



Report on the investigation of the free fall lifeboat accident on board

MV Louise Russ IMO 9226360

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Maritime Administration
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Synopsis

During a routine free fall lifeboat drill held on board MV Louise Russ at the port of Rotterdam, Netherlands on the 3rd January 2011, the lifeboat was accidentally released during which Mr. Piotr Godyn an able seaman serving on the vessel sustained a major injury as a result of falling from the stern of the lifeboat onto the poop deck of the vessel. Mr. Godyn sustained broken ribs, shoulder and finger as a result of the accident.

The conclusions of the accident investigation conducted by the Gibraltar Maritime Administration indicate that the accidental launching of the lifeboat appears to have been contributed to by one of the lifting hooks of the winch having caught the lower side of the lifeboat stern and subsequently lifting the lifeboat over the davit locking device causing its release.

It was also ascertained that the sequence for the release of the lifeboat securing hook and attaching of the lifting hooks of the winch were performed in the wrong order.

Additional measures in the way of safety harnesses worn by operating crew and procedures for the launching of the lifeboat by davit may have served towards preventing the accident.

Section 1 – Factual Information

Particulars of MV Louise Russ and accident

1.1 Ship's Particulars

Place and year of built	Hamburg 2000
Ship's Flag	Gibraltar
Port of Registry	Gibraltar
Call Sign	ZDEK3
IMO Number	9226360
Owner	Ernst Russ GmbH &
Charterer	
LOA	174
LPP	160.65
Breadth moulded	25.47
Maximum draft	6.75 / 6.89
Deadweight	8800
Displacement	15987.00
Gross Tonnage	18265
Net Tonnage	5479
Block coefficient	0.601
Air draught	
Maximum height from BL	42.6
Container capacity	426
Trailer capacity	171
Bale capacity	27000 c.m.
Main engine type	2 x MAK 9 M43
Main engine power	16800 kW
Main engine revolutions	500 rpm
Shaft generator power	2200 kW
Right handed pitch	4 blades
Bow truster	1200 kW
Stern truster	720 kW
Service speed	22 kts
Heavy fuel capacity	1354 qmtrs
Diesel oil capacity	132 qmtrs
Water balast capacity	6402 mt
Fresh water capacity	105.00
Technical water capacity	
Radio Company	DP05
MMSI	236134000
Inmarsat C	+581 (423) 613410
Inmarsat M Phone	+871 (762) 766797
Inmarsat M Fax	+871 (762) 766798
NMT Phone / Fax	
GSM Phone	+49 (172) 5106249
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GSM Data	+49 (172) 5117469
GSM Master	

1.2 Accident

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, 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. Mr. Godyn sustained broken ribs, shoulder and finger as a result of the accident.

Section 2 – Narrative

2.1 Background Information

MV Louise Russ is a 2000 built Ro Ro vessel managed by Ernst Russ GmbH & Co. KG, and currently trading between the ports of Rotterdam, Netherlands and Purfleet, United Kingdom.

Following a report of an accident during a routine free fall lifeboat drill at the port of Rotterdam, Netherlands on the 3rd January 2011, Gibraltar Maritime Administration attended the vessel on 11th January 2011 in order to conduct an investigation into the accident and possible causes in accordance with Gibraltar Merchant Shipping (Accident Reporting & Investigation) Regulations 2006.

The purpose was to investigate the sequence of events leading to accident, and to determine if any factors which may have contributed to the event.

The vessel during the investigation was located at the same berth in the port of Rotterdam where the incident had taken place. However, the vessel had performed a round trip to Purfleet between the time of the incident and the time of the investigation taking place.

2.2 Accident Timeline

- 09:20 – Lifeboat drill commenced
- 09:25 – Lifeboat accidentally released and Mr. Godyn falls to poop deck
- 09:30 – Ambulance requested
- 09:50 – Ambulance arrival and paramedics attend to Mr. Godyn
- 10:00 – Mr. Godyn transported to Erasmus Medical Centre, Rotterdam

2.3 Accident description

Duties assigned:

- Master overall command
- Bosun winch operator
- A/B attaching lifting slings and release of securing hook

Master - The Master was standing at the bottom of the steps leading to the embarkation platform of the free fall lifeboat facing the lifeboat. According to the Master, he did not have a clear view of the stern of the lifeboat from his position, and was not directly monitoring the release of the securing hook or the engaging of the lifting slings. The Master did see Mr. Wawryniuk giving the hoisting signal to the Bosun. Moments after hoisting commenced an unscheduled release of the boat occurred and he saw Mr. Godyn fall between the stern of the boat and the davit. The Master then rushed down to the poop deck and found Mr. Godyn lying on the deck in an unconscious state. The Master checked Mr. Godyn's vital signs and was checking for injuries when Mr. Godyn started to come round but apparently very incoherent as to what had happened or where he was. The Master instructed the duty officer on the bridge to call for an ambulance, and remained with Mr. Godyn until the arrival of the ambulance.

Bosun - The Bosun's task in relation to the lifeboat launching is to operate the winch using the remote controls whilst positioned next to the stern mooring drums. From his position, the Bosun can only see the A/B positioned on the port quarter of the lifeboat (Mr. Wawryniuk's position) from whom he receives signals for the winch operation. The Bosun received the signal for hoisting from Mr. Wawryniuk and began to slowly hoist the winch. The lifeboat suddenly came free and came sliding down the davit runners although not in the appropriate position and the bosun saw Mr. Godyn fall coming into contact with the deployed mooring lines and then almost immediately the deck surface. The Bosun immediately stopped the winch. Mr. Dettlaff stated that the incident occurred extremely quickly and moments after Mr. Godyn fell, the Master arrived at the scene.

A/B's - Both A/B's are tasked with securing the lifting slings and releasing the securing hook of the lifeboat. Mr. Wawryniuk's position was on the port quarter of the lifeboat with Mr. Godyn on the starboard quarter.

According to Mr. Wawryniuk, both Mr. Godyn and he released the securing hook of the lifeboat, and then released the lifting hooks port and starboard. Mr. Wawryniuk then signalled the Bosun to slack the lifting winch in order to release the lifting hooks. This is necessary, as the lifting hooks are equipped with heavy counter weights and the hooks have

to be hoisted to the height of the rings fitted to the lifting slings in order to attach these to the hooks. Both A/B's are then required to stand on the aft platform of the lifeboat in order to reach the rings and attach the lifting hooks.

Once the lifting hooks were released, Mr. Wawryniuk signalled the Bosun to slowly commence to lift on the winch. At this point both A/B's were positioned on the aft lifeboat platform. As the winch started to hoist, the lifeboat started to move downwards. Mr. Wawryniuk was able to grab onto the handrail on the boarding platform and pull himself to safety. Mr. Godyn fell between the stern of the lifeboat and the davit. Mr. Wawryniuk states that as he turned he saw Mr. Godyn fall towards the poop deck.

The lifeboat after clearing the davit fell at an inappropriate angle coming into contact with the vessels stern loading ramp and then entering the water.

2.4 Post accident actions

Mr. Godyn after the accident occurred was conveyed by ambulance and transferred to the Erasmus Medical Centre in Rotterdam, and after initial treatment transferred to the traumatology ward at the same hospital. Mr. Godyn sustained broken ribs, shoulder and finger as a result of the accident, but had been discharged and repatriated at the time of the investigation and as such was not available for interview. The Master according to a copy of an e-mail dated 7th January 2011 visited the injured A/B on the 6th January but according to the correspondence Mr. Godyn had very little recollection of the accident, limiting his account to just prior and just post the accident occurring.

After the accident, the free fall life boat was recovered and stowed back on the davit where it was present during the investigation. The life boat was not in use with a temporary measure in the way of additional life rafts in place on both the port and starboard side of the vessel. A Flag State exemption certificate (certificate No. GIB/11/001) reflecting the temporary arrangement valid until the 2nd February 2011 was present on board.

2.5 Environmental conditions

The wind was West South West force 8, good visibility and temperature was 8 degrees Celsius.

2.6 Planned maintenance system

The electronic planned maintenance system (PMS) in use on board was checked and schedules for the periodic maintenance of the life boat were included. Records showed periodic maintenance as having been carried out on 19th December 2010, however, the Master stated that the maintenance routine was normally performed in conjunction with the life boat drills and the drill had been postponed until January due to adverse prevailing weather conditions in Northern Europe during the months of November and December 2010. As such, the maintenance of the life boat had not been carried out as scheduled, and the intention was to perform the maintenance routine on the 3rd January 2011 after the life boat drill.

2.7 Drills and exercises

The drill schedule implemented on board was checked during the investigation with the life boat drill showing as having been completed during December 2010. This was determined by the Master to be an error on behalf of the Safety Officer. The Master's statement was corroborated in the PMS which also contains scheduling for drills, and showed as overdue due to adverse weather conditions.

The Master was asked on the frequency and type of life boat drills; in this case the Master stated that a free fall launch was performed once a year, with a launching by davit at three month intervals. The Master added that the davit launch was normally performed during port calls whilst the vessel is alongside performing cargo operations, and that this was the most convenient option due to the vessel's trading patterns being of short voyages and as such not allowing sufficient time to perform the drill at sea or anchorage. A copy of an e-mail from the company dated 4th January 2011, now instructs masters of fleet vessels to not conduct davit launches whilst the stern ramp is deployed.

2.8 Lifeboat procedure

It was noted, that the Safety management System (SMS) does not include any procedure for the types of life boat drills or any specific schedule for what type of life boat drill is to be conducted or the frequency. In addition, the Safety of Life at Sea (SOLAS) training manual available on board does not contain specific information to the type of free fall life boat installed on the vessel. It does contain information relating to other types of life boats and a section on a type of free fall life boat but with different arrangements to that installed on board.

Section 3 – Conclusion

3.1 Issues directly contributing to the accident which has resulted in recommendations.

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.

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.

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.

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.

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.

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.

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.

Section 4 – Recommendations

4.1 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.

Section 5 – 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.

5.4 Training manual

The section concerned with the launching of the free fall lifeboat contained within the training manual has been amended and now incorporates specific procedures supplied by the manufacturers.

5.5 Physical alterations

Physical alterations have been made to both the lifeboat and the davit in way of:

- an additional rubbing strake being installed on the edge of the lifeboat's stern platform in order to reduce the gap between the launching/embarkation platform and the boat to reduce the possibility of the lifting hook becoming lodged under the stern of the boat.
- Repositioning of the securing eyes for the lifting hooks to a more elevated position enabling better access.

Section 6 – Acceptance of corrective and preventative actions

- 6.1 Gibraltar Maritime Administration has reviewed the corrective and preventative actions taken by the company subsequent to the accident, and concludes that these measures are sufficient in meeting the recommendations detailed in section 4.