

“Herald of Free Enterprise” — lessons for management

Chris O’Meara*

At the last MLAANZ conference, Tim Howard from Norton Rose, Solicitors, London, presented a paper on the ‘Lessons from the ‘Herald of Free Enterprise’’. Ian Dixon presented the commentary on Tim Howard’s paper. Ian pointed up the similarities with the ‘Straitsman’ disaster, stimulating sufficient interest to provoke Captain Smith into a colourful interpretation and recapitulation of what Ian had very carefully and tactfully said — and not said! In discussion, attention was drawn to an address given by Chris O’Meara to the Victorian Branch of the Association on the ‘Herald of Free Enterprise’. In view of the general interest in the subject, Chris O’Meara has kindly agreed to publication here of an edited version of that address.

I. INTRODUCTION

This paper considers the lessons to be learned by management in its role as a shipowner from the *Herald of Free Enterprise* disaster, and details the findings against management by the Court of Inquiry and its recommendations as to what qualities management should have had.

Those who attended the Eleventh Maritime Law Association Conference in Christchurch in October 1984 will remember a paper by Ron Salter which dealt with shipowners being able to limit their liability for damages if they could show the absence of fault or privity. That is, the shipowner could limit its liability for damage if it had not been at fault or in some way privy to the occurrence. The issues of that paper, which is readily available, will not be reiterated here. It examines the concept through a sad tale of wreck and disaster but it does show that the management of shipowners has been subject to scrutiny in the past to see what role, if any, was played by it in any disaster. Even if there had not been a Court of Marine Inquiry into the wreck of the *Herald of Free Enterprise* any claimants would certainly have explored the part of management in any litigation at least to prevent or rebut any contention by the shipowner that, in the absence of blame, liability could be limited.

* Australian National Line.

At the Court of Inquiry, there was separate legal representation for —

- (1) the Secretary for State of the Department of Transport
- (2) the Department of Transport
- (3) the Shipowner, Townsend Car Ferries Ltd
- (4) the Master
- (5) the Senior Master
- (6) the Chief Officer
- (7) the Assistant Bosun
- (8) the National Union of Seamen
- (9) the deceased persons' next-of-kin and the injured passengers.

Some of these parties had competing interests.

The Wreck Commissioner criticized the management of the shipowners of "The Herald", Townsend Car Ferries Ltd. Mr Justice Sheen's report¹ states that² —

At first sight the faults which led to this disaster were the aforesaid errors of omission on the part of the Master, the Chief Officer, the asst. bosun, and also the failure by Captain Kirby to issue and enforce clear orders.

He then goes on to say that a fuller investigation into the circumstances leads to the conclusion that the underlying fault lay higher up in the company. A number of individuals were singled out —

Mr Develin — a director of the company, a Chief Engineer, a Fellow of the Royal Institution of Naval Architects and a former Government Marine Surveyor in Hong Kong.

Mr Ayers — a naval architect and a director of the company. He was described as being verbose, rambling and at times misleading. He was the company's technical director and "At the relevant time, a director"³ indicating a subsequent change in position.

Mr Young — the company's operations director. The Court found that despite being aware of passenger overloading, he made "no proper or sincere effort to solve the problem".⁴

The Wreck Commissioner said that he was singularly unimpressed by both Mr Ayers and Mr Young.

But it was not just individuals. Mr Justice Sheen found⁵ —

All concerned in management, from the members of the Board of Directors down to the junior superintendents, were guilty of fault in that all must be regarded as sharing

¹ *MV Herald of Free Enterprise, Report of Court No 8074 Formal Investigation* (HMSO, London 1987).

² *Ibid* 14.

³ *Ibid* 26.

⁴ *Ibid* 22.

⁵ *Ibid* 14.

responsibility for the failure of management. From top to bottom the body corporate was infected with the disease of sloppiness.

What caused Mr Justice Sheen to come to this finding?

Firstly, let us examine the area which led directly to the disaster; the failure to close the doors and put to sea. The Inquiry found that primarily management had failed in its duty to give clear and proper directions both within the shore organisation and also in its ship's standing orders.

How should a good shipping company be run? Not surprisingly, the Department of Transport issued a Notice about that in July 1986 entitled "Good Ship Management". The advice given in that Memo included the following points⁶ —

The efficient and safe operation of ships requires the exercise of *good management both at sea and ashore* The overall responsibility of the shipping company requires the need for *close involvement* by management ashore. To this end it is recommended that every company operating ships should *designate a person ashore with responsibility for monitoring the technical and safety aspects* of the operation of its ships and for providing appropriate shore based back-up Stress is placed upon the importance of providing the Master with *clear instructions* to him and his officers. The instructions should include adequate Standing Orders. There should be close co-operation and regular and effective communication in both directions between ship and shore.

The company failed to implement that advice. This was shown at a meeting of the management with Senior Masters in March 1986 where Mr Develin said that he would not define the roles of the Chief Officer as Head of Department, or of the Maintenance Master but would allow them to evolve. This was described by the Inquiry as an abject abdication of responsibility as clear instructions are the foundation of a safe system.

The lack of clear orders about the duties of the officers on the Zeebrugge run contributed to the tragedy. It was conceded by the company that somebody ought to have been responsible for drafting company orders but no one was.

It was found by the Inquiry that the Board of Directors must accept a heavy responsibility for their lamentable lack of directions. Individually and collectively they lacked a sense of responsibility. This left, what was so aptly described as, "a vacuum at the centre".⁷

II. PARTICULAR ISSUES

A. Ship's Standing Orders

The ship's standing orders provided to "The Herald" were defective in that they made no mention of closing the bow and stern doors and also, they led the Master to assume that his ship was ready to sail if he did not

⁶ *Ibid* 15. Emphasis added.

⁷ *Ibid* 15.

have a report to the contrary. It seems that the reference to closing the bow doors was overlooked for "The Herald" type of ro/ro because originally the orders dealt with earlier ro/ro ships with visor doors. With those doors, the Master could, from the bridge tell whether the visor doors were closed. When the new class of ship came with "clam" doors, no manager gave any thought as to whether the standing orders should include any instruction that the closure of the doors should be reported to the bridge.

Of course, in relation to the present case such an instruction might not have prevented the tragedy. "The Herald" like other cross channel ferries had put to sea before with its bow doors open. The turnaround time at Zeebrugge was meant to be as quick as possible. A way of saving time was to close the doors while putting to sea. No doubt had the Master been informed that the bow doors were open, he would not have gone "full steam ahead" but once the ship is at sea with the doors open then it is really just a disaster waiting to happen. At some channel ports it was impossible to close the doors whilst at the berth.

The pressure of time on procedures can be laid squarely on management. There was a sense of urgency to sail from harbour at the earliest possible moment. The operations manager at Zeebrugge wrote to his subordinates in August 1986⁸ —

There seems to be a general tendency of satisfaction if the ship has sailed two or three minutes early. Where, a full load is present, then every effort has to be made to sail the ship 15 minutes earlier I expect to read from now onwards . . . that the ship left 15 minutes early put pressure on the first officer if you don't think he is moving fast enough. Have your load ready when the vessel is in and marshall your staff and machines to work efficiently. Let's put the record straight, sailing late out of Zeebrugge isn't on. It's 15 minutes early for us.

All of us in the past have been guilty of this sort of motivational claptrap. But the problem was that the turnaround time at Dover was sometimes only 30 to 40 minutes for loading and unloading and it was impressed on the staff at Zeebrugge that an early departure would give more time in Dover. However, it was suggested by the Inquiry that time pressure may have had a more direct bearing on the disaster. The loading officer Mr Sabel had left G deck (the vehicle deck) before Mr Stanley, the man whose job it was to close the doors had arrived. Mr Sabel's station after loading was on the bridge. It took 3 minutes to close the doors and it was put by the company that if Mr Sabel had stayed on G Deck for another 3 minutes, then the disaster would have been averted.

According to the Inquiry, the system put the officers under pressure to leave berth as soon as possible. Had the loading officer remained on G Deck, Captain Lewry would have delayed the order to sail until he was on the bridge. It is worth remembering that "The Herald" sailed 5 minutes late on its last voyage. The deck officers felt that no time could be wasted. The

⁸ Ibid 11.

order "harbour stations" was given before loading was completed. It was given as soon as the loading officer decided that by the time the crew arrived at their stations everything would be ready for sea.

The ship's standing orders were also ambiguous. It was the responsibility of the Loading Officer on G Deck to ensure that the bow doors were "secure when leaving port".⁹ This instruction was regularly ignored and the Loading Officers interpreted it as meaning that all that was necessary was to see that someone was there ready to close the doors. Of course, this was often the only practical way of dealing with it because the standing orders required the Loading Officer, when he was the officer on watch to be on the bridge 15 minutes before sailing! This would have meant that the vessel instead of sailing 15 minutes early would not have sailed until 15 minutes after the loading officer got to the bridge which, of course, was after loading was completed. No wonder, the Inquiry found that this order illustrated the lack of thought given by management to the organisation of the officers' duties.

The failure of the ship's standing orders becomes crucial when it is remembered that the vessel had three crews and five sets of officers. This made uniform and clear orders essential. A Senior Master of the vessel, Captain Kirby wrote to management pointing out the serious loss of continuity in maintenance, safety, crew training and smooth running, all of which could have been averted if the ship had a permanent crew.

These matters illustrate the failure of the company organisation as a whole and the need for a Marine Superintendent which the company lacked. Supposedly, the Board collectively were responsible for considering safety matters but it was clear that the shore management ignored the suggestions of its Senior Masters. There were four major areas where this was so —

- (i) the overloading of passengers;
- (ii) the installation of indicator lights on the bridge to show when the bow doors were closed;
- (iii) the inability to read draught marks;
- (iv) and the need for a high capacity pump to deal with Zeebrugge trimming ballast.

B. *The Overloading of Passengers*

The company ferries regularly carried more passengers than permitted. If the ship was loaded to a draught of 5.5 m it could carry 1400 passengers and crew. If loading to a draught of 5.7 m it could carry only 630 passengers and crew. It was necessary, therefore, to ensure a suitable mix between the vehicles and cargo loaded and the number of passengers. Masters on a number of occasions complained to management about passenger over-

⁹ Ibid 8.

loading. This could only be established by doing a head count on board (after the ship had sailed) to see if the passenger numbers tallied with the shore count.

Head counts on the sister ship the *Pride of Free Enterprise* over a three week period in 1982 showed an excess on the Calais/Dover run of 250, 40, 100 and 171 passengers. The Master, Captain Blowers, wrote to Mr Young, the company's operation manager expressing concern. Unfortunately, Captain Blowers was not politic enough. In his memo, he mentioned that on one occasion when he had told shore based staff of his concern about overloading, and that he would be conducting a head count, the figures tallied to within 15 souls.

What was the upshot of the Master's concern? He was sent a memo from Mr Young which read in part, "Frankly, I am amazed and annoyed. . . ."¹⁰ What was Mr Young amazed and annoyed about? He was cross about the aspersion cast by Captain Blowers that the shore based staff had only come up with a proper count because they were forewarned about the ship's count.

Other masters complained to Mr Young. Captain Pearson was able to establish that on two sailings, the number of excess passengers was the same as the number of commercial drivers. Mr Young did by memo bring the matter to the attention of shore staff that drivers were to be included in passenger figures. Mr Young went on to say . . . "it is still my intention to eventually retain all tickets ashore, which will cut out the differences between head count and ticket count"¹¹ The Inquiry felt that this suggested that by retaining all tickets ashore, the ship's purser would not be able to establish whether there was a discrepancy between the number of tickets sold and the number of passengers carried. The proposal by Mr Young met strong opposition from the Masters so that despite Mr Young's intention, the head counting went on and the problem became quite serious in 1986.

It was clear to Masters what the attitude of management was and some of the memo's became quite caustic. One Master found that he was carrying an excess of about 450 passengers. He wrote¹² —

This total is way over the life saving capacity of the vessel. The fine on the Master for this offence is £50,000 and probably confiscation of certificate. May I please know what steps the company intend to take to protect my career from the mistakes of this nature?

The answer he got was that the system did not change.

Another Master detailed overloading and wrote: "May I ask that you and your staff urgently look at your current methods and either make them work or amend as necessary".¹³

¹⁰ Ibid 18.

¹¹ Ibid 19.

¹² Ibid 20.

¹³ Idem.

Also in 1986 another Master wrote¹⁴ —

. . . the number of passengers over and above our certified number . . . can only be described as a blatant and flagrant disregard of the system, and backs up other complaints from Masters of this and other fleet vessels.

He requested that immediate steps be taken to remind shore staff of their responsibility. He was told that the matter would be discussed.

The overloading went on with Mr Develin suggesting to Mr Young in October 1986 that he meet with him and look at the problem in detail. Mr Young did not do it. However on 27 May 1987 (almost 3 months after the disaster) Mr Young came up with a solution — the introduction of boarding cards for passengers. Such a system would not have worked on "The Herald" before, as it was necessary to establish with precision, the draught of the vessel to determine the number of passengers carried.

C. Ascertaining the Draught

No attempt was made to read the fore and aft draught of the ship on a regular or routine basis. The official log book was falsified so that officially it was recorded that the ship always sailed on an even keel. The ship was trimmed by the head. One Master raised with management the difficulties of trimming by the head, and its effect on stability. His concern was dismissed by Mr Develin who said that if he had been really concerned he would have come in and banged the desk. Also, had he been sufficiently concerned then he would not have sailed. Mr Develin thought that the Master was exaggerating.

Captain Blowers sent a memo to Mr Ayers, a director of the company and naval architect. He felt¹⁵ —

With all our ships it is very difficult to read the draught with the result that for record purposes it is often as not guesstimated. Suggest fitting automatic draught recorders with read-out in the wheel house

Mr Ayers knew that it was, in his view, impossible to read the ship's draught. He had been told in a report on the capsizing of a company ship *European Gateway* that the ship's draught was not read before sailing and that the draught entered into the log book was erroneous. Nevertheless, he did not investigate the installation of automatic draught gauges because of a belief, ill-founded as it turned out, that they were inaccurate.

D. The Indicator Lights

"The Herald's" safety at sea required her doors to be closed before she left the berth. Her sister ship "The Pride" had left Zeebrugge twice before 1984 with her doors open. Captain Blowers in June 1985 wrote to Mr Develin again and suggested the installation of an indicator light on the

¹⁴ Ibid 21.

¹⁵ Ibid 27.

bridge to show whether the doors were closed or not. This suggestion was circulated to the managers of the company. The comments were: "Do they need an indicator to tell them whether the deck storekeeper is awake and sober?"¹⁶ The Inquiry found that this comment was ominously prescient or showed an awareness of this type of incident in the past. There had of course, been an incident in the past. In October 1983, a bosun on "The Pride" had fallen asleep and the ship had sailed with the doors open. The Inquiry did not discuss whether management was aware of this earlier incident. If it had been, it stands condemned for not reviewing its procedures adequately in 1983. If it was not aware of it, then it stood condemned for failing to have in place an appropriate mechanism for ensuring that it was made aware of such incidents.

Other comments by directors were¹⁷ —

"Nice but don't we already pay someone!"

"Assume the guy who shuts the door tells the bridge if there is a problem."¹⁸

This assumption was tragically incorrect as, on "The Herald", the guy was not there!

The need for an indicator light was raised by other Masters in 1986. A Master submitted a job specification for preliminary costing which was torpedoed on the basis that if doors were left open then the seaman responsible should be disciplined.

Within a few days of the disaster indicator lights were installed on all remaining Spirit class ships. The Inquiry found that had the suggestion been acted upon in 1985 the disaster may well have been prevented. Although it did recognise the evaluation took time and that indicator lights might not have been installed on "The Herald" before the disaster. Had management decided to instal them, it would probably have been done on "The Herald's" next refit which was due after the disaster.

E. The Need for a Ballast Pump

In 1984, a Chief Engineer, Mr Crone wrote to Mr Develin about the problem of trimming the ship. Two tanks, Nos. 1 and 14 were filled for arrival at Zeebrugge and emptied on completion of loading. With two pumps, it took 1½ hours at best to discharge the tanks. This meant that the ship was often half way across the channel. The ship was, therefore, well down at the head until discharge was completed which caused bad steerage and high fuel consumption. It also put the bowdoors under considerable stress. Mr Crone suggested a high capacity ballast pump be installed and even went to see Mr Develin on several occasions to press for his recommendation to be acted upon. However, he obviously did not thump

¹⁶ Ibid 24.

¹⁷ Idem.

¹⁸ Ibid 30.

the desk. But the company evaluated his proposal and found that the pump would cost £25,000 which was considered to be prohibitive.

F. Further Management Deficiencies

Lastly, the Inquiry found that the shore management did not always support their Masters in matters of discipline. Senior management had advised a Master to rescind penalties on crew who had threatened to strike. This had also occurred on another occasion. The Inquiry held that "No Master can maintain discipline in his crew unless he has the confidence and backing of the management". This finding caused me to pause because have I perhaps at times, merely balanced up the cost of ship delay against the cost of discipline. I believe that the Inquiry raised this aspect because it was clear that there had been a failure by the Loading Officer, Mr Sabel, to comply with the Standing Orders. That is, bow doors were not properly secured. This is a failure of discipline and it is clear that the Inquiry sheeted home part of the responsibility for that failure of discipline on management.

So what should management do? Townsend Car Ferries Ltd had problems. The overall structure of the organisation was found wanting in that there was a failure to harmonise the requirements of sea and shore. The real problem was a lack of a Marine Superintendent who could review and deal with sea going concerns. The organisation lacked a shore focal point. Meetings between Masters and management were infrequent. There was a period of 2½ years during which there were no formal meetings between management and the Masters. Suggestions by the Masters were shelved, sometimes misinterpreted or improperly investigated. On the eighth day of the Inquiry counsel for the company conceded that the company had been at fault.

III. CONCLUSION

From the Inquiry came recommendations about the future operation of the company management —

- (a) Clear and concise orders should be issued.
- (b) Strict discipline should be maintained.
- (c) Attention should be given at all times to all matters affecting the safety of the ship and those on board. There must be no "cutting of corners".
- (d) There should be proper channels of communication between ship and shore for the receipt and dissemination of information.
- (e) There must be a clear and firm management and command structure.

The company has changed —

- A new General Manager (with nautical experience) has been appointed.
- There is a new Chairman and there have been changes in the Board of Directors.

Not surprisingly —

- The Ship's Standing Orders are being rewritten.
- Berth's are being modified so that doors can be closed whilst the ship is at the berth.
- Masters will not be able to leave berth until a positive report is received that the bow doors are closed (This is an effective delay of 3 minutes — the time it takes to shut the doors).

The Court of Inquiry by way of penalty ordered the shipowners to pay £350,000 in costs. This is about 14 times the cost of a high capacity pump.

It is clear that for management to discharge its responsibilities, it must fully integrate shore and sea so that safety issues and suggestions by Masters (the men in the wheelhouse) are properly considered ashore. The most effective way of dealing with this is to have a shore based manager with nautical experience.

At Australian National Line, we are happy with the seagoing expertise of our shore management but we have summarised the findings of the Inquiry and sent it to all our Masters inviting their comments in relation to Standing Orders and safety. Any concerns by them are to be followed up. We have reminded the Masters of the role of our Fleet Operations Division who monitor technical and safety aspects of our vessels.

As can be gleaned from this Inquiry, the matters considered are far-reaching and include those areas of management not directly related to the cause of the disaster. It is management who set the tenor of the company. If the organisation is not shipshape then management will find it very difficult indeed to show that there has been an absence of fault by it in any disaster.