



**REPORT OF THE
INVESTIGATION INTO THE
FIRE AND SUBSEQUENT
DEATH OF ONE MEMBER
OF THE CREW ON THE
"ARKLOW VENTURE"
AT IRWELL PARK WHARF,
ECCLES, ENGLAND ON
TUESDAY JUNE 3RD 1997.**

The Marine Casualty Investigation Board was established on the 23rd, May 2002 under The Merchant Shipping (Investigation of Marine Casualties) Act 2000

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1. SYNOPSIS.

- 1.1 The "Arklow Venture" arrived at Irwell Park Wharf, Eccles, Manchester, England, during the afternoon of Sunday 1st June 1997 after a voyage from Bayonne, France. At approx 0300 hours all onboard were woken by either their colleagues or the fire alarm. A fire in the Galley, which was caused by a chip pan, had set off the fire alarm. This fire resulted in the loss of life of one deck rating, Mr. Wayne Start.

2. FACTUAL INFORMATION

2.1 The following are the principal particulars of the "Arklow Venture":-

Name:	Arklow Venture
Port of Registry:	ARKLOW.
Official Number:	402668
Owners:	Invermore Shipping Ltd
Managers:	Arklow Shipping Ltd, North Quay, Arklow.
Built:	1990
Length (overall):	88.20 metres.
Beam:	13.60 metres.
Draft:	5.802 metres.
Propulsion:	"Krupp MaK" diesel engine of 1300 kW "Stork" reverse reduction gear
Gross Registered Tonnage:	2827
Nett Tonnage:	1743
Deadweight:	4299
Classification Society:	Germanischer Lloyd

(A general layout of the ship in the area of the galley and messroom is shown at Appendix 8.1).

3. EVENTS PRIOR TO THE INCIDENT

- 3.1 The vessel arrived at Irwell Park Wharf, Eccles, Manchester, during the late afternoon of Sunday 1st June 1997, the vessel being reported as all secure on the berth at 1720 hours. The vessel had loaded 4170 tonnes of grain in Bayonne, France, for discharge at the "Cerestar" plant in Eccles. The vessel was berthed at the Irwell Park Wharf, approximately a quarter mile from the "Cerestar" wharf on the Manchester Ship Canal, while another Arklow vessel completed discharge at the "Cerestar" plant. The passage from Bayonne to Manchester is a regular run for the "Arklow Venture" and her crew, this particular voyage being reported as uneventful.
- 3.2 The vessel arrived at Irwell Park Wharf, Eccles, Manchester, England during the late afternoon (approx 1700 hours) of Sunday 1st June after an uneventful voyage from Bayonne, France.
- 3.3 The crew of the vessel comprised of the following personnel:
Mr. M. Morton - Master
Mr. David Bell - Mate
Mr. Rodney Hodges - Chief Engineer
Mr. Melvyn Ford - Deck rating
Mr. Wayne Start - Deck rating
Mr. Peter Moreton - Deck rating
Mr. John O'Driscoll - Deck Cadet.
- 3.4 The following two supernumeraries joined the vessel in the afternoon of June 2nd:-
Mr. Richard Eames - Marine consultant (Chart Corrector)
Mrs. Carol Bell - Wife of mate.
- 3.5 During Monday 2nd June 1997 all crew were employed on routine ship maintenance, a normal day being worked from 0830 until 1700 hours. During the afternoon the Master went home to Hull leaving the Mate in charge of the vessel.
- 3.6 During the course of the evening various members of the ships crew went ashore, the three deck ratings being joined by the deck cadet at some stage. Various establishments were visited in the Eccles area, drink being taken in each establishment. The evening finished in a snooker hall where more drink was taken. Mr. Peter Moreton left the other three at around 2330 hours. The security officer at the gate to Irwell Park Wharf records the three remaining crewmembers as returning to the vessel at 0137 hours.

4. THE INCIDENT

- 4.1 Mr. O’Driscoll went to his cabin while Mr. Ford and Mr. Start went to the galley/messroom to prepare a snack. Mr. Ford prepared himself a sandwich whilst Mr. Start decided to make some chips. Mr. Ford left Mr. Start in the messroom and went to his cabin.
- 4.2 The Mate reports being woken by a "whoosh or dull thud" followed immediately by the fire alarms sounding. From the deposition of the security gateman this would have been at 0300 hours. The Mate immediately took charge of the incident ensuring the following actions were taking place:-
- Checking cabins
 - Starting emergency fire pump
 - Stopping ventilation
 - Rigging fire hose
 - Preparing breathing apparatus
 - Calling shore fire brigade
 - Supernumeraries being sent ashore.
- 4.3 The shore fire brigade arrived at 0306hours, as recorded by the security gateman, received a briefing from the ship’s crew and entered the galley. A small delay occurred at this point due to difficulty being experienced in unscrewing the lid to the container holding the vessel’s fire plans. At about this time the Chief Engineer returned from shore and immediately went to the machinery space and isolated galley power supplies. It was established that Mr. Start was missing from his cabin, virtually simultaneously the fire brigade reported finding Mr. Start in the galley. Mr. Start was taken to hospital by ambulance and pronounced dead on arrival.
- 4.4 Depositions were taken from other key personnel and all consistently confirmed the series of events and actions taken.
- 4.5 Mr. Start was found by the fire brigade in a crouching position by the galley hot plate. Mr. Ford reported leaving Mr. Start in the messroom next to the galley. The fire blanket from the galley was found removed from its container near Mr. Start in the galley.

5. EVENTS FOLLOWING THE INCIDENT

- 5.1 Examination of the vessel following the fire revealed smoke and fire damage to the galley, a small amount of fire damage in the adjoining mess room aft of the galley, and further smoke damage in the mess room and forward stair well leading up to the navigation bridge. (See photographs at Appendix 8.2). The forward and aft doors to the galley appear to have been open at the time of the fire. A fire door at the top of the forward stairwell appears to have been closed and effective in preventing any smoke damage occurring on the bridge.
- 5.2 The fire brigade removed some loose items to the wharf from the galley following the fire. Examination of these items revealed the pot that appears to have been used for deep fat frying of the chips to be a simple open aluminum cooking pot.
- 5.3 Further examination of the galley revealed a closed electrical type of deep fat fryer (a "Moulinex Masterfry") readily available in a cupboard in the galley. The crew members normally employed on galley duty (the vessel carries no cook) stated that this would have been used if only a small quantity of chips were being prepared, but the aluminum pot was normally used when making a larger quantity of chips.
- 5.4 The initial response to the fire by the crew on board appears to have been faultless, and in accordance with the posted muster list (see Appendix 8.3). The Master of the vessel was at home in Hull for the night, this appears to have no bearing on the sequence of events. Mr. Start was also from Hull and his death was reported to his family by the Master early in the morning of Tuesday June 3rd. Arklow Shipping reported on the 18th June that all fire damage to the vessel was repaired to the satisfaction of the Classification Society on 14 June 1997.

6. CONCLUSIONS AND FINDINGS

- 6.1 Statutory Instrument No. 110 of 1988 Merchant Shipping (safety officials and reporting of accidents and dangerous occurrences) Regulations 1988 require the vessel to have a safety officer appointed by the employer and responsible under the Master for accident prevention. The duties of the safety officer are specific in the statutory instrument and require him to ensure that the provisions of the "Code of safe working practices for merchant seaman" are complied with. This code is again quite specific in that deep fat fryers should be provided with safety lids, a control thermostat and a second safety thermostat. The duties of the safety officer as stated in the statutory instrument require him to carry out occupational health and safety inspections of all accessible parts of the ship at least once every three months or more frequently.
- 6.2 Statutory Instrument No. 109 of 1988 Merchant Shipping (Health and Safety: General Duties) Regulations 1988 require both employer and employee to ensure as far as is reasonably practicable the health and safety of employees and other persons aboard ship.
- 6.3 The finding of a fire blanket removed from its container, and the statement that Mr. Start had last been seen in the messroom aft of the galley, together with the fire officers description of the position in which Mr. Start was found lead one to conclude that on realizing that the chip pan was either on fire or about to ignite (and possibly after falling asleep) Mr. Start had made an attempt to deal with the situation.
- 6.4 The doors at the forward and aft end of the galley being left open could have resulted in this incident being considerably more serious, the door if left closed would have prevented the fire and smoke from spreading to other parts of the ship if the fire had been of greater intensity or longer duration. The closed door leading from the forward stairwell to the bridge appears to have been effective in preventing smoke spreading to the bridge.
- 6.5 The apparently accepted practice of using the galley late at night when in port is questionable. The absence of a cook on these vessels ensures that all crew have ready access to the galley, possibly without being fully aware of the particular hazards in a galley.
- 6.6 The small delay experienced due to difficulty in unscrewing the lid of the container (the lid was smashed off by one of the ships crew) containing the vessels fire plans was not relevant on this occasion. However it does raise a question in relation to procedures for ensuring that all fire equipment is ready for immediate use.
- 6.7 The fire was caused by an open chip pan becoming overheated and igniting.

RECOMMENDATIONS

7. RECOMMENDATIONS

- 7.1 The following recommendations are made in order to prevent a recurrence of this type of accident:
- 7.1 Open chip pans or similar open utensils containing cooking fats or oils should never be used on board ship. Shipping companies should issue internal instructions to all their ships and seagoing personnel banning the use of such cooking utensils and methods, under any circumstances.
- 7.2 Cooking, which involves quantities of oil or fat, should only be carried out using proper deep-fat fryers, which comply with marine specifications. Such units must be fitted with dual thermostatic devices, which will ensure isolation of the electrical supply in the event of failure of the normal regulating thermostat. Such deep-fat fryers must be secured in position to prevent movement in rough weather conditions.
- 7.3 The owners and Masters of all Irish registered vessels must ensure that on-board training, together with frequent drills, is carried out to ensure that all crewmembers are familiar with their duties in an emergency. Crewmembers must also be instructed in relation to the location and use of fire-fighting and life-saving equipment. Furthermore, all crewmembers, especially those who may not have attended formal fire-fighting training, should be instructed on how to react in smoke filled situations.
- 7.4 Owners should consider the installation of fire detection equipment in high-risk areas, such as galleys, even where no such requirement exists in the regulations.
- 7.5 Personnel assigned to galley duties, should receive special instruction in relation to the fire risks associated with galleys including the risks with unattended grilling or frying, the need to keep extraction filters, hoods and ducting clean and free from grease, safe disposal of combustible food packaging, safe use of deep-fat fryers, etc. Unauthorised or untrained personnel should not have access to the use of cooking facilities in galleys.
- 7.6 Fire doors should never be secured in the open position unless such securing involves a mechanism which will ensure that the door will close in the event of fire e.g. by remotely released magnetic devices or fusible links which will melt in a fire situation. Fixed hooks or similar devices must not be used.
- 7.7 The Department of the Marine* should issue a Marine Notice bringing to the attention of all owners, masters, skippers, officers and crewmembers of all Irish registered merchant and fishing vessels, the lessons learned from this accident and making them aware of the above recommendations.

* [Note: written in the context of the relevant Department at the time of the accident].

8. APPENDICES

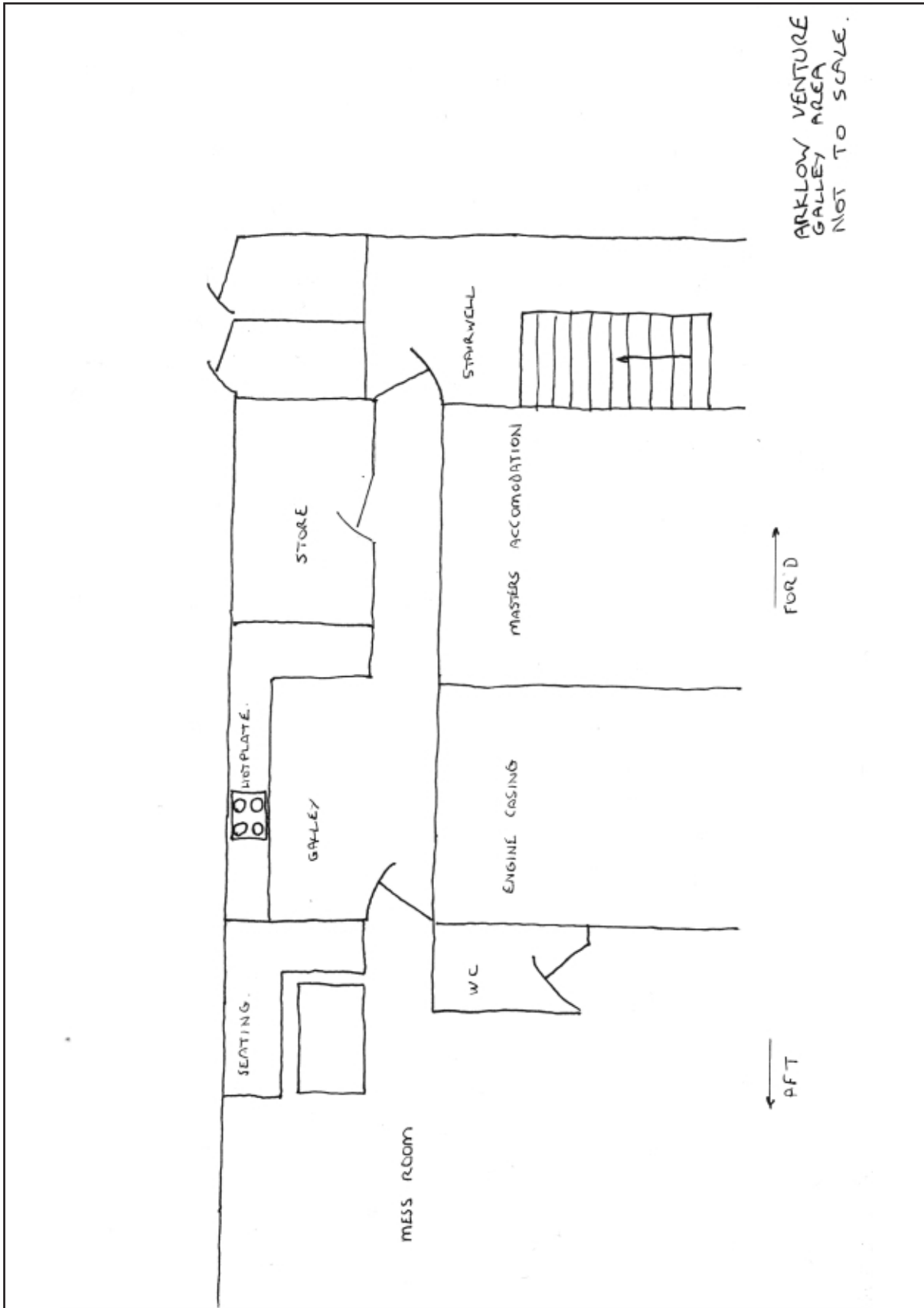
8.1 General plan of vessel in galley area

8.2: Photographs

8.3: Muster Plan

APPENDIX 8.1

8.1 General plan of vessel in galley area



8.2: Photographs







CORRESPONDENCE

8.3: Muster Plan

MV ARKLOW VENTURE			
BOAT, FIRE AND EMERGENCY STATIONS			
STATUS	BOAT	FIRE	REMARKS
MASTER	BRIDGE#	BRIDGE#	FOR OTHER COMMAND POSN
MATE	I/C LOWERING (AND COXN)	I/C HOSE PARTY EXTINGUISHER	(EMERGENCY FIRE PUMP)
ENGINEER	MOTOR	ER OR EMERGENCY FIRE PUMP	OR HALOGEN RELEASE STN
SMN 1 ()	MAN BOAT (2ND COXN)	BA/HOSE/ EXTINGUISHER	FIRESUIT?
SMN 2 ()	GRIPES, PINS, ETC RADIO	HOSE/ EXTINGUISHER	SMOKE HELMET?
SMN 3 ()	MOTOR, FIRST AID, ETC	ASST BA/ SMOKE HELMET	DRESS FIRE SUIT MAN, ETC
(CADET)	BRIDGE/RADIO/ BOAT	BRIDGE/COX/ RADIO	
SPNMY 1	MESSROOM FIRST AID	POOP FIRST AID	OR AS ORDERED BY MASTER

EMERGENCY: STATIONS :	UNLESS LOCATION GIVEN - ALL MUSTER IN MESSROOM CARRYING LIFEJACKET, IMMERSION SUIT, BOOTS, ETC		

ALARMS: WHISTLE OR INTERNAL ALARM	BOAT: 6 SHORT BLASTS PLUS LONG BLAST FIRE: REPEATED LONG BLASTS EMERGENCY: CONTINUOUS SOUNDING		
ABANDON SHIP:	VERBAL ORDER BY MASTER OR SENIOR SURVIVOR.		
NOTE:	THE ABOVE STATIONS ARE A GUIDE FOR INITIAL ACTIONS ONLY. BE PREPARED TO FILL ANY POSITION ABOVE. IF YOU FALL OVERBOARD, ARE INJURED OR TRAPPED, SOMEONE ELSE WILL HAVE TO DO YOUR JOB. DOES HE KNOW HOW? IF NOT, TAKE A LITTLE TIME TO SHOW HIM BEFORE TOMORROW!		
		 MASTER

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CORRESPONDENCE

Mr. John O'Driscoll
MCIB Response

11-02-03.

Dear Sir,

I write to inform you that I have received my copy of the draft report of the investigation into the fatal fire on board the M.V. Arklow Venture, on Tues 3rd June, 1997.

This letter is to confirm, in accordance with the wishes expressed in the reports cover note, that upon consideration of the draft report, I have no worthwhile comments or observations to offer you.

Yours Sincerely

John O'Driscoll.

J. Driscoll.



MCIB RESPONSE

The MCIB notes the contents of this letter.

MCIB RESPONSE

The MCIB notes the contents of this letter.

Mr. Rodney Hodges
 MCIB Response

8th FEB 03

Dear Mr. Holan,
 Thank you
 for the report on the "ARKLOW
 VENTURER" incident, in which
 Mr. Wayne Stark crewmember
 died.

I find the report fair
 & just, and have no further
 comments.

Yours faithfully
 Rodney Hodges.

MCIB RESPONSE

The MCIB notes the contents of this letter.

