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Ref. T1/12.01

MSC-MEPC.3/Circ.1
26 September 2005

CASUALTY-RELATED MATTERS[1]
REPORTS ON MARINE CASUALTIES AND INCIDENTS

Revised harmonized reporting procedures - Reports required under SOLAS regulation I/21 and MARPOL 73/78, articles 8 and 12

ANNEX 1

IMO MARINE CASUALTY AND INCIDENT REPORT

SHIP IDENTIFICATION AND PARTICULARS

Administrations are urged to supply the ship identification information listed in this annex for all marine casualty reports submitted to the Organization.

SHIP PARTICULARS

1. IMO Number: 9226360

2. Name of Ship: MV Louise Russ

3. Flag State: UK - Gibraltar

4. Type of Ship:

.1 Liquefied Gas Tanker ☐

.2 Chemical Tanker ☐

.3 Oil Tanker ☐

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[1] In order to facilitate the identification and retrieval of information circulated by means of joint MSC-MEPC circulars, from now on such information will be disseminated through the following circular series:

1 Organization and methods of work, as MSC-MEPC.1/Circ…
2 General matters, as MSC-MEPC.2/Circ…
3 Casualty-related matters, as MSC-MEPC.3/Circ…
4 Port State control-related matters, as MSC-MEPC.4/Circ…
5 Survey and certification-related matters, as MSC-MEPC.5/Circ…
6 National contact points for safety and pollution prevention and response, as MSC-MEPC.6/Circ…

.4	Other Liquids (non-flammable) Tanker	☐
.5	Bulk Dry (general, ore) Carrier	☐
.6	Bulk Dry / Oil Carrier	☐
.7	Self-Discharging Bulk Dry Carrier	☐
.8	Other Bulk Dry (cement, woodchips, urea and other specialized) Carrier	☐
.9	General Cargo Ship	☐
.10	Passenger / General Cargo Ship	☐
.11	Container Ship	☐
.12	Refrigerated Cargo Ship	☐
.13	Ro-Ro Cargo Ship	X☐
.14	Passenger / Ro-Ro Cargo Ship	☐
.15	Passenger Ship	☐
.16	High Speed Craft	☐
.17	Other Dry Cargo (livestock, barge, heavy cargo, etc.) Carrier	☐
.18	Fish Catching Vessel	☐
.19	Fish Factory Ship / Fish Carrier	☐
.20	Offshore Supply Ship	☐
.21	Other Offshore Ship	☐
.22	Research Ship	☐
.23	Towing / Pushing Tug	☐
.24	Dredger	☐
.25	Other Activities Ship	☐
.26	Non-Propelled Ships	☐
.27	Other Ships Structures	☐

5. Type of service:

(X) International

( ) Short international
( ) Coastal sea trade
( ) Inland waters
( ) Other, please state:

( ) Not reported

6. **Were any voyage related restriction limits placed on the ship?** No

7. **Gross Tonnage: 18265GT**

8. **Length overall: 174 metres**

9. **Classification Society: GL**

10. **Registered Shipowner: Ernest Russ GmbH**

11. **Ship Manager/Operator: As above**

12. **Previous names: None**

13. **Previous Flag: None**

14. **Previous Class Society: None**

15. **Date of contract/keel laid/delivery: December 2000**

16. **Date of major conversion: N/A**

17. **Deadweight: 8800**

18. **Hull material:**

.1 steel	X☐
.2 light alloy	☐
.3 ferrocement	☐
.4 wood	☐
.5 GRP	☐
.6 composite materials	☐

19. **Hull construction:**

.1 single hull	X☐
.2 double hull	☐
.3 double bottom	X☐
.4 double sides	☐
.5 mid deck	☐
.6 other	☐

20. Propulsion Type (type, fuel, etc.): Steam ☐ Diesel X☐

Other ☐

.1 Bunkers:

Heavy Fuel Oil (HFO) X☐ Medium Fuel Oil (MFO) ☐ Marine Diesel Oil (MDO) X ☐

21. Nature of cargo (e.g. oil, dry bulk and goods under the IMDG Code): Containers and Ro-Ro

22. Building yard:

23. Hull number:

24. Date of total loss/constructive total loss/scrapping: N/A

25. Number of Crew on ship's certificate: _____

26. Number of Passengers on ship's certificate: __N/A_____

27. Number of persons onboard at the time of the casualty / accident:

.1 Crew: _____

.2 Passengers: ___N/A___

.3 Others_____None

PRELIMINARY CASUALTY DATA

1. Date and time (local onboard): 3rd January 2011

2. Position/location: Rotterdam

3. Initial event[1]:

☐ collision
☐ stranding/ grounding
☐ contact
☐ fire or explosion
☐ hull failure/ failure of watertight doors/ports, etc.
☐ machinery damage
☐ damages to ship or equipment
☐ capsizing/ listing

[1] For an explanation of the terms below see annex 2.

☐ missing: assumed lost
✠ accidents with life-saving appliances
☐ other

4. Consequences:

☐ total loss of the ship
☐ ship rendered unfit to proceed*
☐ ship remains fit to proceed**
☐ pollution
☐ loss of life
✠ serious injuries

5. Summary of events

1. The accident occurred during a routine free fall lifeboat drill held on board MV Louise Russ at the port of Rotterdam, Netherlands on the 3rd January 2011,
2. The lifeboat was accidentally released causing Mr. Piotr Godyn an able seaman serving on the vessel to fall from the stern of the lifeboat onto the poop deck of the vessel.
3. Mr. Godyn sustained broken ribs, shoulder and finger as a result of the accident.
4. The securing hook for the release of the free fall lifeboat was released prior to attaching the lifting hooks onto the lifting wires of the winch. This was performed in the wrong order and should the securing hook have been in place at the time of the accident, this may have restrained the lifeboat in the davit.

5. A specific davit launching procedure and launching instructions posted on location in place may have better contributed to the crew's familiarization of the launching operation and sequence.

6. When attaching the hoisting hooks to the lifting rings this position leaves both A/B's exposed to a height of around 8 meters to the poop deck. Neither of the A/B's was equipped with a safety harness which may have prevented Mr. Godyn's fall.

7. It was observed during the investigation that Mr. Godyn would have been unable to jump to the safety of the boarding platform as it does not fully extend to the starboard quarter of the lifeboat. The handrail would also possibly impede him from getting to the platform as it causes an additional obstruction.

8. It appears from the physical evidence observed during the investigation, as if the lifting hook on the port quarter caught the lifeboat under the stern gunwale lifting it over the locking device causing the accidental launch, this is also the conclusion of

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* The ship is in a condition, which does not correspond substantially with the applicable conventions, presenting a danger to the ship and the persons on board or an unreasonable threat of harm to the marine environment.

** The ship is in a condition, which corresponds substantially with the applicable conventions, presenting neither a danger to the ship and the persons on board nor an unreasonable threat of harm to the marine environment.

investigations conducted by both North Sea Davit and Lifeboat Services and the P&I. This could be of a better design as the angle of the lifting wire coupled with the counter weight causes the hook to be drawn in the direction of the lifeboat aft platform.

9. It was stated by Mr. Wawryniuk that the lifting hooks are kept clear by the A/B's and was done so at the time of the accident. It is however difficult to understand how the hook caught the back of the lifeboat platform if it was being held clear.

10. It was also observed that arrangement for the securing eye for the port lifting hook on the davit could also easily cause the hook to become lodged due to its proximity with the boarding platform.

PRELIMINARY CASUALTY DATA

1. Date and time (local onboard): 3rd January 2011

2. Position/location: Rotterdam

3. Initial event[1]:

- ☐ collision
- ☐ stranding/ grounding
- ☐ contact
- ☐ fire or explosion
- ☐ hull failure/ failure of watertight doors/ports, etc.
- ☐ machinery damage
- ☐ damages to ship or equipment
- ☐ capsizing/ listing
- ☐ missing: assumed lost
- ✠ accidents with life-saving appliances
- ☐ other

4. Consequences:

- ☐ total loss of the ship
- ☐ ship rendered unfit to proceed*
- ☐ ship remains fit to proceed**
- ☐ pollution
- ☐ loss of life
- ✠ serious injuries

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[1] For an explanation of the terms below see annex 2.

* The ship is in a condition, which does not correspond substantially with the applicable conventions, presenting a danger to the ship and the persons on board or an unreasonable threat of harm to the marine environment.

** The ship is in a condition, which corresponds substantially with the applicable conventions, presenting neither a danger to the ship and the persons on board nor an unreasonable threat of harm to the marine environment.

5. Summary of events

11. The accident occurred during a routine free fall lifeboat drill held on board MV Louise Russ at the port of Rotterdam, Netherlands on the 3rd January 2011,
12. The lifeboat was accidentally released causing Mr. Piotr Godyn an able seaman serving on the vessel to fall from the stern of the lifeboat onto the poop deck of the vessel.
13. Mr. Godyn sustained broken ribs, shoulder and finger as a result of the accident.
14. The securing hook for the release of the free fall lifeboat was released prior to attaching the lifting hooks onto the lifting wires of the winch. This was performed in the wrong order and should the securing hook have been in place at the time of the accident, this may have restrained the lifeboat in the davit.

16. A specific davit launching procedure and launching instructions posted on location in place may have better contributed to the crew's familiarization of the launching operation and sequence.

18. When attaching the hoisting hooks to the lifting rings this position leaves both A/B's exposed to a height of around 8 meters to the poop deck. Neither of the A/B's was equipped with a safety harness which may have prevented Mr. Godyn's fall.

20. It was observed during the investigation that Mr. Godyn would have been unable to jump to the safety of the boarding platform as it does not fully extend to the starboard quarter of the lifeboat. The handrail would also possibly impede him from getting to the platform as it causes an additional obstruction.

22. It appears from the physical evidence observed during the investigation, as if the lifting hook on the port quarter caught the lifeboat under the stern gunwale lifting it over the locking device causing the accidental launch, this is also the conclusion of investigations conducted by both North Sea Davit and Lifeboat Services and the P&I. This could be of a better design as the angle of the lifting wire coupled with the counter weight causes the hook to be drawn in the direction of the lifeboat aft platform.

24. It was stated by Mr. Wawryniuk that the lifting hooks are kept clear by the A/B's and was done so at the time of the accident. It is however difficult to understand how the hook caught the back of the lifeboat platform if it was being held clear.

26. It was also observed that arrangement for the securing eye for the port lifting hook on the davit could also easily cause the hook to become lodged due to its proximity with the boarding platform.

10.2 Hardware: ☐

10.2.1 Equipment not available ☐

10.2.2 Ergonomics ☐

10.2.3 Design failures (other than ergonomics) X

10.2.4 Maintenance and repair ☐

10.2.5 Other ☐

ANNEX 3

IMO MARINE CASUALTY AND INCIDENT REPORT

SUPPLEMENTARY INFORMATION ON VERY SERIOUS AND SERIOUS CASUALTIES

To assist completion of marine casualty analysis, in addition to the information in annexes 1 and 2, the following information is required:

1. Principle findings and form of casualty investigation:

GMA conducted an Accident Investigation in accordance with local legislation and the IMO Code.

Recommendations to Ernst Russ GmbH & Co. KG

Launching procedure and instructions should be developed by the company utilising a risk assessment method and should also extend to any additional safety measures and equipment.

The above procedure and instructions together with specific details of the type of lifeboat installed should be included in all copies of the SOLAS training manual on board.

The company should clearly define within their SMS as to the type, frequency and locations for lifeboat drills.

The lifeboat manufacturers should be contacted and the arrangements for stowing of the lifting hooks should be investigated to explore an alternative / improved option.

2. Action taken:

Corrective and preventative actions taken by the company

Ernst Russ GmbH & Co. KG have subsequent to the accident taken corrective and preventative measures in order to prevent a recurrence. These measures include:

5.1 Risk Assessment

A risk assessment addressing the hazards associated with the lowering of the lifeboat by davit has been performed and control measures introduced to mitigate the hazards identified.

5.2 Toolbox talk

A discussion with crew involved in the lowering of the lifeboat was performed in order to ensure that personnel are aware of associated risks and precautions and instructions to be followed.

5.3 Safety bulletin

A fleet wide safety bulletin was developed and circulated by the company incorporating details of the accident together with subsequent corrective and preventative actions taken.

3. Findings affecting international regulations:

The design of the lifeboat lifting hooks to be re-viewed

4. Assistance given (SAR operations):

N/A

ANNEX 10

LIFE-SAVING APPLIANCE CASUALTY RECORD

The purpose of this casualty record is to enable the gathering and collation of statistical data on both novel and traditional life-saving appliances, in order that the safety of these appliances may be assessed and improvements made if necessary on the basis of reliable risk information.

Administrations are urged to supply the additional information listed in this annex for all casualties involving life-saving appliances, adding any other information which would provide lessons to be learned concerning the use of life-saving appliances.

1 Location of casualty:
(See annex 2, items 3.1-3.10)

.1 Was the ship: underway ☐ in port X at anchor ☐

2 Local conditions:

- ***2.1 Local time (24-hr clock)****:* 09:20 – Lifeboat drill commenced

  Daylight X Darkness ☐

2.2 Wind force (Beaufort scale): N/A

2.3 Wave height (observed): N/A

2.4 Sea Temperature: ___N/A

2.5 Air temperature: ____N/A

2.6 Ice conditions Yes ☐ No X

2.7 Warm Climates Yes ☐ No X

3 Type of life-saving appliance involved:

3.3 Lifeboat X Capacity: _____ POB: _____

.1 Davit launched ☐ Free fall X

5 Reason for deployment of life-saving appliance:

5.1 Emergency evacuation / abandonment ☐

5.2 Crew training X

5.3 Deployment as required by regulations X

5.4 Approval Trials (give details) ☐

6 Nature of casualty/incident

(See annex 1, paragraph 5)

7 Details of injuries/fatalities:

7.1 Number of life-saving appliance related fatalities

Crew: _____ Passengers: _____Others: _____

7.2 Number of life-saving appliance related injuries

Crew: __1____ Passengers: _____ Others: _____