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COMMANDER-IN-CHIEF FLEET

LOSS OF HMS SHEFFIELD BOARD OF INQUIRY

Annex R

AMALYSIS OF CASUALTIME, FIRST AID AND MEDICAL FACTORS

- Scope This annex describes the Medical Staff and their qualifications, the Medical Organisation and Medical Stores availability. It discusses casualties at impact, and causes of death both on impact and later, together with the causes, and subsequent treatment of all significant injuries. The use of the AGR in smoke and the protection afforded by clothing is covered. The effects of stress, sessickness and tiredness on the Ship's Company is investigated.
- - 3. Medical Stores Medical stores for war had been delivered at Ascension. Although these were generally satisfactory, the controlled drags, Morphine monojects, were cut of date and some of the extra equipment was considered superfluous to requirements. In SHEFFIELD, the medical stores had been distributed for action. However, Morphine in ampoules or as Osmopon Monojects, was under the control of the medical staff and held in the Sick Bay, in the First Aid Box (FAB) in the Hangar, the FAB on the Bridge and in the Emergency Operating Station, (EOS), 2F. At Action Stations Morphine was distributed to the Petty Officers in charge of each First Aid Party (FAP) by the Medical Staff. Thus, at Defence Watches, Morphine had not been distributed in accordance with BR 2170 Volume 2, Chapter 36 which requires Morphine to have been distributed and not locked in supposards. Accounting for Morphine is at Appendix 1.
 - 4. Medical Organisation The distribution of First Aid Lockers (FAL) and position of the FAPs at Action Stations was not as expected (1). The forward FAP was in the EOS, 2F. The CPO's Mess, 1J, was found to be an unsatisfactory FAP at Action Stations due to inaccessibility. The fitted FAL remained there as an additional stock. The After FAP was sited in the Port POs' Mess, 2P, with a complete FAL. Thus the Sick Bay was free to receive serious casualties from either FAP. The Board considers this a sensible arrangement. Extra FABs had been fitted in some machinery and workshop spaces, in addition to those listed (1). First aid bags were held by all members of FAPs, but the orders for carrying these in Defence Watches were unclear. Some bags were being carried while some had been left in the EOS.
 - 5. Casualties at Impact Those killed or injured at impact (see Annex Q) were invariably close to the site of missile entry. The most serious injuries occurred in H, J and K Sections on 1, 2, 3 and 4 Decks and relatively minor injuries in the MCR/HQ1 and in the Ope Room. Hany of the injured received burns, others sustained cuts and
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penetrating wounds from flying debris. Some saw a blinding flash, others felt a hot blast, while others again witnessed fireballs, sparks with intense-heat or flames. As 2 Deck access was out off midships, casualties proceeded forward or aft for treatment. Later, the normal FAPs became untenable due to smoke, as did the Sick Bay. Emergency FAPs were set up in the Hangar and on the Foc'sle. The serious casualties were evacuated to ARROW and HERMES.

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- 6. Cause of Deaths at Impact Eight duty watch chefs were in the Galley, 2J. It is most likely that they were all killed outright by the impact. If not they died of asphyxia from the very dense acrid black smoke which rapidly filled the 2J, 2K and 2L and spread up to 1H, 1J and 1K.
- Cause of Deaths After Impact Nine men died after impact:
 - a. Many bulkhead doors were ruptured, buckled or sprung at impact, and one man was trapped by his lag in 20/H door starboard. Attempts to free the door from forward were unsuccessful and the trapped man most probably died from asphyxia soon after impact. Two men who escaped from the Naval Stores and comforted this casualty reported that the smoke was very thick in 2H starboard passageway within two to three minutes of impact and that their ACRs were not entirely effective at that time.

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b. One man who was last seen in the Neval Stores, 3H, failed to escape with the two other survivors from that space. No comfident cause of death can be given but eventually he must have died from smoke asphyxia and carbon monoxide poisoning.

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c. One man was felt at the foot of the ladder between 1K and 2K port, immediately forward of the 2K/L port door which was jammed. It appears likely that he was asphyxiated; he may also have been injured. He was unable to climb the ladder. A survivor was unable to pull him out (see Annex W).

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- d. Five members of the Ship's Company died in the Computer Room, 3G. They appear to have remained at their place of duty unaware that the entire forward section of the ship had been evacuated due to snoke. Their reasons for not leaving this space when the Ops Room was abendoned are not known. It is highly likely that they died in the Computer Room or trying to escape later. The cause of death in either case is most likely to have been asphyxis or carbon monoxide poisoning.
- e. Only one man was positively pronounced dead. He had carried out two re-entries forward, wearing only an AGR, to retrieve Damage Control equipment from the Forward DC Base. His heavy breathing and frothing at the mouth, ocupled with the milder symptoms of weakness and dissiness in other personnel who were affected at the same time indicate that he died from carbon monoxide poisoning, despite heroic efforts by several members of the Ship's Company to rescue him and full cardiopulmonary resuscitation by the MO and staff on the Foc'sle.
- 8. Cause of Death Unknown Three members of the Ship's Company were not sighted immediately before or after impact and cannot be accounted for in any way. They are therefore missing presumed dead.

- 9. Causes of Injuries at Impact Eighteen ratings were injured at impact:
 - a. Forward Auxiliary Machinery Room, 4J The seriously injured nam in this space was thrown down to the deck plates and probably knocked unconscious. On recover, he was unable to reach the normal access ladder due to a major fire in the starboard after corner. His overalls were on fire, he beat these out, turned forward but found a wall of fire. He covered his face with his hands and traversed the fire. The compartment was full of smoke. He then proceeded to the port escape ladder and ascended to 2J port passageway. He proceeded forward and received first aid and medical treatment. His serious burns, 44% variable skin thickness, are compatible with this ordeal.
 - b. Forward Engine Room, 48 The seriously injured man reported a blinding flash which lingered and that the compartment rapidly filled with smoke. He covered his face with his hands and then attempted to climb the access ladder to the starboard passageway. The ladder was too hot to hold and he tried to put his arms around the ladder to climb up. Because of the ingress of smoke and the heat he retreated and made an escape via the escape hatch and Olympus uptake space to the Drying Room O'L. He proceeded aft and was given treatment in the Sick Bay. His burns were assessed as 10 15% which are compatible with a serious flash and holding the very hot ladder.
 - c. Main Communications Office, 2E Two personnel were seriously injured in this space. One man was about to open the starboard door to the passageway. The blinding flash and blast blow his trousers off completely and left him with flash burns to his hands, face, head and both legs. He was blown six feet and covered in debris. The other man was approximately 12 feet from the door but in line with and facing the door. He was blown four to five feet and sustained flash burns to his face, legs and ankle. Both had foreign body particles in small wounds on their faces. Of the other four injured personnel, three had relatively minor flash burns to unprotected skin on necks, faces and hands. One man was thrown approximately six feet forward and sustained concussion; another in the MSO area was injured by the shredding machine. All these injuries are commensurate with blast, flash and debris.
 - d. <u>Chief Petty Officers' Mess</u>, 13 All three injuries were relatively minor; two had deep lacerations to the head and minor burns, the other had a head injury and minor burns to the back. All the injuries were probably caused by flying debrie. The occupants described complete collapse of all the fittings.
 - e. Operations Room, 20 The injuries to all three are compatible with the blast entering the compartment via the starboard door; the head injuries were caused by the door and other equipment.
 - Wardroom, 1H The two Stewards had head injuries and bruises caused by flying debris and blast.
 - g. 966 Office Lobby, O2H The soute smoke inhalation and facial burns sustained by the casualty looking down the hatchway while retrieving his anti-flash gear was caused by flash, blast and sucke.

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- h. MOR/HQ1, 2K The one minor back injury was caused by the man being thrown adress the MBCD Officer's deak.
- 95925
- 10. Causes of Injuries After Impact Eight ratings were injured after impact:
 - a. Five personnel suffered with smake inhalation/carbon monoxide poisoning. Of these one was probably affected because he was the last person to evacuate the Ops Room. Of the other four one initially inhaled a significant quantity of smake in the MCR/HQ1 soon after impact and then re-entered aft to retrieve clothing. Twenty-four hours later he suffered from severe chest pain, indicative of Nitrous fuse inhalation. He had not worn an AGR. Two re-entered to the Forward Section Base without Breathing Apparatus (BA) but donned AGRs. They became dissy and weak, and were recovered by other personnel wearing BA. The history suggests carbon monoxide poisoning. The final one was affected by smake but had worn BA throughout. It is not clear whether the face seal on the BA leaked or whether he was breathing fuses at 1½C escapse hatch prior to donning BA. He was also feeling exhausted.

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b. Two men were seriously shocked, one also suffering from mild hypothermia. The latter arcse from a prolonged period on the port and starboard waists and being thoroughly drenched wearing only No 8s and a woolly pully. Q5071

c. One man had a lifting injury to his back while handling a Rover Gas Turbine. Q5361-Q5;

Q4903

- 11. Treatment of Casualties Casualties were treated as follows:
 - a. <u>Trapped Man</u> The man trapped at the G/H starboard door received no treatment. He was briefly comforted by a First Aider from the Naval Stores but no Morphine was carried and therefore none given.

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c. Snoke Two unconscious casualties rescued through the forward escape hatch were resuscitated by the XXXXXXXXXXX Others recovered in the fresh air.

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Comment The above and all other casualties were treated very well by first aid measures.

12. Use of ACR The use of the ACR for re-entry is contrary to BR 2170. Although it appears to have been effective in filtering out funes, it was less effective in heavy snoke where the filter probably blocked. Its ineffectiveness against carbon monoxide is highlighted by one death and the fact that two survivors were pulled out unconscious and another two were close to unconsciousness. Their symptoms are classic for carbon monoxide poisoning.

13. Stress Factors, Sessickness and Tiredness. The Board carried out a survey of all those interviewed and on watch at 14002 on 4 May to assess the above factors. An example questionnaire is at Appendix 2. An analysis of the replies for Ops Room personnel is at TABLE R1.

TABLE R1

PACTOR RESULT No. on watch in Ope Room at 1400Z 31 No. of quasticmnaires completed 23 Time on Natch (watch assumed at 2 hrs. 1200(2)Previous watch 02002 - 09002(Except Senar Watch (1 man) (0200Z - 0600Z)3(2-5)Average sleep before assuming watch (range in brackets) Average hours watchkeeping per 11 (10 - 13) 24hrs over previous 2 days (range in brackets) 8.5 (5 - 11)Average hours sleep per 24hrs over previous 2 days (range in brackets) No affected by sessickness No routinely taking Stugeron (Cinnarazine) Time of taking Stugeron 0800Z XXXXXXXXXXXXXXX No reporting consumption of alcohol in previous 24hrs

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TABLE R1 (cont)

Besult
1 hour
17 hours .
23
21

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Table R1 indicates that alcohol was not generally being consumed, that seasickness was not a major problem, that the crew were sleeping satisfactorily, and none were being overworked. From this questionnaire and statements in evidence there is no indication that the Ops Room team were under unreasonable stress nor suffering any strain.

9243, 9244. 9245, 91068 96236 - 9624 9386

14. Clothing In the appendices to Annex Q the Board asked for evidence concerning clothing worn and injuries sustained. Although the Board are unable to give an authoritative answer on this subject, as such of the swidence has been removed or destroyed, two items of clothing have been retrieved and sent to the Stores and Clothing Research and Development Establishment at Colchester for analysis. Their preliminary report is at Appendix 3. From an assessment of the injuries it is clear that protection against fires is best provided by layers of clothing. Nylon is a poor substance, as it melts; in particular a nylon sock les to a burn on one man's ankle. TABLE B2 gives a comparison between two similar casualties. This shows that the casualty further sway received a burnt ankle wearing nylon socks.

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TABLE R2

FACTOR	XXXXXXXXXXXX	XXXXXXXXXXXX	
Position at impact	MCO Stbd door	12ft from MCC door	
Clothes	No 8 shirt Woolly Pully No 8 trousers Mylon underpants Woollen socks IMS shoes	No 8 shirt Woolly Pully No 8 trousers Nylon underpants Nylon socks Standard Shoes	

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TABLE R2 (Cont)

PACTOR	************	CXXXXXX
Injuries	Flash burns face, hands, both legs; hip to ankles. No burns to butt- ocks, lower abdomen	Flash burns face, 1 hand, slight burn to lower legs. Rankle burnt. No burns to buttocks or lower abdomen.
Clothes	Moclly pully singed, Trousers dis- appeared except for seams. Sooks intact.	Woolly pully singed, Trousers shredded, Slightly hardened sooks.

15. Overalls The exact state of the polyester/cotton overalls of the two seriously burnt casualties from the FAMR and FER and the extent to which clothing exacerbated their injuries are not known. It is understood that the XXXXXHEHMES found the overalls stuck to burns, as did the XXXXHEFFIELD in one case (see para 11b). The precise significance of this is not known to the Board.

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16. Summary Fortuitously, the injuries sustained in SHEFFIELD were light and the casualties were treated very satisfactorily on board and speedily evacuated where necessary. The deaths at impact, certainly eight and probably all eleven, are likely to have been instantaneous. Nine others died of asphyxia after impact; one of these was in considerable pain. The ineffectiveness of the AGR against carbon monoxide is highlighted. There is no evidence of stress, seasickness or tiredness reducing efficiency.

Appendices:

- Accounting for Drugs Governed by the Controlled Drugs Act.
- Specimen Questionnaire.
- Stores and Clothing Research and Development Establishment Preliminary Report - Clothing Items ex HMS SHEFFIELD - NN/727/01 dated 5 Jul 82.

APPENDIX 1 TO ANNEX R TO SHEFFIELD BOI REPORT DATED 22 JUL 82

ACCOUNTING FOR DRUGS COVERNED BY THE CONTROLLED DRUGS ACT

1.	Issued	to	SHEFFIEL	D.
	LINE THE THE THE TANK	- 11.75		

a.	144 Omnopon Monojects	Basic Issue
ъ.	20 Ampoules Pethidine 50mg)	
c.	24 Ampoules Morphine Sulphate 15mg)	Conversion Unit
d.	15 Ampoules Omnopon/Scopolomine)	Conversion only
0.0	100 Tablets Pethidine 20mg)	
f.	6 Omnopon Monojects	Field Service
		Valise
8.	4 Ampoules Morphine Sulphate 15mg)	MO's Energency
h.	2 Amoules Pathidine 50mg)	Pacic

- Used by SHEFFIELD on 4 May. One Ampoule Pethidine. Two (Omnopon) Monojects.
- Returned by SHEFFIELD to Chief Pharmacist HASLAR. 3.
 - a. 5 Ampoules Morphine 15mg

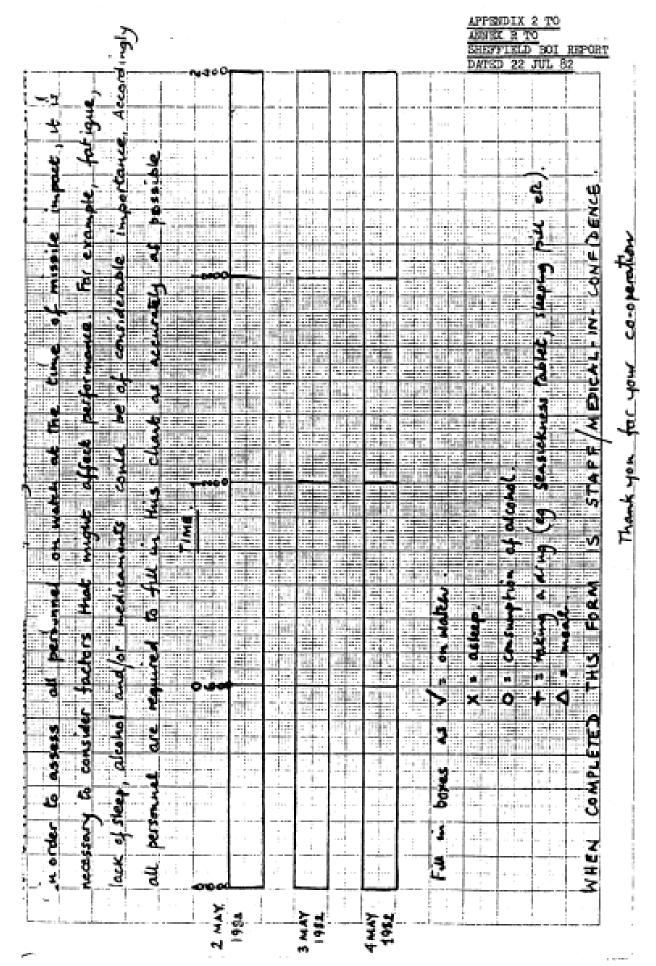
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b. 2 Omnopon Monojects

4. Transferred to Other Ships.

- Nil to ARROW. 8..
- Returns from YARMOUTH and FORT AUSTIN not rendered.
- Conclusion. Remaining Morphine not accounted for but probably sank in SHEFFIELD.
- Recommendation. SHEFFIELD to write off CDA drugs in accordance with QHRN 4280.



FIOR:XXX



STORES AND CLOTHING RESEARCH AND DEVELOPMENT ESTABLISHMENT

Ministry of Defence
Flagstaff Road Colchester Essex CO2 7SS
Telephone 0206 (Colchester 2502) ext

a 4230

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ANNEX R TO SHEFFIELD BOI REPORT DATED 22 JUL 82

All replies should be addressed to the Director

HMS Sheffield Board of Inquiry Hardy Block HMS Nelson Portsmouth Hammshire

Our reference NII/727/01

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5 July 1982

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CLOTHING ITEMS EX HMS SHEFFIELD

- We have conducted a preliminary examination of the items you sent to us and can make some observations now.
- 2. No 8 Trousers. These are standard issue No 8 Trousers; the fabric is an intimate blend of polyester (67%) and cotton(35%). There are small pieces of fabric missing from the centres of some damaged areas and we can obviously make no comment on those.
- 3. In the damaged areas the fabric has hardened because the polyester component melted, flowed together and subsequently resolidified in a non-fibrous form. This damage is almost exclusively confined to the outer surface of the cloth. At the inner surface, the polyester fibres remain undamaged. Skin damage beneath the cloth will have been caused by thermal energy transmitted through the fairly light weight fabric. The fabric itself did not contribute to the periousness of the injuries. It is probable that any cloth of similar weight and thickness would have provided no nore or less protection to the underlying skin.
- 4. It seems probable that the thermal energy in the flash caused the outer surface of the fabric to degrade. The immediately following blast wave in the confined space had a cooling effect and threw the man further from the source which may have prevented further destruction of the fabric.
- 5. I understand that his socks were more completely degraded and that he suffered ankle burns. This is understandable since they were of lighter weight material of 100% mylon and could have been more completely destroyed in the time which only caused degradation of the cuter surface of the trouser fabric.
- 6. <u>Coverall</u> (forwarded with your letter dated 29 June 1982). This is a standard GS Coverall made from a blend of 67% polyester and 33% cotton. The garment is old and the fabric on the back is worm extremely thin to the point that it is translucent.
- 7. There is no detectable thermal damage to the material. It is probable that the relatively low level of radiant energy in this location was insufficient to cause any degradation to the material but some was able to pass through the open structure of the fabric to cause the "sunburn" type of skin damage.

8. We are carrying out more detailed tests related to the damage to the No 8 Trousers. It is unlikely that the results will be of direct value to the Board of Inquiry but may provide information of use in future decision making about protective clothing. We will of course pass any useful results to you and will be pleased to provide any additional comments or answer questions about these items. We would also welcome opportunity to examine any other items with which you think we can help.

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