At 2109 on 3 January 2015, the pure car and truck carrier Hoegh Osaka was rounding West Bramble buoy in The Solent (south coast of England, approach to the port of Southampton) when it developed a significant starboard list causing some cargo shift and consequent flooding.

With the list in excess of 40°, the ship lost steerage and propulsion, and subsequently drifted onto Bramble Bank, grounding at 2115.

Hoegh Osaka had sailed from the port of Southampton, bound for Bremerhaven, at 2006. A pilot was embarked and there were 24 crew on board. Following the accident, all crew were successfully evacuated from the ship or recovered from the surrounding waters. There was no pollution. A major salvage operation successfully refloated Hoegh Osaka and it was subsequently taken to a safe berth in Southampton on 22 January.

The (UK) Marine Accident Investigation Branch (MAIB) has now published a report into the investigation of the listing, flooding and grounding of this pure car and truck carrier (PCTC).

Steve Clinch, Chief Inspector of Marine Accidents commented: ‘The MAIB’s investigation found that Hoegh Osaka’s stability did not meet the minimum international requirements for ships proceeding to sea. The cargo loading plan had not been adjusted for a change to the ship’s usual journey pattern and the number of vehicles due to be loaded according to the pre stowage plan was significantly different from than that of the final tally. The estimated weight of cargo was also less than the actual weight. Crucially, the assumed distribution of ballast on board, bore no resemblance to reality, which resulted in the ship leaving Southampton with a higher centre of gravity than normal.

‘This accident is a stark reminder of what can happen when shortcuts are taken in the interest of expediency. It is therefore imperative that working practices adopted by the car carrier industry ensure that there is always sufficient time and that accurate data is available on completion of cargo operations to enable the stability of such vessels to be properly calculated before departure.’

The full MAIB report is available at: https://www.gov.uk/government/news/hoegh-osaka-report-published
A safety flyer (to be found nearby in pdf format) has been produced highlighting three key safety lessons arising from the accident which the Chief Inspector of Marine Accidents urges the industry to take forward.