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MAIB
MARINE ACCIDENT INVESTIGATION BRANCH

Marine Accident Investigation Branch
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ACCIDENT REPORT FORM (ARF)

The Merchant Shipping (Accident Reporting and Investigation) Regulations 2012 requires that marine accidents (including serious injuries) and marine incidents (commonly known as 'near misses') be reported to the MAIB.

Follow the link below for the relevant regulations and MGN guidance:
https://www.gov.uk/government/organisations/marine-accident-investigation-branch/about#regulations-and-guidance

There are 2 steps in the reporting process:

STEP 1: NOTIFICATION

The notification is to be carried out immediately after the accident or marine incident by the quickest means available.

Those directly involved with the operation of a vessel (masters or skippers, and owners or managers) or authorities ashore (harbour authorities, inland waterway authorities, and the Maritime and Coastguard Agency) are obliged to notify the MAIB.

24 Hour Reporting Line: +44 (0)23 8023 2527

STEP 2: COMPLETION OF THE ACCIDENT FORM FORM (ARF)

It is the responsibility of the vessel's master/skipper or owner/manager to complete the ARF and send it to the MAIB as soon as is practicable. Please try to answer as many questions as possible. If information is not known, select 'unknown' or type 'n/k' and if a particular question is not applicable, select or type 'n/a' (leaving numerical fields blank).

Please complete the form electronically if possible. It is designed to be easier to answer questions with the required information, and therefore less need for the MAIB to contact you to clarify answers submitted. If you are unable to complete the form then please contact maib@dft.gsi.gov.uk.

One form should be completed for each accident or marine incident. Completing and returning this form does not constitute an admission of liability of any kind, either by the person making the report or any other person.

The MAIB's job is to help prevent further avoidable accidents from occurring, not to establish blame or liability

SECTION A: OCCURRENCE DETAILS

Local Date: 28/07/2018 | Local time (UTC): 10:00 (+) | Occurrence type: Accident to person (not caused by an option listed below) | Search & rescue (SAR) operation involved: Yes ○ No ◉ Unknown ○

Coastal State: United Kingdom | Port of occurrence: Stornoway

Latitude: 58 ° 12 . 40 ' ◉ North ○ South | Longitude: 006 ° 23 . 40 ' ○ East ◉ West | Tick box if unable to specify a location ☐

External environment

Sea state: 3 - Slight - (0.5 – 1.25 m) | Wind force: 3 - Gentle Breeze - 7-10kts | 4-5m/s

Natural light: Daylight | Weather conditions: Rain | Visibility: Good - 5.0 <= Vis < 25.0 nm

SECTION B: VESSEL DETAILS

Name of vessel: MPV Minna

Type of vessel: Unknown

IMO number: 9 2 6 6 7 1 2

Please provide any other forms of vessel identification (select as many as appropriate)
Note: tick at least one option if there is no IMO number

☑ MMSI ☐ RSS/SSR number ☑ Call sign ☐ None applicable

MMSI: 2 3 5 7 1 0 0 0 0 Call sign: M A S H 6

Did the occurrence involve a vessel's boat? (do not include SAR involvement)

☐ Rescue ☐ Fast rescue ☐ Ship's lifeboat ☐ Tender ☐ Other

Flag State: UNITED KINGDOM Length overall (m): 47.7 Registered length (m): 42

Gross tonnage: 781 Year of build: 2003 Hull material: Steel Propulsion type: Diesel/electrical

Number of persons on board at time of the occurrence

Crew: 15 Passengers: Other:

Categorisation of people: Other

'Other' includes non-crew (eg pilots, shore workers) working on board vessels.

'Other' can also be people who have paid to be actively involved in crewing a vessel. A typical example would be people paying to crew a yacht (eg sailing school students); they are not crew (as they have paid for their involvement), nor are they 'passengers' because they have an active role on board. Also in this example the yacht would not be categorised as a 'passenger vessel'. People on board the same yacht who are paid for their services (eg skipper, mate) remain classed as 'crew'.

Were any other vessels involved in the occurrence No ○ Yes ○

SECTION C: VOYAGE DATA

Voyage segment	Vessel routeing	Under pilotage or PEC direction
Arrival	Pilotage area	No

Port of departure	Port of destination
Greenock	Stornoway

Vessel operation(s) at the time of the occurrence

Normal service > Manoeuvring	n/a

SECTION D: CONSEQUENCES

Did your vessel sink: No Was your vessel unfit to proceed: No

Tick relevant box(es) if, following the occurrence, either of these were necessary to prevent a further accident ☐ Shore assistance ☐ Towage

Was your vessel damaged: No Was your cargo damaged: No Pollution from cargo: No Pollution from bunkers: No

External damage to structures and environment
(exclude damage to other vessels involved in the occurrence)

Third party damage: No Air Pollution: No

SECTION E applies to occurrences resulting in injuries, lives lost or missing persons. Tick box if you have any to report, otherwise go to Section F. ☑

SECTION E: INJURY/FATALITY RELATED DATA AND CONSEQUENCES

Number of people with minor injuries
(up to 72 hours incapacitated/off work)

Crew | Passengers | Other | Total 0

Number of people with serious injuries
(over 72 hours incapacitated/off work)

Crew 1 | Passengers | Other | Total 1

Number of lives lost

Crew | Passengers | Other | Total 0

Number of missing persons

Crew | Passengers | Other | Total 0

Total number of casualties 1

For each casualty please give the following details

Person 1

Person type: Crew | Age: 38 | Gender: Male | Physical status: Serious Injury: OVER 72 hours incapacitated/off work

For injuries only: total number of days incapacitated/off work if known (do not delay submitting form if situation is ongoing)

Nationality (by country): United Kingdom | Was a lifejacket used: n/a

Where on vessel did the injury happen: Ship > Forecastle | Tick if this area is an enclosed space ☐

Type of injury: Multiple injuries

Part of the body injured: Back > Other, not mentioned above

Add new person

Click to delete added person details

SECTION F: DESCRIPTIONS

Description of the sequence of events leading to and including the occurrence

On the 16th July 2018 a full crew change was conducted. The on-signing crew noticed a slight difference in colour between two sections of paint on the forecastle deck. The smaller of the two portions of deck measured approximately 3.5m fore and aft, measured from the accommodation to a weld marginally astern of the foremost mooring bits and from the port side 7 metres across the deck.
When it rained on the 17th July, the bosun reported that this smaller portion of deck was much slippier than the larger portion of deck. He believed that the wrong paint may have been used. The off-signing bosun was telephoned by the on-signing bosun and he confirmed that this portion of deck had been painted with International 'Interlac 665' as the vessel had run out of the required 'Interbond 201'. On the vessel's paint-spec, it is stated that 'Interlac 665' should be used for internal decks only. The handover notes between the on-signing and off-signing teams made no mention of this change to vessel's painting specifications.

The Officer in Charge contacted the Marine Superintendent and the Safety Superintendent to explain the situation and to report on the control measures he intended to put in place. These were:

1. Contact the paint manufacturer for recommendations on how to fix this problem – The paint representative confirmed that a disc sanding of the affected area would provide a sufficient key, so that Interbond 201 parts A and B could be placed on top.

2. Purchase new paint so the affected area could be re--coated – The paint manufacturer was contacted, as was a local paint supplier, but neither were able to deliver paint within the 24 hours required before the vessel was expected to sail. This paint order would be delivered instead in three weeks-time, when the vessel returned to port.

3. Create a walkway on the deck using adhesive, non-slip tape, so that crew could move safely from the affected portion of the deck to the area that was not affected. – this was done before the vessel set sail.

4. Inform all crew that the forecastle was to be avoided in heavy weather and to take extra care when walking across the affected area, with full PPE to be worn at all times – This was explained to the crew in the Muster drill held within 24 hours of leaving port.

5. Post additional signage, warning of the dangers on the forecastle deck – This was purchased before sailing and posted in a prominent position on the forecastle.

6. Write a safety incident report – This was completed by the vessel's safety officer and disseminated to the safety superintendent on 21st July.

Before sailing, the forward mooring station was discussed as was the need to take extra care on the forecastle area. The affected area was risk assessed by the Officer in Charge, The First Officer, the Safety Officer, the Safety Representative and the Bosun and, as it was aft of the main area the mooring party would be using, it was felt that this area should and could be avoided. The vessel then sailed without incident.

On the 28th July the vessel was due to make a scheduled stop in Stornoway. The weather conditions were raining and light winds. The vessel was maneuvering at slow speed whilst coming alongside the pier. The casualty was wearing full PPE inclusive of hard hat and non slip shoes.

The vessel was nearly alongside the pier (port side to) and the spring line was on the bollard. The casualty recognised that a fender was going to be needed and went to put this out. Whilst moving from the forward end to the aft of the focsle the casualty walked across the affected area of deck and slipped and fell heavily onto his back and his head/helmet hit the deck. The helmet was still in tact and did not crack however paint had transferred onto it. The casualty was temporarily unconscious and the boson reported over VHF that there was a 'man down on the deck'. The AB who was tending to the spring line went to the casualty as he was not moving. After a few minutes the casualty started to come round and the AB and Boson managed to tie up the ship safely.

The casualty was able to get up with some assistance however his back was in pain. The safety helmet was observed to have some green paint markings and has been disposed of. The casualty was taken to A&E at Stornoway hospital where he was fully examined and X-rays taken. It was observed he had concussion and a suspected fractured RIB.

The casualty was released back into the care of the vessel, stood down from all work duties and was put under 24 hour observation. With no further symptoms of the concussion, he was repatriated the following afternoon.

Please state why you think the occurrence happened

The proximate cause was the slippery deck as a result of indoor paint being used on that part of the deck.

1 Give details of any actions recommended by you or anyone else to prevent similar occurrences in the future

Recommended action

1. Additional adhesive non-slip tape has been applied to the area of deck that the incident happened.
2. The deck is still scheduled to be re-surfaced once the new paint arrives on the vessel at the next port visit.
3. An additional incident report has been compiled and sent to the Safety Superintendent

Who issued the recommendation?

The Officer In Charge

Who was it addressed to?

The crew have put the non-slip tape down as requested. The Marine and Safety Superintendents have been informed.

Add new recommendation

Click to enable deletion of added items

SECTION G: ADDITIONAL DATA OR INFORMATION CONSIDERED RELEVANT

SECTION H: CONTACT DETAILS

Name and address of manager, owner or operator

Name	Marine Scotland Compliance	Company type	Other
Company	Scottish Government		
City	Edinburgh	County/State	Edinburgh
Postcode/Zip code	EH6 6QQ	Country	United Kingdom
Phone Number	01312443062	Email	MPVMinna@gov.scot
Website			

Person completing the form

Name	[redacted]	Date	29/07/2018
Address	As above		
Job role	Officer in Charge	Phone Number	01312443062
Email	MPVMinna@gov.scot		

Tick box if there is a Safety Officer on board your vessel ☑

To be completed by the vessel's Safety Officer

Name	[redacted]	Date	26/05/1981

Phone Number 01312443062 Email MPVMinna@gov.scot

Tick box if the incident involved a reportable personal accident and there is an elected Safety Representative on board the vessel. In these cases the safety representative must be shown the completed ARF and are allowed to add comments if they wish to. ☑

SECTION I: FOR COMPLETION BY SAFETY REPRESENTATIVE (if applicable)

If the injured persons are represented by different Safety Representatives, each may make additional comments if desired by adding further instances of the form fields (but in any event, they should all declare all information is true and complete to the best of their knowledge).

1 Comments

Area was risk assessed and toolbox talked before the operation.

Name [redacted] Date 25/06/1967

Add more safety representative comments

Click to enable deletion of added comments

Incident Report Form

No: MIN 18-009

Type of Incident: **< Hazardous Occurrence / Accident >**

Incident Details

Date: 28th July 2018	Time: 10:00
Originator *(Vessel)* : MPV Minna	
Location of Incident : Focsle	
Reported and/or Witnessed by: *Witness statements attached where appropriate* [redacted] [redacted]	Rank/Rating/Grade: CPO AB
Description of Incident: Whilst coming alongside in Stornoway the 1OS slipped and fell on the focsle.	
Name(s) of Person(s) injured *(if any)* : [redacted]	Rank/Rating/Grade : 1OS
Nature of Injuries *(if any)*: Concussion and suspected fractured rib	
Nature of Damage to Vessel, Equipment or Environment *(if any)* : None	
Possible Safety Consequences: The 1OS could have been more seriously injured and the disablement of a crew member during mooring operations could have resulted in other injuries to crew or damage to ship whilst distracted attending to injured crew member.	
Is incident reportable to MAIB?	**Yes**
Is there a current Risk Assessment for this task ?	**Yes**
Commanding Officer : [redacted]	**Date** : 28/07/2018

Investigation

Results of Investigation, Recommendations and Immediate Action Taken:

To be completed by vessel safety officer.

The weather conditions were raining and light winds. The vessel was maneuvering at slow speed whilst coming alongside the No1 pier in Stornoway. Part of the focsle was known to be slippery. The C/O made everyone aware of the issue at the start of the trip, a sign was put up at the entrance onto the focsle and velcro tape used on the deck to create a walkway to the main working area on the focsle. The 1OS was wearing full PPE inclusive of hard hat and non slip shoes.
The vessel was nearly alongside the pier (port side to) and the spring line was on the bollard. The 1OS recognised that a fender was going to be needed and went to put this out. Whilst moving from the forward end to the aft of the focsle the 1OS slipped on the deck and fell heavily onto his back and his head hit the deck. The 1OS was temporarily unconscious and the CPO reported over VHF that there was a 'man down on the deck'. The AB who was tending to the spring line went to the 1OS as he was not moving. After a few minutes the 1OS started to come round and the AB and CPO managed to tie up the ship safely.
The 1OS was able to get up with some assistance however his back was in pain. The safety helmet was observed to have some green paint markings and has been disposed of. The 1OS was taken to A&E at Stornoway hospital where he was fully examined and X-rays taken. It was observed he had concussion and a suspected fractured RIB.
All crew have again been reminded that part of the focsle remains slippery and is subject to a current incident report MIN 18-007.

Vessel Safety Officer: [redacted] (temp 1OS)	**Date** : 28/07/2018

Proposed Corrective Action (To be completed by D.P.A. / Safety Superintendent)

Specific action to vessel:

As per the notes from report 007 which was completed on 27/8, it had been discovered that the wrong paint had been used to complete the painting of the focsle. This had the effect of making that area especially slipper when wet. All crew had been made aware of this and the area taped off and signs posted.
My reply in that situation was "Crew should be aware of what coating is used for a particular task, there would appear to be some lack of planning and forethought here which could have prevented this slip hazard". The 1/O/S was therefore well aware of this potentially dangerous situation but unfortunately it would appear that his attention was diverted by putting out the fender, rather than keeping a safe footing.
As all on board should be well aware, mooring operations remain one of the most potentially hazardous tasks undertaken on board with multiple sources of serious injury present, the additional slip hazard here due to the use of incorrect paint added to this.
This highlights the facts that personnel need to take particular care during mooring operations and also the importance of applying the correct deck coatings where slip / trip hazards are an issue.

Action required for/by fleet?: **Yes**

- ☐ SMS amendment required.
- ☐ Fleet Notice to be distributed.
- ☑ Incident report to be circulated.
- ☐ Risk Assessment(s) to amend.
- ☐ Incident to be discussed at vessel safety meetings.
- ☐ Other (as specified below).

DPA / Safety Super. : [redacted] Safety Superintendent	**Date** : 4/9/18

Incident Report Form

No: MIN 18-007

Type of Incident: **Hazardous Occurrence**

Incident Details

Date: Unknown, last trip.	Time: Unknown
Originator *(Vessel)* : MPV Minna	
Location of Incident : Focsle	
Reported and/or Witnessed by: *Witness statements attached where appropriate* [redacted] [redacted]	Rank/Rating/Grade: CPO 1/O/E
Description of Incident: On joining the vessel and preparing to work on focsle, the crew found the deck to be dangerously slippery.	
Name(s) of Person(s) injured *(if any)* : None	Rank/Rating/Grade :
Nature of Injuries *(if any)*: None	
Nature of Damage to Vessel, Equipment or Environment *(if any)* : N/A	
Possible Safety Consequences: Slip hazard created, even safety shoes and anti slip boots were slipping on the deck. Various possible injuries from falls could have occurred.	
Is incident reportable to MAIB?	**No**
Is there a current Risk Assessment for this task ?	**Yes**
Commanding Officer : [redacted]	**Date** : 21/07/2018

Investigation

Results of Investigation, Recommendations and Immediate Action Taken:

To be completed by vessel safety officer.

CPO [redacted] was proceeding to focsle deck to work and found the deck to be dangerously slippery. It had been raining and upon further investigation with other teams CPO it was discovered that the wrong type of paint had been used to paint the deck. They had used the correct paint, Interbond 201 2 pack, but did not have sufficient quantity to complete the whole deck. They decided to use Interlac 665 single pack, which is an interior deck paint to complete the job. This paint is unsuitable for exterior decks and became dangerous when wet.

As no correct paint was available to correct the error, anti slip tape was put on the deck to allow safe passage over the affected area. All crew made aware and safety signs were posted.

When new, correct, paint arrives, crew to key the existing paint and apply the correct Interbond 201 deck paint.

Vessel Safety Officer: [redacted]	**Date** : 21/07/2018

Proposed Corrective Action (To be completed by D.P.A. / Safety Superintendent)

Specific action to vessel:

Crew should be aware of what coating is used for a particular task, there would appear to be some lack planning and forethought here which could have prevented this slip hazard.

However, above action regarding tape and making crew aware of the situation agreed. Correct paint now on board and applied.

Action required for/by fleet?: **No**

- ☐ SMS amendment required.
- ☐ Fleet Notice to be distributed.
- ☐ Incident report to be circulated.
- ☐ Risk Assessment(s) to amend.
- ☐ Incident to be discussed at vessel safety meetings.
- ☐ Other (as specified below).

DPA / Safety Super. : [redacted] Safety Superintendent	**Date** : 14/08/18