of a Traffic Separation Scheme in 1972.

- The Piper Alpha disaster (1988) was his next example. This was another case where the fact that the accident happened at sea meant that loss of life was unavoidable. The rig was ablaze, the sea surface was aflame and there was a thick cloud of black smoke. Personnel were trapped – the rig and accommodation were burning around them and their only route of escape was a jump into a fire-covered sea , work boats couldn't approach because of the intense heat and helicopters were hampered by poor visibility due to the thick smoke. 165 people died.

- "The Herald of Free Enterprise" capsize was a disaster fresh in the minds of all of us. Simply, the bow door was left open and, the minute the ferry faced the swell outside the harbour entrance, water came in through the front of the vessel and it capsized. The assistant bosun who should have closed the bow door neglected to do so, the officer responsible for this area didn't check that it had been done – his duties required that he be on the bridge for departing – and there was no "door closed" indicator on the bridge.

  The whole thing happened so quickly that a lot of passengers were trapped in the hull and 193 people died as a result. Now, there are more indicators, interlock systems and more stringent checks on operations.

- His final example, while not being a maritime disaster as such, was a case where the sea factor led to a serious loss of life. It was the death by suffocation of 58 Chinese, illegal immigrants in a lorry arriving by ferry in Dover.

  60 Chinese had been hidden between piles of boxed tomatoes in a closed lorry before departure by ferry from Rotterdam. A vent had been left open to allow air into the enclosed space. Unfortunately, between then and the lorry's being parked on the lorry deck that vent had been closed. Regulations ensure that vehicle decks on ferries are cleared of passengers while at sea. This, of course, meant that the cries and knockings of the, by now, suffocating Chinese went unheard. Only two of these unfortunates were found alive on opening up the lorry on arrival in Dover.

Richard stressed that it was usually a combination of factors or errors that led to an accident and its ensuing complications and he had interesting diagrams of path analysis to demonstrate this.

He quoted a theoretical model of Statistical Probability – Prof. Jim Reason's "Swiss Cheese". Efforts or obstacles reducing the probability are represented by moving slices of Swiss cheese into the path of a beam of light which represents the likelihood of something happening. Since Swiss cheese has holes in it, it is possible that at some stage these holes may line up in such a way as to allow the passage of the light. More blocks of cheese and/or smaller holes reduce will reduce the probability.

In our case the slices of cheese would be regulations or safeguards put in place and the smallness of the holes could be the strictness of the regulations or effectiveness of the safeguards.

So, as long as Swiss Cheese has holes in it, accidents are still possible – or did I miss the point??

He finished with an amusing anecdote about an RN minesweeper being waltzed across the Channel by an illegal, French trawler. The situation was eventually resolved by the minesweeper's cook throwing a potato through the trawler's wheelhouse window..... You'd need Richard to tell you the tale!

Thank you, Richard, for an interesting and thought-provoking evening.