SHERIFFDOM OF GLASGOW AND STRATHKELVIN AT GLASGOW

[2020] FAI 40

GLW-B837-20

DETERMINATION

BY

SHERIFF ALAYNE E SWANSON

UNDER THE INQUIRIES INTO FATAL ACCIDENTS AND SUDDEN DEATHS ETC (SCOTLAND) ACT 2016

into the death of

STANISLAW BANIA

Glasgow, 27 October 2020

DETERMINATION

The Sheriff, having considered the information presented at the inquiry, determines that in terms of section 26 of the Inquiries Into Fatal Accidents and Sudden Deaths Etc. (Scotland) Act 2016:

(1) Stanislaw Bania ("the deceased") date of birth 17 September 1952 ordinarily resident at 62 Legionow Street, Gydnia, Poland was pronounced dead on 13 December 2010 at 19:53 within the Southern General Hospital in Glasgow.

(2) In terms of section 26(20(a) the death occurred at 19:53 within the Southern General Hospital, Glasgow.

(3) In terms of section 26 (2) (b) the accident resulting in the death occurred at King George V Docks in Glasgow at around 18:00 on 13 December 2010 when the deceased fell from the vessel on which he was working into the water.

(4) In terms of section 26 (2) (c) the cause of death was cold water immersion.

(5) In terms of section 26 (2) (d) the accident was caused by the deceased falling while climbing up to the port side platform of the crane used to move the vessel's hatch covers.

(6) An instruction had been given by the Chief Officer at around 17:45 to close the hatches, discharge of the cargo having been completed.

(7) In terms of section 26(2) (e) the Sheriff suggests that had the following precautions been adopted the accident resulting in the death might have been avoided:

- The method of access to the platforms by climbing from the main deck using the guard rails as support should not have been used
- The ladder which is part of the structure of the crane which only went up beyond the platform could feasibly have been extended down to the deck thereby providing a safe means of access

(8) In terms of section 26 (2) (f) the Sheriff identified the following defects in the system of working on the vessel which contributed to the accident resulting in the death:

- The working practice on the vessel in respect of working the crane was defective

- There were no written procedures for operations with the crane
- There was no written alcohol and drugs policy

(9) In terms of section 26 (2) (g) the following are considered to be relevant facts:

The concentration of alcohol in the deceased's blood was nearly four times in excess of the prescribed limit for blood alcohol specified in the Railways and Transport Safety Act 2003 which is 50mg/dL. However no-one saw the deceased drinking prior to the accident. None of the witnesses commented on his state of sobriety or presentation, which might be expected if the blood alcohol level was as stated. The Sheriff considers that the level of alcohol in the blood is unlikely to be a contributor given the unsafe working practices.

RECOMMENDATIONS

In terms of section 26 (1) (b) the Sheriff makes no recommendations.

NOTE

Introduction

[1] A mandatory inquiry under section 2 (1) and 2 (3) of the 2016 Act was held at Glasgow Sheriff Court on 16 October 2020 into the death of Stanislaw Bania. The death was reported to the Procurator Fiscal on 30 July 2012. The Procurator Fiscal apologised on behalf of the Crown for the delay in bringing this case to an inquiry. The court was advised that procedures had now been amended.

[2] A preliminary hearing was held on 12 August 2020 with a view to identifying any person or party wishing to become a participant. None of the parties to whom intimation was made indicated any wish to participate. An order was made for all productions, statements, cctv footage and a notice to admit information to be intimated by 25 September 2020. Productions and witness statements were lodged timeously and no objections received.

[3] No representatives attended the inquiry. The court heard evidence from Captain Allan Marsh, who at the time of the accident was an enforcement officer for the Marine Coastguard Agency and heard the submissions on the part of the Procurator Fiscal.

The legal framework

[4] An inquiry into the death of Stanislaw Bania was held under section 1 of the Act; the inquiry was governed by the Fatal Accident Inquiry Rules 2017 (Act of Sederunt 2017 SSI 2017-103). The purpose of the inquiry is to establish the circumstances of the death

and consider what steps (if any) might be taken to prevent other deaths in similar circumstances. In terms of section 26 the matters which should be covered in the determination are when and where the death occurred, the cause or causes of death, the cause or causes of any accident resulting in the death, any precautions which could reasonably have been taken which had they been taken might realistically have resulted in the death or any accident resulting in the death being avoided and any other facts relevant to the circumstances of the death. The procurator fiscal represents the public interest at the inquiry. The inquiry is not an inquisitorial process and it is not for the purpose of an inquiry to establish civil or criminal liability.

Evidence:

[5] The following material was placed before the court for the purposes of the inquiry:

1. Crown Production 1: Post Mortem Report by Robert Anderson, Forensic Toxicologist, University of Glasgow dated 18 January 2011
2. Crown Production 2: Report by the Marine Accident Investigation Branch (MAIB) number 8/2011 dated June 2011
3. Crown Production 3: a set of photographs of the vessel
4. Crown Production 4: Report by Adam Nutt and William Hughes, Surveyors, with the Maritime and Coastguard Agency (MCA) dated 14 December 2010

5. Crown Production 5: handwritten notes of the deceased's possessions and clothing
6. Crown Production 6: the Ship Agency & Operation Agreement between Jan Stepniewski & Company Limited and Joanna Shipping Limited dated 26 February 2003
7. Crown Production 7: English translation of the company's Operating Procedure for loading and unloading cargo PS-11
8. Crown Production number 8: Chapter XI ISM A.741(18) International Management Code for the Safe Operation of Ships and for Pollution Prevention (International Safety Management (ISM) Code).
9. Crown Production number 9: Chapter 1 of the Code of Safe Working Practices for Merchant Seamen 2010.
10. Crown Production number 10: Chapter 4 of the Code of Safe Working Practices for Merchant Seamen 2010.
11. Crown Production number 11: Chapter 6 of the Code of Safe Working Practices for Merchant Seamen 2010.
12. Crown Production number 12: Chapter 15 of the Code of Safe Working Practices for Merchant Seamen 2010.
13. Crown Production number 13: Copy statement by Ryszard Nowacki taken at Helen Street Police Office by PC Ian Smith at 2130 hours on 13 December 2010.

14. Crown Production number 14: Copy statement by Tadeusz Pasek taken at King George V Docks by Captain Allan Marsh at 1325 hours on 14 December 2010.

15. Crown Production number 15: Copy statement by Tadeusz Pasek taken at Helen Street Police Office by PC Paul MacDonald at 1020 hours on 15 December 2010.

16. Crown Production number 16: Copy statement by Tadeusz Pasek taken at Helen Street Police Office by DC Jacqueline Carroll at 1200 hours on 16 December 2010.

17. Crown Production number 17: Copy statement by Dawid Lapigrowski taken at the Southern General Hospital by PC Amy McCabe at 1900 hours on 13 December 2010.

18. Crown Production number 18: Copy statement by Dawid Lapigrowski taken at Helen Street Police Office by DC Lesley-Ann McLelland at 1025 hours on 15 December 2010.

19. Crown Production number 19: Copy statement by Ryszard Gadzinski taken at King George V Docks by Captain Allan Marsh at 1220 hours on 14 December 2010.

20. Crown production number 20: Copy statement by Ryszard Gadzinski taken at Helen Street Police Office by DC Andy Kinnear at 1445 hours on 15 December 2010.

21. Crown Production number 21: Copy statement by Piotr Klawon taken by DC Jacqueline Carroll at Helen Street Police Office at 1420 hours on 15 December 2010.

22. Crown Production number 22: Copy statement by Wieslaw Makowski taken by DC Claire McNish at Helen Street Police Office at 1200 hours on 15 December 2010.

23. Crown Production number 23: Copy statement by Stephen Russell taken by PC Mark Robertson at King George V Docks at 0000 hours on 14 December 2010.

24. Crown Production number 24: Copy statement by Alan Nesbit taken by DC Lesley Reid at King George C Docks at 1430 hours on 16 December 2010.

25. Crown Production number 25: Copy statement by Nick Taylor taken by DC Lesley Reid at King George V Docks at 1545 hours on 16 December 2010.

26. Crown Production number 26: Copy statement by Andrew Keenan taken by DC Andy Kinnear at King George V Docks at 1525 hours on 16 December 2010.

27. Crown Production number 27: Copy statement by Alastair MacKinnon taken by PC Mark Robertson at 1900 hours on 15 December 2010.

28. Crown Production number 28: Copy statement by Philip Munro taken by PC Amy McCabe at the Southern General Hospital at 2030 hours on 13 December 2010.

29. Crown Production number 29: Copy statement by Police Constable Martin Dale on 14 December 2010.

30. Crown Production number 30: Copy statement by Police Constable Amy McCabe on 14 December 2010.

31. Crown Production number 31: Copy statement by Police Constable Mark Robertson on 15 December 2010.

32. Crown Production number 32: Copy statement by Police Constable Ian Smith on 14 December 2010.

33. Crown Production number 33: Copy statement by Police Sergeant David Higgins on 14 December 2010.

34. Crown Production number 34: Copy statement by Police Inspector Louis Jeffrey on 14 December 2010.

35. Crown Production number 35: Copy statement by Detective Constable Lesley-Ann McLelland (now McGee) on 20 December 2010.

36. Crown Production number 36: Copy statement by Detective Constable Jacqueline Carroll on 17 December 2010.

37. Crown Production number 37: Copy statement by Paul MacDonald on 18 December 2010.

38. Crown Production number 38: Copy statement by Detective Constable Claire McNish (now Anderson) on 17 December 2010.

39. Crown Production number 39: Copy statement by Adam Nutt taken by Captain Allan Marsh at Greenock at 1600 hours on 2 August 2012.

40. Crown Label number 1 comprises a true and accurate copy of video footage recorded at the said King George V Docks on the said 13 December 2010.

Summary

[6] The deceased was employed by Jan Stepniewski & Company Limited having a place of business at 20/18 Powstania Styczniowego Str, Pl, 81-519 Gydnia, Poland ("the company"). At the time of the accident he was working on a general cargo vessel called Joanna owned by Joanna Shipping Limited having a place of business at 112 Bonadie Street, Kingstown, St Vincent and the Grenadines. The deceased had been employed by the company as an able seaman since around 2006. The Joanna was around 30 years old.

[7] The Joanna berthed at the King George V Docks in Glasgow at about 16:45 on Sunday 12 December 2010. The vessel was berthed with the starboard side of the vessel nearest to the quay. The vessel's cargo was to be unloaded the following day. That exercise was completed at around 17:45 on 13 December and an instruction given to the deceased and the bosun to close the hatches covering the hold.

[8] The hatch covers were moved using a crane fitted to the vessel which spanned the width of the cargo hold. The crane is operated by the bosun from a platform on the

starboard side assisted by another crew member on a platform on the port side. Access to the platforms was usually gained by climbing up from the main deck or via the hatch covers. Climbing from the deck required climbing up the guardrails while facing the crane and holding on to the hand/foot supports on the aft upright. Once he reached the top guardrail the crew member would step across to the platform.

[9] The bosun made his way along the starboard side of the vessel nearest to the quay and the deceased made his way along the port side. The bosun reached the starboard platform from where he could see the port platform. There was no sign of the deceased so the bosun called out to him; there was no response. The bosun immediately climbed back down on to the hatch covers and walked across to the port side. He saw the deceased face down in the water between 1 and 2 metres from the vessel's hull. No-one saw the deceased fall from the vessel.

[10] The alarm was raised and steps taken to recover the deceased's body from the water. It was a difficult exercise because of the height of the quay and the deceased's build which was completed within approximately 25 minutes. The deceased loss of consciousness was rapid; he was motionless and face down in the water when first seen. The water temperature was very cold as was the air temperature. The deck was icy in places. Another crew member who went into the water as part of the attempt to rescue the deceased had freezing hands and numb legs within minutes.

[11] The post mortem examination was unable to confirm death due to drowning and as death as the result of vagal inhibition could not be excluded the cause of death was

recorded as cold water immersion which encompasses both potential mechanisms. The level of alcohol in the deceased's blood was found to be 193mg/100ml.

Discussion and conclusions

[12] The accident was investigated by the Marine and Coastguard Agency ("MCA") on 14 December 2010. Captain Marsh explained that their function is to investigate maritime incidents around the Scottish coastline and where appropriate make a report to the Procurator Fiscal. Captain Marsh had 18 years' experience with the MCA and was a Master Mariner Unlimited.

[13] On 14 December 2010 Captain Marsh attended at the vessel and was shown by the bosun the bridge, the main deck and the spaces around it. He was shown the crane platforms and the bosun demonstrated for him how access to the platforms was usually obtained from the main deck by climbing using the ship's rails. Reference was made to Photographs A, B, H, I, J and K within Crown Production 3. Captain Marsh's view of the procedure he was shown for accessing the platforms was that there was a considerable risk of a slip or fall whilst performing it. The risks would be exacerbated if the surfaces were wet or icy. He concluded that there was no safe means of access to the crane for the crew when the hatch lids were stacked above the hold. The other means of access to the platforms was via the hatch lids which was safer in general terms but not available to the crew when the hatch lids were open and stacked. The fact that the bosun could not see the deceased as they accessed the platforms confirms that the

method of access adopted was climbing up; if the deceased had accessed via the hatch lids the bosun would have been able to see him.

[14] As part of his evidence Captain Marsh was shown CCTV footage from the dock side of the activities leading up to the accident and the rescue procedures. There was no footage of the accident itself. He was able to assist the court with his commentary on the CCTV from which it was established that crew members were working with dockside personnel to unload the cargo until around 16:53. At 17:57 Captain Marsh noted that several people had gathered at the aft mooring and were looking down into the water. The first ambulance arrived at 18:13. A cage was lowered at 18:14 and recovered at 18:17. The ambulances left the scene at 18:26.

[15] Captain Marsh gave evidence that any training on equipment like the crane would be done "on the job" by the bosun. The deceased was an experienced able seaman. Captain Marsh assumed that the crew members had devised the route to the platforms by climbing themselves as there was no evidence of any training in that respect. He said that in today's culture it would definitely be expected that crew members would wear a safety harness whilst on the platform but on that age of vessel at that time it would be unfair to say that. In today's culture this is an operation at height requiring all relevant safety precautions. However there was no evidence that any risk assessment had been carried out for the vessel. There was no evidence that there was an alcohol and drugs policy.

[16] Reference was made to Crown Production 8 which is the International Management Code for the Safe Operation of Ships and for Pollution Prevention

(International safety Management (ISM) Code) adopted on 4 November 1993 which applied to vessels of a similar tonnage to Joanna. The Code sets out the safety management objectives including the requirement for risk assessments and written procedures. The Merchant Shipping Safety of Navigation Regulations and the Health and Safety at Work Regulations are also relevant. The purpose of the investigation which Captain Marsh undertook was to ascertain whether any Regulations had been broken. The company had a valid safety management certificate and was audited regularly. The lack of written procedures was not picked up until the audit by the Polish Register in 2010 which was done three months before the accident. Reference was also made to Crown Productions 9 to 12 which contained chapters from the Code of Safe Working Practice for Merchant Seamen. Chapters 1, 4, 6 and 15 were relevant. The Code is easily accessed online.

[17] The accident was also investigated by the Marine Accident Investigation Branch ("MAIB"). Their conclusion was that the routes used by the crew to get on to the platforms on the ends of the crane were inherently unsafe because they exposed the crew to the risk of falling from height. Whether access was gained by climbing the ship side guardrails or by moving from the hatch covers any slip or loss of balance had significant potential to result in a fall onto the deck or over the side to the water or the quayside.

[18] Following the accident the company has taken the following steps:

(1) a drug and alcohol policy has been implemented

(2) the key shipboard operations have been reviewed and now include the opening and closing of hatches

(3) written procedures for the operation of the crane have been provided

(4) risk assessments have been completed to improve the safety of operation on board the company's vessels

(5) two safety harnesses and two working lifejackets have been provided on board the Joanna

On the basis of these actions having been taken by the company the MAIB made no recommendations.

[19] In the circumstances, and in particular given the passage of time and the views expressed by Captain Marsh about the changes in health and safety awareness since then, formal findings only are appropriate and there are no recommendations to be made.