**SHERIFFDOM OF GRAMPIAN, HIGHLAND AND ISLANDS AT ABERDEEN**

**[2022] FAI 16**

ABE-B9-21

DETERMINATION

BY

SHERIFF IAN WALLACE

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

into the death of

**PJERO KURIDA**

Aberdeen, 17 February 2022

**DETERMINATION**

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

**In terms of section 26(2)(a) (when and where the death occurred):**

Pjero Kurida, born 18 July 1982, resident in Croatia, died at 12:59 hours on 10 June 2012 within Aberdeen Royal Infirmary.

**In terms of section 26(2)(b) (when and where any accident resulting in the death occurred):**

Pjero Kurida died as a result of an accident which took place at about 09:55 hours on 10 June 2012 on a fast rescue craft deployed from and moored to its parent vessel, the ER Athina ("the Athina"), then at anchor in the tidal waters of the North Sea approximately two nautical miles north east of the entrance to Aberdeen Harbour.

**In terms of section 26(2)(c) (the cause or causes of the death):**

The cause of Pjero Kurida's death was chest and abdominal crush injuries suffered when he was trapped between the lifting frame of the fast rescue craft and the hull of the Athina.

**In terms of section 26(2)(d) (the cause or causes of any accident resulting in the death):**

The causes of the accident that resulted in Pjero Kurida's death were:

i. A decision was taken to paint over damage on the hull of the Athina while at open sea from the fast rescue craft.

ii. When Mr Kurida and his colleague Lukasz Czarny, who were on board the fast rescue craft, attempted to moor the fast rescue craft to the Athina in order to carry out that painting job, they encountered difficulties in doing so due to the motion of the sea.

iii. As a result of these difficulties, Mr Kurida left his position at the controls of the fast rescue craft to assist Mr Czarny in securing the fast rescue craft to the Athina.

iv. The motion of the sea caused the Athina and the fast rescue craft to come together and Mr Kurida was briefly trapped between the lifting frame of the fast rescue craft and the hull of the Athina.

**In terms of section 26(2)(e) (any precautions which (i) could reasonably have been taken and (ii) had they been taken, might realistically have resulted in the death, or any accident resulting in the death, being avoided):**

The precautions which could reasonably have been taken and might realistically have resulted in Mr Kurida's death being avoided are:

i. The hull of the Athina could have been painted when the vessel was in the protected waters of Aberdeen Harbour between the early hours of 7 June 2012 and the afternoon of 9 June 2012.

ii. After the Athina had moved from Aberdeen Harbour in the afternoon of 9 June 2012, a decision could have been taken not to paint the hull when at open sea, given that the damage on the hull was superficial and did not compromise the integrity of the vessel.

iii. In the event that it was decided to paint the hull when at open sea, a decision could have been taken to use a painting platform, such as a stage, suspended from the deck. A pre-prepared risk assessment was in place for such a job in

terms of the Athina's safety management system. This would have helped ensure that the job would only have proceeded subject to a full risk assessment being carried out.

iv. When considering whether to use the fast rescue craft for the painting job, a rigorous *ad hoc* risk assessment could have taken place. This should have involved a more detailed assessment of the conditions of the sea. Assessing the relevant risks could have resulted in the taking of further measures (such as those identified at v. and vi. below) to reduce the risks to an acceptable level. Alternatively, such an assessment may have resulted in a decision not to use the fast rescue craft at open sea.

v. In the event that a decision was taken to use the fast rescue craft, an additional member of the crew of the Athina could have been on the fast rescue craft to assist. This would likely have allowed Mr Kurida to remain at his position at the controls of the fast rescue craft.

vi. In the event that a decision was taken to use the fast rescue craft, steps could have been taken to ensure that the painting job was properly observed and supervised throughout. This would have involved less reliance on Mr Kurida's assurances that he was content to continue with the job, which were given to crew on deck who could not clearly see what was happening. Direct observation would have helped ensure proper ongoing assessment of the feasibility of continuing with the painting job, taking proper account of the conditions of the sea. This could have been achieved by, for example,

deploying the other available fast recue craft and having other crew members supervise the job from that craft.

**In terms section 26(2)(f) (any defects in any system of working which contributed to the death or any accident resulting in the death)**

There was no proper risk assessment carried out in accordance with the Athina's safety management system. In the absence of a pre-prepared risk assessment for painting the vessel of the hull from the fast rescue craft, the painting job proceeded without carrying out a rigorous *ad hoc* risk assessment.

**In terms of section 26(2)(g) (any other facts which are relevant to the circumstances of the death)**

Even though Mr Kurida had suffered chest injuries and had clearly been subject to significant forces, the accident was not treated as a medical emergency. The nature of Mr Kurida's injuries was underestimated. Rather than calling for emergency assistance, the master of the Athina contacted a fishing vessel to take Mr Kurida to hospital. This resulted in a significant delay in Mr Kurida arriving at hospital.

**Recommendation**

**In terms of section s26(1)(b) (recommendations, if any, as to the taking of any other steps, which might realistically prevent other deaths in similar circumstances):**

Those responsible for operating merchant vessels in UK waters should have in place the necessary training, guidance, procedures and rules to ensure informed and appropriate responses to medical incidents of uncertain severity. These measures should ensure that an appropriate assessment is carried out as quickly as possible so that potential medical emergencies are treated as such (see further discussion at paragraphs [127] to [133]).

**NOTE**

**Introduction**

[1] At Aberdeen Sheriff Court on 6 and 7 October 2021 and 10 November 2021 an inquiry was held under the Inquiries into Fatal Accidents and Sudden Deaths etc. (Scotland) Act 2016 ("the Act") into the death of Pjero Kurida on 10 June 2012.

[2] Mr Kurida's death was reported to the Crown Office and Procurator Fiscal Service on 11 April 2013.

[3] The First Notice in relation to this inquiry, in terms of the Act of Sederunt (Fatal Accident Inquiry Rules) 2017 ("the 2017 Rules"), was issued by the Procurator Fiscal on 5 January 2021.

[4] A preliminary hearing in terms of Rule 3.16 of the 2017 Rules was held on 3 March 2021. A further preliminary hearing was held on 20 May 2021.

[5] The inquiry proceeded on 6 October 2021 and 7 October 2021. At the conclusion of the evidence, the inquiry was continued until 10 November 2021. On that date I considered parties' written submissions and supplementary oral submissions.

[6] There were three participants in the inquiry. The Crown was represented by David Glancy OBE, senior procurator fiscal depute. Captain Artur Wnukowksi, master of the vessel Athina on 10 June 2012, was represented by Mark Donaldson, solicitor. OSM Crew Management Limited, the employer of Mr Kurida, was represented by Martin Sinclair, solicitor.

[7] Mr Kurida's family chose not to be represented at the inquiry.

[8] All hearings in this inquiry proceeded by Cisco Webex video conferencing.

[9] As will be clear from the above, there was a significant delay between Mr Kurida's death and the conduct of this inquiry. The procurator fiscal was ordered by the court to provide a timeline explaining this delay in advance of the first preliminary hearing. The Crown fully accepted its responsibility for the delay. This was partly explained as part of a wider backlog of cases which was being addressed.

[10] Any delay risks frustrating an inquiry's purpose. Delay can only add to the upset caused by the friends and family of the deceased. The quality of the evidence before the inquiry is inevitably diminished. There are certain facts in relation to events on 10 June 2012 which will remain uncertain, partly due to the lapse of time, fading of memory, and witnesses having moved on. This is reflected in my summary of facts below. That all said, I do not consider that the lapse of time will have affected any of the findings and recommendations set out in my determination. The inquiry itself was well

conducted by the legal representatives involved. It is of some reassurance that steps were taken in the immediate aftermath of Mr Kurida's death to learn lessons and change procedures.

**Form of evidence**

[11] There were two joint minutes of agreement. The first joint minute agreed the main events leading up to the accident, the accident itself, and events after the accident. This joint minute forms the basis for a large part of the facts set out below. It also incorporated a number of witness statements, and documentary productions.

[12] The second joint minute agreed the medical opinion evidence, including that of the lead pathologist, Dr James Grieve, that Mr Kurida's injuries were not survivable. This joint minute is summarised in paragraphs [76] to [81], below.

[13] The only witness to give oral evidence at the inquiry was Captain Artur Wnukowksi, the master of the Athina at the time of the accident. He gave his evidence from Gdansk, Poland. A Polish interpreter was available. However, Captain Wnukowski was able to give the majority of his evidence without the assistance of the interpreter. Captain Wnukowski gave evidence in relation to all of the circumstances before, during, and after the accident. He explained the decisions that were taken. The inquiry also had the benefit of a statement he had given on 10 June 2012. I formed the impression that Captain Wnukowski did his best to recall the events of June 2012 accurately, although his memory had inevitably faded. His professional experience was clear in the evidence he gave. He was commendably frank

in recognising the mistakes that had been made. He had learned lessons. He would do things differently now. He had done things differently since this incident.

[14] I further considered a number of statements provided in 2012. The statements of the following witnesses were of particular assistance:

- Lukasz Tucholski (chief officer). (In addition to his statement from 2012, Mr Tucholski provided a statement, with a sketch showing how the fast rescue craft was moored to the Athina, dated 16 April 2021.)
- Lukasz Czarny (ordinary seaman)
- Josip Kurtin (third officer)
- Sviatoslav Ushakhin (cadet)
- Marin Balic (third engineer)
- Rok Gorsek (second officer)
- Jacek Grabek (able seaman)
- Peter Grambart (designated person ashore)
- Darren Harper (employee of Seletar, the Athina's Aberdeen agent)
- Richard Greenhowe (fisherman and master of the vessel the Skua)
- Robert Coull (volunteer lifeboatman)
- Stuart Robertson (ambulance technician)

[15] In relation to the medical evidence, I considered statements given in both 2012 and 2021 from the following witnesses:

- Dr Jamie Cooper (accident and emergency consultant)
- Dr Emad Aly (consultant colorectal and general surgeon)

- Dr Vincenzo Giordano (consultant cardiothoracic surgeon)
- Dr James Grieve (consultant pathologist)

[16] The following documents were of particular assistance:

- Athina's deck log book, 7 June 2012 to 12 June 2012
- Books of photographs showing the Athina (including the damage) and the fast rescue craft
- Record of "toolbox talk", dated 10 June 2012
- Risk assessment number O/DE-652 for "Painting from stage", last reviewed on 20 June 2008
- Risk assessment number O-D/351 for "Launching rescue boat", dated 2 June 2012
- Revised risk assessment number O-D/351 for "Launching rescue boat", dated 15 June 2012
- Sketch by Sviatoslav Ushakhin showing position of fast rescue craft when moored to the Athina
- Emergency Operations Manual on board the Athina on 10 June 2012
- Timeline prepared by Darren Harper
- Maritime and Coastguard Agency Incident Log of events on 10 June 2012
- Post mortem report
- Form number H02b "Statement of Facts", completed by Captain Wnukowski after the accident
- Marine Accident Investigation Report into the incident, dated January 2013

- Code of Safe Working Practices for Merchant Seamen 2010
- Report of investigation instructed by ER Offshore between 13 and 15 June 2012
- Safety and Quality Bulletin, dated 2 July 2012
- Article in Offshore Support Journal, dated April 2013

**Legal framework**

[17] This inquiry was held in terms of section 1 of the Act and was governed by the 2017 Rules. This was a mandatory inquiry in terms of section 2 of the Act as Mr Kurida died as a result of an accident in the course of his employment or occupation.

[18] The purpose of the inquiry is set out in section 1(3) of the Act as being to establish the circumstances of the death and to consider what steps (if any) might be taken to prevent other deaths in similar circumstances.

[19] In terms of section 26 of the Act the inquiry must determine certain matters, namely when and where the death occurred, when and where any accident resulting in the death occurred, the cause or causes of the death, the cause or causes of any accident resulting in the death, any precautions which could reasonably have been taken and might realistically have avoided the death or any accident resulting in the death, any defects in any system of working which contributed to the death, and any other factors relevant to the circumstances of the death. It is open to the sheriff to make recommendations in relation to matters set out in section 1(4) of the Act.

[20] The procurator fiscal represents the public interest. The inquiry is not intended to establish liability, either criminal or civil. The inquiry is an exercise in fact finding, not fault finding. It is not open to me to engage in speculation. The inquiry is an inquisitorial process.

**Summary**

***The facts***

*The background*

[21] Pjero Kurida was born on 18 July 1982. He was 29 years old at the time of his death. He was a Croatian national.

[22] On 10 June 2012 Pjero Kurida was employed on the Athina, a vessel owned by NORDCAPITAL Offshore Fonds 4 GmbH & Cie. KG.

[23] The Athina is an offshore supply ship, registered in Liberia. It is 93 metres long, with a beam (width at widest point) of 20 metres, and draught (vertical distance between the waterline and bottom of the hull) of 5 metres. It has a gross tonnage of 4,500 tonnes.

[24] Mr Kurida was employed on the Athina as a bosun (boatswain). In that role he was responsible for the safe management of the crewmen employed on the deck of the vessel. According to maritime custom, he took orders from the vessel's chief officer.

[25] Mr Kurida had been employed since April 2008 by OSM Crew Management Inc, c/o OSM Norway AS, and had worked on various vessels before working on the Athina.

He was considered by his fellow crewmen to be an experienced and competent mariner, was well regarded by them, and was studying to progress to qualifications as an officer.

[26] On 10 June 2012, the Athina was managed and operated by ER Offshore GmbH & CIE.KG ("ER Offshore"), which also employed the vessel's master, Captain Artur Wnukowski, and chief officer, Lukasz Tucholski. On 10 June 2012, E.R. Schiffahrt GmbH & Cie. KG ("ER Schiffahrt") was the parent company of ER Offshore.

*Safety codes, safety management system and risk assessments*

[27] The International Safety Management Code (ISM Code) is an internationally applied safety management code to provide for the safe management and operation of ships. The ISM Code is expressed in broad terms, based on general principles and objectives, and provides companies with the scope to develop their own safety management systems which meet the provisions of the ISM Code.

[28] ER Schiffahrt had drafted its safety management system for implementation by the crew of the Athina. This safety management system included a "Risk Assessment Register", which listed a large number of specific risk assessments for activities carried out on, and in relation to, the vessel. This was available to crew. Each assessment set out "job steps", possible risks and hazards, and potential control measures/instructions.

[29] On 10 June 2012 the risk assessment register contained an assessment entitled "Painting from Stage". This related to the operation of painting a vessel from a stillage (a rectangular metal cage structure) supported by ropes.

[30] On 10 June 2012 the register contained a risk assessment entitled "Launching Rescue Boat". In this context, the term "rescue boat" relates to the type of fast rescue craft which was used to attempt to paint the Athina on 10 June 2012. This risk assessment included, inter alia, instructions to be aware of the ship's movements, in particular during bad weather; not to start work without permission of the chief officer/supervisor; and always to stay in a safe position. Identified risks when boarding and unlashing the boat included "nipped and squeezed fingers and hands" and "…boat striking ship. Excessive sea & swell". There was no risk assessment for painting a vessel from a fast rescue craft.

[31] The management system on board the Athina provided guidance to masters on when risk assessments should be carried out. This included, *inter alia*, "when an unusual or infrequent task is to be carried out".

[32] In terms of the Code of Safe Working Practice for Merchant Seamen 2010, there was a system of "permits to work". This system involved an authorising officer providing a permit (for a time not exceeding 24 hours) for work to be carried out in accordance with organised and pre-defined safety procedures. The code specified that a permit to work was required for "working aloft/overside".

*The crew*

[33] The specified safe minimum number of crew members to be on the Athina was sixteen. There were sixteen crew members recorded as being on the vessel on 10 June 2012.

[34] Captain Artur Wnukowski was the master of the vessel. He had ultimate responsibility for the safety of the vessel and its crew, and for the implementation of all on board procedures in compliance with relevant safety procedures. Captain Wnukowski had been eligible to hold the rank of master since 2006, employed by ER Offshore since 2008, and promoted to master in April 2012. He initially worked on the Athina's sister ship, ER Narvik, and started as master on the Athina on 6 June 2012. Lukasz Tucholski was the chief officer of the Athina. The chief officer is effectively the second in command of the vessel.

*The collision at Blaikies Quay, Aberdeen Harbour*

[35] At 01:20 hours on 7 June 2012, the Athina, while under the command of Captain Wnukwoski, collided with the harbour wall while docking at Blaikies Quay, Aberdeen Harbour.

[36] The port quarter (left rear) of the vessel's hull was slightly damaged. The damage consisted of scratches to the paintwork and some minor denting at a point where the hull tapered (the "cutaway"), close to the waterline. The damage was superficial and did not compromise the integrity of the vessel in any way. It would, however, require to be repaired at some point in order to keep the vessel well maintained.

[37] The Athina remained docked in Aberdeen Harbour until the afternoon of 9 June 2012. In that time, the damage to the hull was inspected by Captain Wnukowski, but it was not repaired.

*Moving to open sea*

[38] In the afternoon of 9 June 2012, the Athina sailed from Aberdeen Harbour and anchored in tidal waters approximately 2 nautical miles north east of the entrance to Aberdeen Harbour.

[39] The Athina had been instructed to leave the harbour. This is normal practice. Space in the harbour is limited, and port duties are paid for every day a vessel is berthed in the harbour.

*Discussions on 9 June 2012*

[40] While at anchor on 9 June 2012, Captain Wnukowski indicated to crew members that he wanted to carry out a routine safety drill to test the two fast rescue craft on the vessel the next day, provided the weather conditions were suitable. This was discussed on the 9 June 2012 between Captain Wnukwoski and Lukas Tucholski (chief officer).

[41] The fast rescue craft are small boats which are secured to either side of the main vessel and can be lowered into the water to carry out a rescue if necessary. They are open boats, with no cabin or cover. At the rear of the craft are the controls and a lifting frame used for taking the craft on and off the parent vessel. The safety drills were supposed to be carried out once every three months, and involved the craft being deployed from the vessel.

[42] On 9 June 2012, Captain Wnukowski also told Lukasz Tucholski that, if the weather permitted, he would like the crew to start painting the hull of the Athina the following day.

*Discussions on 10 June 2012*

[43] There were discussions between Captain Wnukowksi, Lukasz Tucholski, Pjero Kurida, and Josip Kurtin (third officer) in the morning of 10 June 2012 in relation to the drill to test the fast rescue craft, and the plan to paint the hull of the vessel. The specific detail of these discussions remains obscure, partly because there was little about any such discussions in the statement Captain Wnukowski gave in 2012, and his recollection had understandably faded by the time of the inquiry.

[44] Nevertheless, it is clear that, after discussions with the crew, Captain Wnukowksi directed that the port side fast rescue craft was to be tested that morning by Pjero Kurida and Lukasz Czarny, and that after that test they should paint over the damage on the hull of the Athina from the fast rescue craft.

[45] Captain Wnukowksi recalled having a discussion with Pjero Kurida on the bridge of the vessel about painting the hull. Captain Wnukowski's idea was to use a bench, which could be lowered from the deck and used as a painting platform. However, Mr Kurida considered it would be quicker and easier to paint the hull from a fast rescue craft. Captain Wnukowski ultimately agreed with Mr Kurida. There was some discussion about how this would be done.

[46] Marin Balic (third engineer) saw Captain Wnukowski with Mr Kurida and Mr Czarny in the engine room at 08:00 hours. It looked like he was giving them instructions to do something.

[47] Mr Tucholski recalled that shortly after 09:00 hours on the morning of 10 June 2012, Captain Wnukowski said to him that they could carry out a drill to test the fast rescue craft that morning. He wanted the port side fast rescue craft tested that morning so that scratched paintwork could be touched up on the side of the Athina. Mr Tucholski agreed that the work could be done from the fast rescue craft as the weather conditions at the time were good.

[48] Josip Kurtin (third officer) started his shift at 08:00 hours, at which time he was told to expect instructions from Captain Wnukowski about a drill with the fast rescue craft. A short time later, Captain Wnukowski spoke to Mr Kurtin about the drill to take place. Captain Wnukowski and Mr Kurtin discussed the need to hold a "toolbox talk" to discuss the drill. This is a discussion intended to focus on safety issues before a particular job is carried out. Mr Kurtin's understanding was that the purpose of the talk was to discuss and log the drill to be carried out in relation to the fast rescue craft, as this drill was not done very often. Captain Wnukowski did not tell him about the plan to paint the hull of the vessel. Mr Kurtin understood that the drill involved merely lowering the fast rescue craft into the water in order to test it.

[49] Mr Kurtin logged a "toolbox talk" form, the time and date of which was recorded as 09:00 hours on 10 June 2012. Before that, Mr Kurtin had seen Mr Kurida and other crew preparing ropes and other things necessary for the drill. There were four

names listed on the "toolbox talk" form: Lukasz Tucholski; Pjero Kurida; Lukasz Czarny; and Sviatoslav Ushakhin (a cadet in training). Captain Wnukowski had told Mr Kurtin to add the names of Mr Tucholski and Mr Ushakhin to the form.

[50] The subject of the meeting was recorded as "launching the rescue boat", and the form notes that that risk assessment was discussed at the meeting. Mr Kurtin heard no mention of the painting of the vessel. Although the head of the form records that Mr Kurtin was in charge of the meeting, it was in fact Mr Tucholski who took charge of the meeting that took place, and Mr Tucholski signed the form to confirm that. Further, Mr Tucholski took the form from Mr Kurtin and went to have further discussion with the crew on deck. Mr Kurtin was therefore not present for all of the discussions to which the "toolbox talk" form relates.

[51] Shortly before the fast rescue craft was launched, Lukasz Tucholski delivered a briefing to Pjero Kurida, Lukasz Czarny and Sviatoslav Ushakhin. At that time they were preparing to launch the port side fast rescue craft, test its engine, and thereafter undertake the painting of the Athina's port quarter. The crew were also preparing the relevant equipment for painting the hull of the Athina at this time.

[52] Mr Tucholski confirmed that Mr Kurida and Mr Czarny were both wearing the appropriate personal protective equipment, including personal flotation devices. Mr Tucholski directed each member of the crew in relation to their task. Mr Kurida was directed to control the fast rescue craft (he was suitably qualified to do so). Mr Czarny was directed to accompany Mr Kurida on the fast rescue craft and handle the mooring line that would secure the fast rescue craft to the stern of the Athina.

Sviatoslav Ushakhin was directed to take the other end of the mooring line from the deck of the Athina itself.

[53] After the meeting, all the crew members were required to sign to show they understood the instructions. Mr Tucholski, Mr Kurida, Mr Czarny and Mr Ushakhin all signed the "toolbox talk" meeting form.

*The launching of the fast rescue craft*

[54] Before the fast rescue craft was launched, Mr Kurida and Mr Czarny prepared two mooring ropes from the main vessel to be used to secure the fast rescue craft in order to carry out the painting work. The first rope was attached to the Athina's rear quarter, and was in turn to be attached to the stern of the fast rescue craft. The second rope was attached to the Athina's stern, and was in turn to be attached to the bow of the fast rescue craft. All the painting equipment (including extension poles, paints and brushes) was also prepared.

[55] At about 09:45 hours, the port side fast rescue craft was lowered safely into the water. Mr Kurida then manoeuvred it, accompanied by Mr Czarny, away from the Athina out to sea. The fast rescue craft was tested for a short period.

*Sea conditions*

[56] At this time, it was recorded that there was a swell of around 0.5 metres on the surface of the sea. This was noted by Mr Tucholski to be a "slight swell". In his assessment, such a swell would make the job both more risky and more difficult to

complete. In addition, Mr Tucholski understood that, when at anchor, a vessel such as the Athina would move in a constant figure of eight motion. This can cause water at the stern of the vessel to become displaced. In turn, that can cause a boat alongside, such as the fast rescue craft, to be moved towards and away from the vessel. Around that time the tidal stream was recorded as 0.5 knots. Between 09:05 hours and 09:55 hours (the time of the accident) the Athina had swung significantly on its anchor. As a result, her stern and port quarter were far more exposed to the north easterly swell.

*The attempt to paint the hull of the Athina*

[57] After a short period testing the engines, Mr Kurida brought the fast rescue craft alongside the stern of the Athina, where the painting was to take place. Mr Kurida and Mr Czarny identified the scratches on the hull. They were approximately one metre to one and a half metres above the waterline. As previously noted, the scratches were at a point where the hull tapered inwards (the "cutaway"). This meant that when the fast rescue craft was beside this damage, the hull of the Athina rose diagonally over the top of the fast rescue craft. Similarly, this shape of the vessel meant that those on the deck were unable to see the fast rescue craft when it was positioned beside the damage on the hull.

[58] Mr Kurida initially attempted to approach the damaged area directly from the Athina's port side. However, Mr Kurida and Mr Czarny were unable to catch the mooring rope. Mr Kurida then moved the fast rescue craft to approach the Athina from the stern. While Mr Kurida controlled the craft, Mr Czarny attempted to catch the

mooring ropes which were hanging from the deck of the Athina. He managed to catch the rope hanging from the stern of the Athina. However, he was not able to tie it to the fast rescue craft himself, and so Mr Kurida assisted him in tying that rope to the bow of the craft. Mr Czarny then managed to catch the second rope and tied it to the stern of the fast rescue craft, while Mr Kurida remained at the controls of the craft.

[59] At this time, the rescue craft was bobbing up and down with the swell. Further, the swell or tidal stream was dragging the fast rescue craft underneath the Athina. Mr Kurida and Mr Czarny both took turns pushing against the hull of the Athina to keep the vessels apart. Both Mr Tucholksi and Captain Wnukowki were at this time on the deck above the fast rescue craft. In the course of mooring the craft alongside the Athina, Mr Tucholski asked Mr Kurida if he was content to carry on with the work and to commence painting. According to both Mr Tucholksi and Captain Wnukowski, Mr Kurida had been assured beforehand, and continued to be assured, that if he was not comfortable with attempting to paint the hull from the fast rescue craft, the operation would be stopped. Captain Wnukowski described this as a "stop job" policy, which meant that anyone has the right to say at any point that they are not happy to continue with a particular job. Mr Kurida confirmed that he was comfortable to continue.

[60] Mr Kurida and Mr Czarny requested that Mr Tucholski on deck pull the mooring ropes tighter in order to more securely attach the fast rescue craft close alongside the main vessel. Mr Tucholski and Mr Ushakhin started to pull the rope attached to the stern of the fast rescue craft more tightly. The rope on the bow of the fast rescue craft then started to come loose. Mr Czarny thought that they were going to lose the rope

entirely, but he managed to catch it. Mr Czarny's back was turned to Mr Kurida, who was at the controls of the craft.

[61] The fast rescue craft then rose in the swell relative to the Athina. Mr Czarny heard Mr Kurida scream. He turned round and saw Mr Kurida trapped between the two boats. His chest was against the lifting frame of the fast rescue craft and his back was against the underside of the Athina's hull. As soon as the vessels came apart again, Mr Kurida fell forwards onto the deck of the fast rescue craft.

[62] Mr Kurida was able to speak to Mr Czarny. He was complaining about pains in his chest. He remained lying on the deck of the fast rescue craft.

[63] Those on board the Athina had been alerted to the incident by Mr Kurida's screams. Mr Tucholski transferred via a ladder from the Athina onto the fast rescue craft. Mr Kurida and Mr Czarny were taken back onto the Athina. Mr Kurida was still conscious, and complaining of pains in his chest.

*Response after the accident*

[64] At about 10:05 hours, Captain Wnukowski contacted Darren Harper, an employee of Seletar, the vessel's Aberdeen agent, to report that a crewman had suffered suspected fractured ribs and required to go to hospital. Captain Wnukowksi did not request an ambulance and did not indicate that it was a medical emergency. Mr Harper understood that it was a minor medical matter.

[65] At about 10:07 hours Darren Harper contacted Richard Greenhowe, a self-employed fisherman and master of the Skua, a fishing vessel which also provided

a service for Seletar transporting crew to and from vessels from shore in Aberdeen. Mr Harper requested that Mr Greenhowe pick Mr Kurida up from the Athina and take him to Aberdeen for medical treatment.

[66] Meanwhile, Mr Kurida was secured in a stretcher on board the Athina. Rok Gorsek (second officer) had a responsibility for administering first aid on the vessel at that time. He had been told there had been an incident. He saw Mr Kurida lying on the stretcher. He was breathing heavily and coughing, but he was not obviously bleeding. Mr Kurida stated that he felt like he had broken four or five ribs. Mr Kurida was pale and not speaking unless spoken to. Mr Gorsek gave him painkillers.

[67] Richard Greenhowe arrived in the Skua alongside the Athina at 10:30 hours. He went aboard the Athina. He saw that Mr Kurida was conscious and able to communicate, including asking other crew to collect some of his belongings to take to hospital. He looked to be in shock. Mr Kurida was transferred onto the Skua, along with three other crewmen to assist.

[68] En route to Aberdeen, Richard Greeenhowe contacted Darren Harper and asked him to contact the emergency services for an ambulance to meet them at Aberdeen Harbour, as he was concerned that Mr Kurida was in a more serious condition than had initially been thought. Darren Harper was unable to do so directly from his office, so Mr Greenhowe contacted Aberdeen Coastguard by VHF radio to alert them to the incident. This was the first time that the coastguard or other emergency service had been made aware of the incident. The Aberdeen Coastguard instructed the Skua to land with Mr Kurida at Aberdeen RNLI station. About 10:43 hours Captain Wnukowski

contacted Peter Grambart, the designated person ashore and point of contact between the vessel and the management of ER Schiffart and ER Offshore, to report the incident.

[69] The Skua arrived at the lifeboat station at Aberdeen Harbour at 11:25 hours, where it was met by Robert Coull, a volunteer lifeboatman, who assessed Mr Kurida and contacted the coastguard to arrange the urgent attendance of an ambulance. Although an ambulance was on its way, he wanted the ambulance more quickly as it was clear to him Mr Kurida was not well. Mr Coull administered oxygen to him at that time.

[70] At 11:28 hours Stuart Robertson, a Scottish Ambulance Service paramedic, arrived at the lifeboat station in a fast response vehicle in advance of the ambulance. Mr Kurida was lying on a stretcher at the back of the boat. He was not properly secured in the stretcher. Mr Robertson noticed that Mr Kuirda looked very unwell. He was conscious and was complaining of pain in his lower right chest. On examination there was no sign of blood loss into the abdomen and no impairment of air flow into his lungs.

[71] The ambulance arrived at 11:30 hours. Mr Kurida received further treatment. The ambulance left the harbour at about 12:02 hours. Mr Robertson accompanied Mr Kurida, who had been administered morphine, to Aberdeen Royal Infirmary. He was still conscious and able to speak. However, Mr Robertson noticed that there was blood on Mr Kurida's teeth and lips when he changed his oxygen mask.

*Treatment at Aberdeen Royal Infirmary*

[72] The ambulance arrived at Aberdeen Royal Infirmary at 12:08 hours. Mr Kurida was taken immediately to the accident and emergency department. Mr Kurida was examined by Dr Jamie Cooper, a consultant there. Mr Kurida was initially alert, and able to speak. However, he was very pale in appearance. Dr Cooper observed fresh bruising across Mr Kurida's chest and upper abdomen, with petechiae bruising on his upper chest indicative of a crush injury, and reduced air intake on his right side. A transfusion protocol was initiated, and medication was administered to control any bleeding and alleviate pain.

[73] At 12:28 hours Mr Kurida's condition deteriorated and he became unresponsive. Chest drains were inserted into both sides of Mr Kurida's chest as a result of a suspected haemothorax (accumulation of blood in the space between the lungs and the walls of the chest), and a large quantity of blood was drained from his right side. At around 12:34 hours Mr Kurida went into cardiac arrest and a clam shell thoracotomy (opening of the chest) was performed. A large quantity of blood was found on the right side of his chest, and Dr Cooper identified a pulmonary vein as the source of the bleeding. That vein was clamped. Internal cardiac massage was performed and was ongoing when a surgeon opened his abdomen and found a large quantity of blood. There had been no cardiac activity for twenty-five minutes. Efforts to continue resuscitation were stopped and life was pronounced extinct at 12:59 hours.

*Post mortem examination*

[74] On 13 June 2012, a post mortem examination was carried out by Dr James Grieve and Dr Paul Brown, both forensic pathologists, and the cause of death was certified as: 1(a) chest injuries; (b) Incident at work offshore.

[75] The post mortem report noted the serious injuries Mr Kurida had suffered. He had suffered multiple rib fractures on both sides of the chest. The chest injuries were significant. In particular, he had suffered a laceration of one of the major pulmonary veins, with massive haemorrhage into the chest cavity. In addition, the liver was severely lacerated. This was consistent with blunt force injury to the chest when he was crushed between the two vessels. Dr Grieve and Dr Brown further noted evidence of extensive surgical intervention which they stated "would have been futile given the circumstances and nature of the injuries."

*Further medical opinion evidence*

[76] The accident which caused Mr Kurida's death happened at about 10:00 hours. He did not arrive at Aberdeen Royal Infirmary until 12:08 hours. Further medical opinion evidence (obtained by further statements provided in 2021) addressed the part that this delay had in his death. This is set out below.

[77] Dr Jamie Cooper, the accident and emergency consultant who had treated Mr Kurida, emphasised that the potential severity of Mr Kurida's injuries could be inferred from the mechanism of their cause: he had been caught between two vessels and significant forces were involved. Dr Cooper emphasised the importance of getting

Mr Kurida to hospital quickly, but concluded that there was a significant risk that the injuries would have proved fatal regardless of what treatment Mr Kurida received.

[78] Dr Emad Aly, consultant colorectal and general surgeon at Aberdeen Royal Infirmary who had been involved with the treatment of Mr Kurida in 2012, was also asked in April 2021 to comment on the survivability of Mr Kurida's injuries. He stated that he could not give an opinion in relation to Mr Kurida's chest injuries. In relation to the liver injuries he stated: "For liver injuries, most patients survive if managed appropriately, however some of these injuries could involve major veins and therefore [patients] are less likely to survive."

[79] Dr Vincenzo Giordano was a registrar in the cardiothoracic department at Aberdeen Royal Infirmary in 2012. He had assisted Dr Cooper, and had carried out the thoracotomy on Mr Kurida. He is now a consultant cardiothoracic surgeon with NHS Lothian. He emphasised the seriousness of the injuries suffered by Mr Kurida. He had only dealt with two or three patients in his career who had suffered such severe crush injuries, and Mr Kurida's injuries were unique in terms of what Dr Giordano had experienced. Dr Giordano was asked to comment on whether it was possible that Mr Kurida could have survived his injuries. Dr Giordano commented that this would depend on Mr Kurida having been taken quickly to a hospital where there is a cardiothoracic unit. Dr Giordano's opinion was that Mr Kurida may have survived had he arrived earlier at hospital, and "certainly within an hour of the injury happening" (ie to have a chance of survival, Mr Kurida required to arrive at hospital at least within an hour of the accident.)

[80] As stated above, the authors of the post mortem report had concluded that the extensive surgical intervention carried out on Mr Kurida "would have been futile given the circumstances and nature of the injuries." Dr Grieve was further asked for his opinion in relation to the survivability of Mr Kurida's injuries on July 2021. He accepted that an earlier arrival at hospital "would have been to Mr Kurida's advantage". However, his conclusion was that the accumulation of injuries sustained at the time of the accident was "not survivable".

[81] There was a delay in getting Mr Kurida to hospital. Dr Giordano's opinion goes no further than raising a possibility that Mr Kurida may have been able to survive his injuries had he arrived at hospital within an hour of the accident happening. However, Dr Grieve, the experienced pathologist who carried out the post mortem, is best placed to comment on the totality of Mr Kurida's injuries. His opinion was ultimately clear: Mr Kurida's injuries were not survivable. I accept that opinion.

**Submissions**

[82] The findings in terms of sections 26(2)(a), 26(2)(b), and 26(2)(c) of the 2016 Act were uncontroversial. There was further agreement that Mr Kurida had been trapped between the Athina and the lifting frame of the fast rescue craft when attempting to paint the larger vessel, and that the swell had caused those two boats to come together. It was also common in parties' submissions that Mr Kurida's injuries were not survivable.

[83] The agreement in relation to these matters is reflected in my findings and discussion, and so I do not rehearse parties' submissions in full in relation to those matters.

***Submissions for the Crown***

[84] Mr Glancy for the Crown identified three causes of the accident resulting in the death in terms of section 26(2)(d): i) the decision to paint the hull of the Athina at sea, particularly in light of the relatively minor nature of the damage; ii) the use of the fast rescue craft for the purpose of painting the Athina, a purpose for which it was not risk assessed; and iii) a failure to conduct a comprehensive risk assessment for a task for which no risk assessment form existed.

[85] The precaution which the Crown identified in terms of section 26(2)(e) of the Act was the carrying out of a comprehensive risk assessment. Mr Glancy referred to the Code of Safe Working Practice for Seamen, which set out how a risk assessment should be conducted if one did not exist for a particular task. The discussions that took place on the Athina before the work was carried out were inadequate. Too much emphasis had been placed on Mr Kurida's willingness to carry out the task. If an adequate risk assessment had been carried out, the risks could have been properly identified and subject to control measures to eliminate those risks or reduce to them to a level as low as reasonably practicable.

[86] The Crown identified three defects in the system of working in terms of section 26(2)(f): i) the use of the fast rescue craft as a floating platform from which to

pain the hull; ii) the use of mooring lines from the Athina to the fast rescue craft which were bereft of an "eye" for securing to the "bitts" on the fast rescue craft, which in turn contributed to difficulties securing those mooring ropes; iii) there only being two persons on the fast rescue craft, which caused Mr Kurida to be required to leave his position at the controls; and iv) the failure of the crew to alert the coastguard after Mr Kurida was injured, which delayed his evacuation from the vessel and arrival at hospital.

[87] This delay in getting Mr Kurida to hospital (along with the non-survivable nature of Mr Kurida's injuries) was further explored by Mr Glancy in terms of other factors relevant to the circumstances of the death in terms of section 26(2)(g) of the Act.

[88] Mr Glancy submitted that those responsible for the management of merchant vessels operating in UK waters direct the masters of vessels to inform the coastguard as quickly as possible when injuries are sustained on board. The coastguard could then make the assessment as to the appropriate arrangements to be made for any evacuation of the injured person from the vessel.

***Submissions for Captain Artur Wnukowski***

[89] Mr Donaldson highlighted, in terms of the causes of the accident under section 26(2)(d), the difficulty securing the fast rescue craft to the Athina, which caused Mr Kurida to have to move from his position at the controls. The fast rescue craft was not a suitable platform from which to carry out the painting activity in open water.

[90] Mr Donaldson identified two precautions under section 26(2)(e): i) a more detailed risk assessment which balanced the benefits of the proposed painting operation with alternatives such as painting from a "bosun's chair" (a plank or harness which can be suspended from a rope); and ii) if a fast rescue craft were to be used for the painting operation, this could have been done within the harbour.

[91] Mr Donaldson highlighted that Captain Wnukowski accepted his responsibility, as master of the vessel, for the decisions that had been taken in the lead up to Mr Kurida's death. Captain Wnukowski had recently taken over the Athina, and was still relatively early in his career as a master. It was against this background that he had discussed the work to be carried out with, and took account of the opinions of, experienced crew members who knew the vessel. Mr Donaldson submitted that all those experienced crew members agreed that it was safe to carry out the painting operation from the fast rescue craft. That operation was only to proceed if the weather conditions were appropriate, and it was assessed that they were. A number of crew members were familiar with such a painting job being carried out from a fast rescue craft at sea.

[92] Lessons had been learned. Captain Wnukowski was clear he would do things differently now. Swift action had been taken by ER Offshore to prohibit the use of fast rescue craft being used for anything other than rescue activities, and an appropriate safety bulletin had been circulated.

[93] Mr Donaldson addressed the decision not to call for emergency medical assistance. He submitted that there may be difficulties in setting out a finite set of

circumstances for what action to take in such circumstances. However, guidance highlighting the potential for serious internal injuries resulting from incidents involving crushing may assist in more informed decisions being taken. Alternatively, there could be a direction to contact an external organisation with a higher level of medical trauma experience in order to explain the circumstances and take advice on what steps to take next.

***Submissions for OSM Crew Management Ltd***

[94] Mr Sinclair highlighted, in relation to the causes of the accident under section 26(2)(d) of the Act, that Mr Kurida had "elected" to leave his position at the controls of the fast rescue craft shortly before he had been caught between the two vessels.

[95] Mr Sinclair identified four precautions under section 26(2)(e): i) Mr Kurida could have decided not to leave his position at the controls of the fast rescue craft; ii) A decision could have been taken not to paint the vessel at sea; iii) Proper regard could have been had to the vessel's safety management system; iv) In the absence of a specific pre-prepared risk assessment form, a more formal "local" risk assessment could have been carried out.

[96] The lack of a proper risk assessment was highlighted as a defect in the system of work under section 26(2)(f) of the Act.

[97] Mr Sinclair emphasised Mr Kurida's senior role on the ER Athina. He was responsible for deck management, which included painting jobs. He had been the

"driving force" in the painting job being attempted from the fast rescue craft at sea. He repeatedly confirmed, when asked, that he was content to proceed both before and during the operation.

[98] Mr Sinclair also discussed the decision not to treat the accident as a medical emergency. He submitted that the decisions taken were made in good faith and for logical and valid reasons. Mr Kurida presented as having rib injuries. There was nothing to suggest internal injuries. Mr Sinclair cautioned against the prescription of too rigid rules for when the coastguard should be contacted.

[99] Mr Sinclair submitted that, for the purpose for which the fast rescue craft was used (ie painting the hull), two crew members was the appropriate number.

[100] In terms of other facts relevant to the inquiry under section 26(2)(g) of the Act, Mr Sinclair highlighted the good safety record of, and safety culture on board, the ER Athina. There had been no similar incidents before or since this incident. There was a comprehensive safety management system on board. Having regard to that, it should have been appreciated by the crew involved that the verbal discussion of the painting job was insufficient.

[101] Swift action was taken after the incident. A safety bulletin was distributed by ER Offshore on 2 July 2012 to ensure full awareness of the incident. The relevant risk assessment relating to fast rescue craft was updated three days after the incident to ensure that these craft were only used for the purposes of testing and emergencies, and that persons on board should not move from their seated position. There had been a full investigation by the Marine Accident Investigation Board (MAIB), which resulted in the

publication of its report in January 2013. That report was well publicised throughout the industry, including by the International Marine Contractors Association (IMCA). The recommendations in that report were made part of onboard safety meetings and of training of crew members. There were subsequent safety assessments by other organisations, including assessment of procedures on board over an extended period of time.

**Discussion and conclusions**

[102] Mr Kurida died as a result of chest injuries suffered when he was attempting to paint the hull of the Athina from one of that vessel's fast rescue craft at open sea. The motion of the sea (including the swell and/or tidal stream) caused the vessels to come together and Mr Kurida was caught between the hull of the Athina and the lifting frame of the fast rescue craft. This caused significant crush injuries to his chest and abdomen. This incident happened at 09:55 hours on 10 June 2012. He died from those injuries at Aberdeen Royal Infirmary later that day.

[103] The starting point for considering the events and decisions which led to those tragic circumstances is the early hours of the morning of 7 June 2012. At that time the vessel Athina collided at slow speed with the quay wall at Aberdeen Harbour. This was an incident which was not in itself of significant concern.

***The decision not to paint the Athina in Aberdeen Harbour***

[104] After that collision, the Athina remained docked in Aberdeen Harbour until the afternoon of 9 June 2012. In that period, Captain Wnukowski, the Athina's master, inspected the damage and was therefore aware that it was superficial.

[105] Captain Wnukowski accepted in his evidence that it would generally be safer to paint a vessel in the protected waters of the harbour than at open sea. This would be done from a painting raft, which could be requested from the harbour authorities or an agent. Captain Wnukowski said that he had considered painting the vessel in the harbour. However, he recalled that there were reasons why this had not been done: the vessel had had to move from one jetty to another; and it had then been instructed to move out to sea at short notice.

[106] It is clear that painting the vessel in the protected waters of the harbour would have helped avoid many of the issues encountered when the crew attempted to paint the vessel at open sea. Any vessels involved would not have been subjected to the same motion of the sea. The painting work could have been overseen by persons standing on the harbour wall.

[107] The decision not to paint the hull in the harbour does not appear to have been a planned one. Rather, events moved on before that particular job was able to be carried out. However, that the hull was not painted in that time period would in turn highlight that the damage was superficial and the job was not an urgent one. That is relevant when considering the subsequent decision to attempt to paint over that damage at open sea, when the risks involved were clearly greater.

***The decision to paint the Athina at open sea from the fast rescue craft***

[108] When at anchor on 9 December 2012, Captain Wnukowksi communicated to his crew that the next day he wanted to test the fast rescue craft and that he wanted to have the damage on the hull painted, provided the weather permitted.

[109] It would appear that it was on the following day that Captain Wnukowksi decided that the two jobs could in effect be carried out together: the hull of the Athina was to be painted from the fast rescue craft.

[110] Any decision to carry out any job on the vessel required to be in accordance with the extant safety management system. Ultimate responsibility lies with the master of the vessel, Captain Wnukowski. He accepted this. However, he had discussed the painting job with crew members.

[111] Captain Wnukowski stated in his evidence that it was Mr Kurida who wanted to paint the Athina's hull from the fast rescue craft. Captain Wnukowski stated that his preference was to use a bench (or stage) which would be suspended from the hull of the vessel using a harness. Ultimately, however, Captain Wnukowski agreed with the Mr Kurida's plan to use the fast rescue craft.

[112] At points in Captain Wnukwoski's evidence it appeared that the operation he had in mind (painting from a wooden bench or similar) was different from the operation envisaged in the relevant risk assessment form entitled "Painting from stage" (which related to using a "stillage" or metal cage). Nevertheless, there was a risk assessment in terms of the vessel's safety management system which broadly corresponded to the

painting operation Captain Wnukowski suggested. He accepted that this operation would have required a permit to work, as it involved work "overside".

[113] It is not clear to what extent painting the hull from a bench or stage would, in the circumstances, necessarily have been safer than doing so from a fast rescue craft. It would no doubt have carried different risks. The tapering of the hull at the damaged area may likely have made that area difficult to reach. The motion of the sea would have presented a challenge even when using a bench or stage, particularly when the damage was so close to the waterline. The option of painting the vessel from a stage was in the event rejected without further detailed consideration of its hazards and risks. However, if that option had been pursued further, the risk assessment in place would have helped ensure such a detailed consideration took place. The job would only have proceeded subject to that risk assessment.

[114] There was no such risk assessment in place for the operation of painting from a fast rescue craft. As Captain Wnukowski now accepts, this raises the question of whether it is the type of operation that should have been carried out. As the Crown stated in its submissions, the absence of a formal risk assessment left Captain Wnukowski with two options: to properly risk assess the proposed activity; or to consider not proceeding. A risk assessment should have been carried out in terms of the vessel's safety management system, as it should have been recognised as "an unusual or infrequent" task.

[115] The risk assessment available for fast rescue craft related only to the launching of the craft. This included instructions to be aware of the ship's movements, especially in bad weather; and always to stay in a safe position. Identified risks when boarding and

unlashing the boat included "nipped and squeezed fingers and hands" and "…boat striking ship. Excessive sea & swell". According to the "toolbox talk" form, this risk assessment was discussed. The risks it identified, which related to the danger of crushing injuries caused by the motion of the sea, were acutely relevant for using the fast rescue craft to paint the hull of the vessel. However, the painting job also carried additional risks which required to be assessed.

[116] Captain Wnukowski discussed the painting job with Mr Tucholski (chief officer) as well as Mr Kurida. They both supported the decision to paint the hull from the fast rescue craft. I would consider it good practice to discuss decisions with experienced operational crew members, and to take account of their views. However, it is insufficient in itself as a risk assessment process. Further, there are risks attached to putting too much reliance on the views of subordinate crew members. They may be keen to impress the ship's captain. Captain Wnukowski had recently taken over command of the vessel, and Mr Kurida was apparently going for promotion. These dynamics emphasise the need for the overarching structure of a more formal risk assessment process.

[117] The only evidence of any formal process was the "toolbox talk", overseen by Josip Kurtin (see paragraphs [48] to [50]). Captain Wnukowksi discussed the need for this talk with Mr Kurtin. He told him who should attend: Mr Tucholski; Mr Kurida; Mr Czarny; Mr Ushakhin. That is indicative of Captain Wnukowski's direct oversight of this operation. However, Mr Kurtin stated he knew nothing of, and heard no discussion of, the intention to paint the hull of the Athina using the fast rescue craft.

Captain Wnukowski's evidence at the inquiry was not clear enough to contradict that. Mr Kurtin's position is consistent with the "toolbox talk" form recording that the risk assessment for "Launching the rescue boat" had been (or would be) discussed in the course of that talk.

[118] However, it was Mr Tucholski who in fact was in charge of the meeting, and there was further discussion relating to the painting of the vessel in the absence of Mr Kurtin. Nevertheless, the form which Mr Tucholski, Mr Kurida, Mr Czarny and Mr Ushakhin signed to show they understood the risks involved in the task they were about to carry out made no reference to painting the vessel.

[119] The evidence available in relation to the briefing held by Mr Tucholski before the fast rescue craft was launched contains nothing about the assessment of risks of the painting job. Rather, this briefing appeared to consist of Mr Tucholski's instructions as to the general functions each crew member was to carry out. Each crew member involved, however, did appear satisfied that the painting job to be carried out was safe in the circumstances. This is against a background of evidence from a number of crew members on the Athina that they were aware of vessels having being painted at sea from a fast rescue craft. It appears to have been an accepted, although certainly not routine, practice.

[120] Regardless, it is clear that the discussions which did take place were inadequate as a risk assessment for the job of painting the hull of the vessel. There was no formal risk assessment for the job in terms of the vessel's safety management system, and there was no rigorous risk assessment carried out in place of such a formal assessment.

[121] No firm conclusion can be drawn as to what action might have been taken had a rigorous risk assessment been carried out. However, it is reasonable to conclude that such an assessment may have identified the risks involved. This might realistically have resulted in a different approach being taken.

***The attempt to carry out the painting job***

[122] The decision to paint the hull of the Athina was always contingent on the weather conditions being appropriate. The weather at the time was recorded as being fair. The wind was approximately 10 knots, the swell (wave motion) was up to half a metre, the tidal stream was approximately 0.5 knots. Mr Tucholski recognised that the "slight swell" would make the job more difficult. However, there was little evidence of any detailed consideration of how those wind and sea conditions would translate into whether or not the painting job was feasible. This is particularly important given the conditions would inevitably be changeable. The conditions did indeed change between the time the decision was taken to use the fast rescue craft and the time the painting job was attempted. The heading of the Athina (the direction in which it was facing) had changed significantly, so that its stern and port quarter were far more exposed to the swell than it had been earlier that morning. There was also the effect of the motion of a vessel such as the Athina at anchor, described by Mr Tucholski as a "circle of eight", to consider. This can cause a smaller vessel alongside, such as a fast rescue craft, to move towards and away from the larger vessel. The damage was under the "cutaway" of the hull, which would affect the condition of the sea at that point. Captain Wnukowski

observed in his statement that he and Mr Tucholski estimated the swell at about 0.5 metres from their position on deck. He, however, qualified this by saying "that is obviously from our position and could be different from the position held in the craft." This is an acceptance that the conditions could not be fully assessed from the deck of the Athina. Nevertheless, the job proceeded on the basis of a general acceptance that it was safe to do so.

[123] It is clear from Mr Czarny's description of events, viewed from sea level on the fast rescue craft itself, (summarised in paragraphs [58] to [61], above) that it was not in fact safe for the job to proceed in the prevailing conditions. This is a conclusion which could be drawn even if Mr Kurida had not been injured. Mr Kurida required two attempts in order to draw the fast rescue craft alongside the Athina. There were problems catching the mooring ropes, and tying them. The fast rescue craft was being dragged underneath the main vessel, and Mr Kurida and Mr Czarny had to push against the side of the Athina to keep the boats apart. One of the ropes came loose, and Mr Czarny just managed to catch it. These challenges would likely only have continued had Mr Kurida and Mr Czarny been able to proceed as far as painting the Athina's hull. They are challenges which would not appear to be worth facing given the superficial nature of the damage.

[124] I consider that the job was made only more challenging as there were only two crew members on the fast rescue craft. There were difficulties manoeuvring the fast rescue craft in relation to the Athina. There were difficulties in securing the mooring ropes, which appear to have in part been exacerbated by the lack of a suitable "eye" on

the mooring ropes. Both Mr Kurida and Mr Czarny became involved in both these tasks. It seems clear that when Mr Kurida was crushed between the two boats he had been diverted from his position at the controls of the fast rescue craft. An additional crew member on board may have helped avoid this.

[125] The deficiencies in assessing the risks of the painting job in advance were compounded by the complete lack of a suitable means of an ongoing assessment of the risk of the job as it progressed. Those on deck could not see the fast rescue craft below, or the problems caused by the sea conditions. There was no one able to monitor and supervise the fast rescue craft from a separate vessel. The only two persons who could see what was happening were fully engaged in the task itself, with their ability to assess and communicate the risks compromised as a result. This highlights again the deficiencies and danger of relying on the "stop job" policy described by Captain Wnukowski, and on the assurances from Mr Kurida that he was happy to proceed.

[126] The suitability of the conditions of the sea for painting were acknowledged to be only partially known by those on deck. This was the precondition for carrying the work out. The dangers of such a large vessel coming into contact with the fast rescue craft were obvious. In these circumstances, it was critical that there was an appropriate way to assess the ongoing risks when those on deck could not clearly see the craft. A third crew member in the fast rescue craft would have assisted, but even that may have been inadequate. A crew member able to view the operation being carried out from a separate vessel at sea level, with authority to call the job to a stop if considered unsafe, would have provided much better oversight. This would have involved more members

of crew being involved at the one time. However, the plan was to test the starboard side fast rescue craft later that day. It is reasonable to assume that the Athina would have been able to have both fast rescue craft in the sea at the same time. Mr Tucholski was able to control a fast rescue craft. If he was to properly oversee the job, it might have been a realistic precaution for him to do so from that other fast rescue craft.

***The failure to call for emergency medical assistance***

[127] After the incident, and once Mr Kurida was recovered to the Athina, it is clear that the potential severity of his injuries was not appreciated. The reasons for this are understandable. Mr Kurida was conscious and talking. It would be reasonable to consider that he might have just broken ribs. However, given the mechanism of the cause, and potential forces involved, it should have been clear that there was a risk Mr Kurida could have suffered much more severe injuries. Mr Czarny was in a position to report to those on deck that Mr Kurida's "body and torso" had been crushed between the hull of the Athina and the lifting frame of the fast rescue craft. The Athina is 93 metres long, with a gross tonnage of 4,500 tonnes. The vessels had come together by the force of the sea. I consider that is enough information to conclude that this should have been treated as a medical emergency.

[128] Those on deck, and in particular Captain Wnukowski, did not treat this as a medical emergency. The potential severity was not communicated to, nor picked up by, Darren Harper, the vessel's Aberdeen agent who was contacted. Rather, arrangements were made for Mr Kurida to be picked up by Richard Greenhowe in his fishing vessel,

the Skua, and taken to shore for onward transmission to hospital. Captain Wnukowski explained in evidence that he did not want to overburden the emergency authorities, or divert resources from what may be a more serious incident. These are understandable motives, which will be familiar to anyone who has dealt with a medical incident of uncertain severity. However, it is clear that the wrong decision was made. The potential of severe injuries (which would require urgent medical attention) should not have been effectively discounted on the basis that Mr Kurida's presentation suggested less severe injuries.

[129] If Captain Wnukowski had called HM Coastguard, it could have assessed the situation and appropriately managed the allocation of resources to this incident. Indeed, it was made clear to Mr Wnukowski in a subsequent call with HM Coastguard that it should have been contacted immediately. In fairness to Captain Wnukowski, he did not seek to defend his decision when he gave evidence at the inquiry.

[130] The delay in getting Mr Kurida to hospital was unnecessary. This is particularly concerning in light of the importance of getting a patient with significant chest injuries to a hospital with a cardiothoracic unit quickly. However, as set out above, I accept that Mr Kurida's injuries were not survivable. It follows that the failure to seek emergency medical assistance was not a cause of Mr Kurida's death (s26(2)(c)), or a defect of any system of work which contributed to his death (s26(2)(f)). Similarly, seeking immediate emergency medical assistance is not a precaution which could realistically have prevented Mr Kurida's death (s26(2)(e)).

[131] The failure to immediately seek emergency medical assistance is, however, a significant fact relevant to the circumstances of Mr Kurida's death in terms of section 26(2)(g). In other circumstances, it could have been the difference between life and death. There was therefore discussion at the inquiry in relation to any recommendations that could be made in terms of section 26(1)(b) and (4) which might realistically prevent other deaths in similar circumstances.

[132] There is difficulty formulating a recommendation from the particular circumstances of the Athina on 10 June 2012. A decision whether or not to call for emergency assistance will always depend on the circumstances. Any recommendation risks being either unhelpfully narrow or unduly prescriptive. However, systems of work and other steps can assist in better guiding the decision making process. That, in turn, may realistically prevent other deaths in similar circumstances. In particular, measures can be taken to guard against: i) a failure to take proper account of the potential severity of injuries; ii) a reliance on a superficial assessment of injuries in the absence of sufficient medical knowledge; iii) a failure to refer to another individual or body who is in a better position to make an initial medical assessment; and iv) a misguided concern about inconveniencing or overburdening emergency services. Measures could involve guidance and training to raise awareness in relation to the risks associated with particular injuries, such as abdominal injuries; procedures to ensure that a specified person with sufficient training makes the decision about calling the emergency services; or rules about certain situations in which emergency services must be called for. These measures should ensure quick assessments take place so that

potential medical emergencies are treated as such. I am conscious that such guidance, training, procedures, and rules will to a greater or lesser extent be in place on merchant vessels. I have noted that the Marine Accident Investigation Board made a similar recommendation in its report of 2013 to ER Offshore. This inquiry is dealing with events nearly 10 years ago. Procedures will have changed, and may have improved. Nevertheless, the potential concerns remain relevant. My recommendation is necessarily a general one. It is for the relevant bodies to ensure the appropriate specific measures are in place to help prevent the sort of decision made on the Athina on 10 June 2012 happening in the future.

[133] I therefore recommend that all those responsible for the operation of merchant vessels in UK waters have in place the necessary training, guidance, procedures and rules to ensure informed and appropriate responses to medical incidents of uncertain severity. After discussion with parties, I consider that the International Marine Contractors Association (IMCA) and the Maritime and Coastguard Agency have an interest in this recommendation.

**Any other information, observation or comment**

[134] I have already dealt with the delay in this inquiry being brought. In this context, I should again recognise that swift action was taken in the aftermath of Mr Kurida's death (see parties' submissions at paragraphs [92] and [101]). A number of investigations were carried out, including by the Marine Accident Investigation Board. The circumstances of Mr Kurida's death were publicised in industry bulletins, which

helped to raise awareness of the risks identified. The risk assessment form relating to the fast rescue craft was quickly amended to ensure that these craft would not be used for any purpose other than emergencies or drills, and that all those within remained seated. A fast rescue craft should not now be used for the purpose of painting a vessel. It was clear also that Captain Wnukowksi had learned a very harsh professional lesson from this tragic incident in 2012. That has shaped the more rigorous approach to the assessment of risk which he has brought to his work as a master of vessels in the years that have passed since.

[135] It was clear that Captain Wnukowski and all those involved with the Athina were deeply affected by Mr Kurida's death. He was by all accounts a dedicated and respected seaman. I would therefore conclude by expressing my condolences, belated though they are, to Mr Kurida's family, friends and colleagues. The time that has passed does nothing to diminish the tragedy of his death.