ANNUAL REPORT

2013

MAIB
MARINE ACCIDENT INVESTIGATION BRANCH

This Annual report is posted on our website: www.maib.gov.uk

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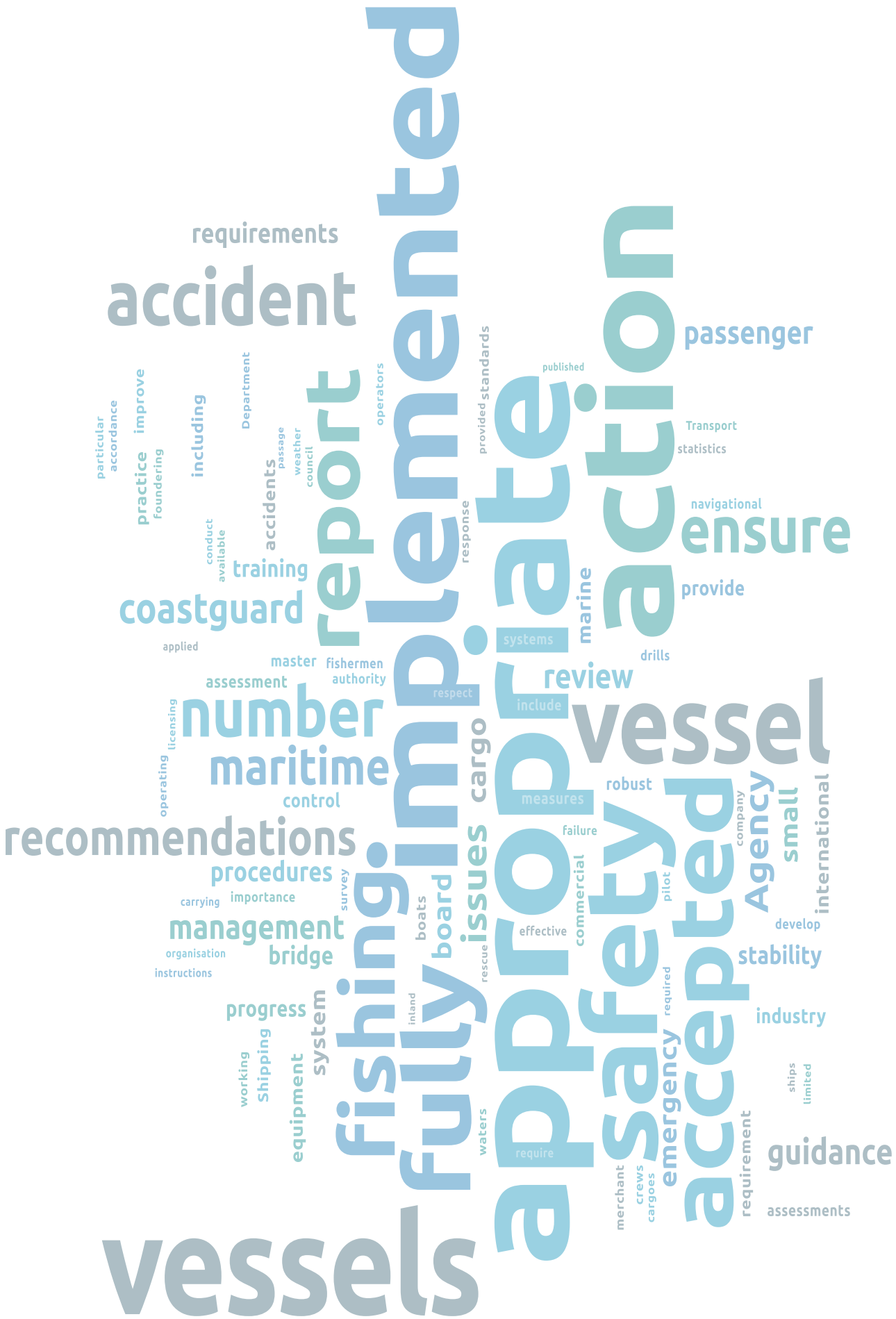
JULY 2014

MAIB ANNUAL REPORT 2013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Transport
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CHIEF INSPECTOR'S REPORT

2013 was a typically busy year for the Branch. 33 new investigations were commenced and 27 investigation reports were published. 2 Safety Digests and 3 Safety Bulletins were also published. The average time taken to complete an investigation, culminating in a published report, increased from 10.1 to 10.9 months with some reports taking significantly longer. This was perhaps the most obvious manifestation of a lack of resilience during the year – staff illness, gapped posts and, when these were filled, the need to properly train the new recruits, all took their toll. However, at the time of writing this introduction our cadre of new recruits is making a very positive contribution. The most obvious benefit is that the Branch is now better able to manage individuals' case loads, but the enthusiasm and new ideas being demonstrated by our new joiners is also proving infectious. Like others in the Civil Service, my staff have endured a period of considerable change and uncertainty. That they have done so without compromise to their work ethic and standards, and continue to find ways that the Branch can become more productive and innovative has been remarkable.

Regular readers will notice a new format for the annual report. More extensive use of graphics and photographs, a more logical layout for the recommendations section and more detailed statistical information are designed to make the report more user-friendly for the casual reader and analyst alike. I would be interested in any views you may have (good or bad!) on the changes that have been made.

The investigations commenced and the reports published by the Branch during 2013 have been diverse and have covered all sectors of the maritime industry. Accidents involving fishing vessels accounted for approximately a third of these, with the failure to wear personal flotation devices, inadequate appreciation of stability issues and an absence of general emergency preparedness contributing to avoidable losses, deaths and injuries. A full listing of the investigations commenced and the reports published is included later in this report but an overview of some of these is as follows:

- The grounding of two cargo vessels, *Beaumont* on the coast of northern Spain in February and *Danio* close to the environmentally sensitive Farne Islands in March, once more highlighted the problem of fatigue on vessels which operate with only two bridge watchkeepers. The watchkeepers on both vessels were asleep when they ran aground and neither had posted an additional lookout as required by international regulations. The same issues were previously identified by the MAIB in 2004 following publication of its Bridge Watchkeeping Safety Study when it was recommended that international action be taken to improve the minimum safe manning levels for ships. Nearly 10 years on, the situation remains unchanged, and accidents continue to occur because sole watchkeepers on the bridges of the vessels concerned are severely fatigued. Such vessels are, in reality, akin to unguided missiles and it is only a matter of time before there is a major accident involving loss of life or pollution.

- In May, six members of the same family were ejected from the RHIB *Milly* when the boat was travelling at speed in the Camel Estuary in Cornwall. Two died and two more were severely injured when they were struck by the RHIB as it continued to proceed at speed on a circular course with no one in the boat. Further injuries and worse were only avoided by the brave actions of several members of the public who brought the RHIB to a stop and also tended to the surviving family members' most severe injuries while still in the water. The accident, which received considerable press coverage, highlighted the importance of the use of kill cords when operating high powered craft. The MAIB published Safety Bulletin 2/2013 designed to emphasise this point to boat operators 12 days later.

- In June, the World War II era amphibious passenger vessel *Wacker Quaker 1* foundered in Salthouse dock, Liverpool. In September, a similar vessel, *Cleopatra*, caught fire while operating on the River Thames in London. The subsequent MAIB investigations raised concerns about the ability of these craft to operate safely and resulted in the Branch publishing its Safety Bulletin 3/2013. The Safety Bulletin made recommendations to the Maritime and Coastguard Agency which, in effect have prevented these vessels from operating until their safety can be verified.

- In October, a young child had a very lucky escape when she fell from the deck of the ferry *Snowdrop* into the River Mersey while the vessel was berthing at the Seacombe Terminal. Fortunately the tidal flow of the river was minimal and ship's staff reacted very quickly so that the child was recovered from the water with just a few bruises to mark the event.

- In November, the MAIB published a report on two separate accidents which involved passenger transfer vessels servicing the offshore renewables industry. Accidents involving this type of vessel have increased in recent years as more wind farms become operational. The MAIB investigations identified a compelling need for this burgeoning industry to develop a Code of Practice that will provide best practice guidance for operators of vessels that service the sector. A recommendation to this effect was included in the MAIB report, which has been fully accepted by industry stakeholders.

- In December, the MAIB's report on the foundering of the cargo vessel *Swanland*, in poor weather conditions off the coast of north Wales provided a disturbing insight into the standards of operation and oversight of one of the many elderly dry cargo vessels that trade in our coastal waters. Structural failure of the hull when the vessel was unevenly loaded with a high density cargo meant that the vessel was overcome by the prevailing sea conditions, and quickly sank. Six seafarers lost their lives. The vessel held all the required documentation to signify that she was being operated in accordance with international standards and was structurally sound. However, the MAIB's investigation concluded that her cargo of limestone had been loaded in a manner that overstressed the vessel, oversight of the structural condition had not been as comprehensive as it should have been and the crew were ill prepared to respond to the developing emergency. Accordingly, the MAIB report included six recommendations designed to ensure the safe operation of such vessels in the future. All were accepted and have been implemented by the three addressees concerned.

Looking ahead, plans are already well advanced to move the organisation from a privately owned building into government owned premises located in Southampton. The current office is now too large for our needs and the move will be an opportunity to create an office layout more suited to the way we work as well as saving the Exchequer a significant amount of public money that would otherwise be paid to a private landlord.

RECOMMENDATIONS

80 recommendations to 90 addressees were issued during 2013, of which 96.7% were accepted. This compares with 94.4% in 2012.

One recommendation was rejected. This was made to the classification society Germanischer Lloyd following the collision involving two cargo vessels and a suction dredger in the port of Immingham (MAIB Report 10/2013 – see page 28).

One recommendation was only partially accepted. This was made to the Maritime and Coastguard Agency following the capsize and foundering of the fishing vessel *Heather Anne* with the loss of one crewman. The recommendation calls for legislation that would make compulsory the wearing of personal flotation devices on the working deck of fishing vessels if it becomes clear that current efforts to encourage fishermen to wear this equipment voluntarily are not successful (MAIB Report 2/2013 – see page 17).

One recommendation was withdrawn. This was made to the owner of the fishing vessel *Betty G,* who has subsequently left the industry (MAIB Report 6/2013 – see page 23).

The MAIB operates a closed loop follow-up process which keeps outstanding recommendations under constant review. Of the 224 recommendations that had been accepted, but had not been implemented between 2004 and 2012, 89.7% were reported to be fully implemented at the time this report was published.

STATISTICS

There are a number of changes to the data used in the tables presenting statistics in this year's annual report. The changes reflect the definitions and terminology used widely by other national marine accident investigation bodies, particularly those that are subject to the requirements of Directive 2009/18/EC, and should enable easier comparison with the accident statistics of other EU member states. The Annex to this report describes in more detail the differences between the data now being recorded and data that was provided in previous Annual Reports. Some historical data is no longer captured in the report but can be obtained from previous MAIB annual reports which are available online (www.maib.gov.uk).

For the fourth successive year, there have been no losses of UK registered ships ≥100gt. The number of accidents, as a ratio of the size of the fleet, was 88/1000 vessels compared with the statistical average over the last 10 years of 93/1000 vessels[1].

One death of a merchant vessel crew member was reported. This is the lowest reported number since the formation of the MAIB in 1989. The statistical average over the last 10 years is 4.4 deaths per year.

[1] Source data: MAIB Annual Report 2012 Table 4.

Eighteen fishing vessels were lost in 2013 compared with 9 in 2012. Although the increase is disappointing it compares favourably with the 10 year statistical average of 20 per year. 15 (83%) of the losses in 2013 were in the small < 15m sector.

Four fishermen lost their lives, which is a historical low.

More detail is now provided about the type, location and causal factors of death and injuries suffered on merchant and fishing vessels. The data reveals some interesting facts:

- Most injuries to merchant vessel crew occurred in vehicle cargo spaces, when climbing or descending stairs or ladders in areas away from the ship's accommodation, or in the engine room (13, 12 and 11 crew respectively).
- Most injuries to fishing vessel crew (42.4%) involved injury to upper limbs.
- There were 9 cases of traumatic amputation out of a total of 33 fishermen injured.

FINANCE

The annual report deals principally with the calendar year 2013. However, for ease of reference, the figures below are for the financial year 2013/14, which ended on 31 March 2014. The MAIB's funding from the Department for Transport is provided on this basis, and this complies with the Government's business planning programme.

£ 000s	2013/14 Budget	2013/14 Outturn
Costs – Pay	2 516	2 584
Costs – Non Pay	1149	974
Totals	**3 665**	**3 558**

Steve Clinch
Chief Inspector of Marine Accidents

PART 1: 2013 OVERVIEW

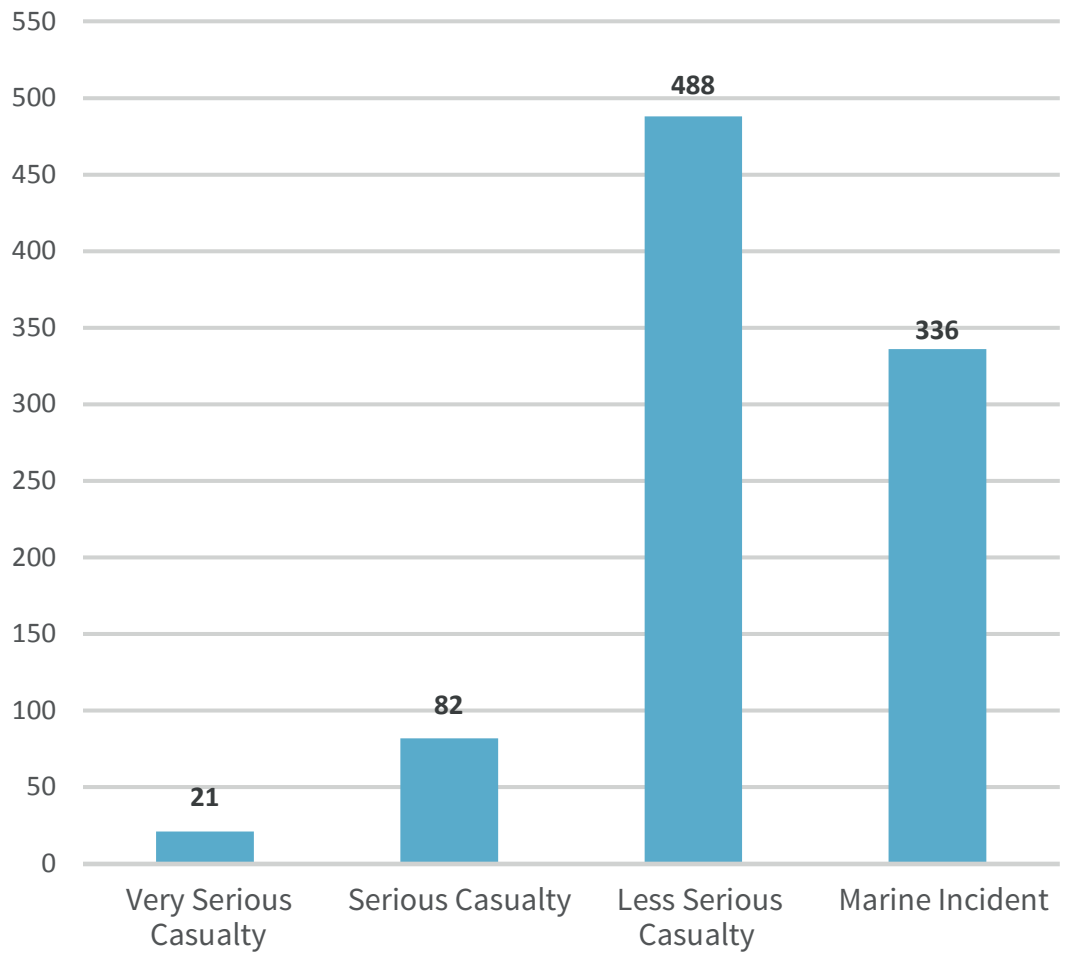
OVERVIEW OF CASUALTY REPORTS MADE TO MAIB IN 2013

In 2013 1332 Accidents (Casualties and Incidents) were reported to MAIB, these involved 1459 vessels.

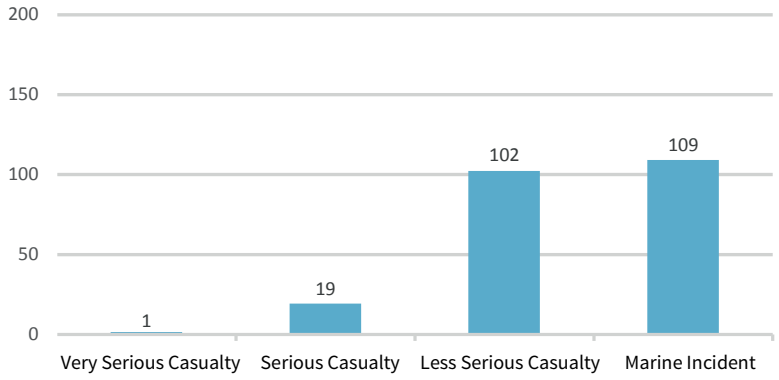
70 of these Accidents involved only non-commercial vessels, 420 were occupational accidents that did not involve any actual or potential Casualty to a vessel.

There were 842 Accidents involving 927 vessels that involved actual or potential Casualties to ships. These are broken down in the following overview:

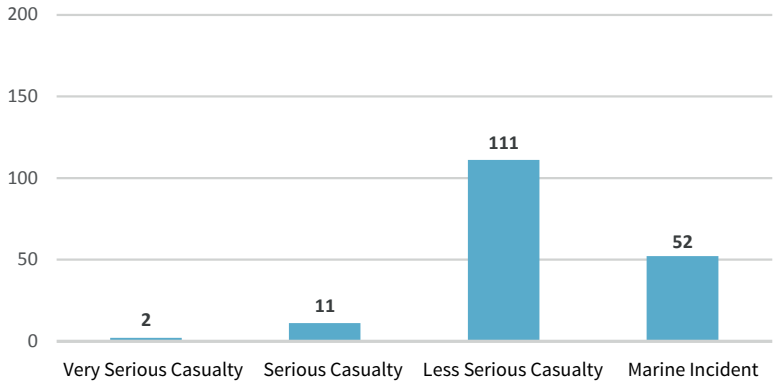
All commercial vessels reported to MAIB in 2013



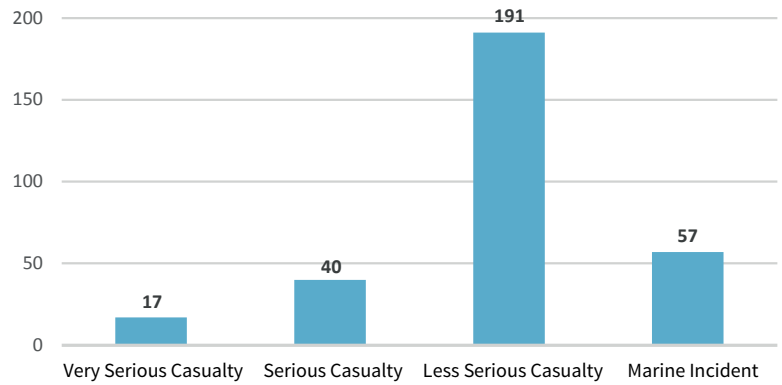
UK merchant vessels of 100gt or more



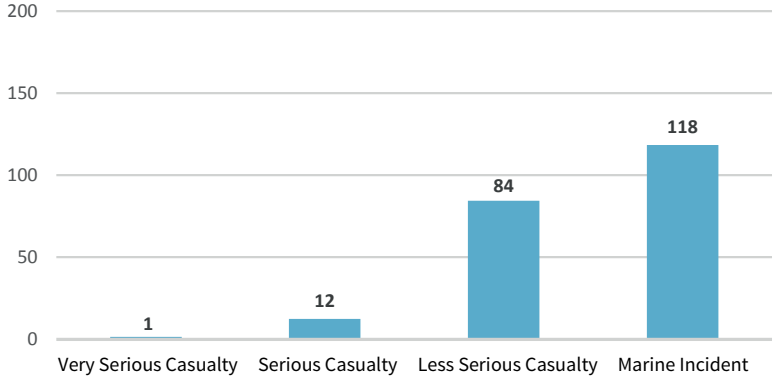
UK commercial vessels of under 100gt (excluding fishing)



UK fishing vessels



Non UK commercial vessels - in UK 12 mile waters



2013 SUMMARY OF INVESTIGATIONS STARTED

13 Jan	The tug *Christos XXII* was holed following a collision with the vessel it was towing in Tor Bay.
16 Jan	The fishing vessel *Amy Harris III* sustained a major engine room fire.
28 Jan	A crewman died after he was washed overboard from the Belgian-registered fishing vessel *Vidar*.
28 Jan	A single-handed skipper drowned after his small fishing vessel *JCK* foundered in Tor Bay.
5 Feb	A crewman died after falling overboard from the tug *Endurance* during operations to re-establish a broken tow.
16 Feb	The port stabiliser fin of the Finnish-registered ro-ro ferry *Finnarrow* made heavy contact with the berth at Holyhead, Anglesey. The stabiliser fin had not been retracted prior to berthing.
21 Feb	One crew member from the creeler *Achieve* died when it foundered 6nm north-west of the island of Taransay, West Scotland.
26 Feb	The cargo vessel *Douwent* ran aground on Haisborough Sands off the Norfolk coast due to a navigational error.
16 Mar	The Antigua and Barbuda-flagged cargo vessel *Danio* ran aground on the Farne Islands off the Northumbrian coast. The officer of the watch had fallen asleep.
19 Mar	The UK-flagged container ship *CMA CGM Florida* collided with Panamanian bulk carrier *Chou Shan* in the East China Sea. There was serious damage to both vessels as well as some pollution.
1 Apr	A mother and her 10 year old daughter died as a result of carbon monoxide poisoning on the cabin cruiser *Arniston* at Bowness-on-Windermere in the Lake District.

25 Apr	The single-handed fishing vessel *Speedwell* foundered in the Firth of Lorn, south of Oban, West Scotland with the loss of her skipper.
26 Apr	A fire in the accommodation area of the UK-flagged general cargo ship *Celtic Carrier* caused serious damage and some minor injuries to crew. The vessel was off Cape Trafalgar and was towed into Cadiz.
5 May	A father and his daughter were killed when all six occupants were ejected from the RHIB *Milly* at Padstow, Cornwall during a turn. It emerged that the kill cord was not being used at the time of the accident.
15 May	A crew member from the UK-flagged cargo ro-ro ship *Tyrusland* was killed during unloading operations at Tripoli, Libya.
14 Jun	The general cargo vessel *Fri Ocean* ran aground in the Sound of Mull 2½ miles south of Tobermory. The officer of the watch had fallen asleep.
15 Jun	The amphibious passenger vessel *Wacker Quacker 1* sank in Salthouse Dock, Liverpool. 31 passengers and two crew abandoned to the water and were safely recovered.
22 Jun	The Danish-flagged ro-ro ferry *Sirena Seaways* made heavy contact with the berth in Harwich causing serious damage to the vessel below the waterline and to the linkspan. There were no injuries.
25 Jul	The Gibraltar-flagged product tanker *Apollo* made heavy contact with the berth at Northfleet Hope Container terminal causing serious damage to the vessel and the quay.
5 Aug	The fishing vessel *Prospect* grounded and subsequently foundered in the north entrance to Lerwick Harbour, Shetland. The four crew were successfully rescued by the RNLI.
17 Aug	The UK-flagged recreational powerboat *Isamar* with 11 people on board grounded on the Grand Écueil d'Olmeto reef off Corsica. All on board were safely evacuated but the vessel subsequently sank in 55m.
17 Sep	The 11m beam trawler *Sally Jane* capsized and sank in Christchurch Bay. The two crew abandoned to a liferaft and were rescued by the RNLI 2 hours later after their flares were seen from the shore.

18 Sep	The Maltese-flagged chemical tanker *Ovit* grounded on the Varne Bank in the middle of the English Channel south of Dover while on passage through the Traffic Separation Scheme (TSS). There were no injuries and there was no pollution.
29 Sep	The amphibious passenger vessel *Cleopatra* caught fire on the Thames in London . The 28 passengers and two crew abandoned to the water and were safely recovered.
14 Oct	A 3 year-old girl fell overboard from the Mersey ferry *Snowdrop*. She was safely recovered with minor injuries.
28 Oct	The UK-flagged ro-ro passenger cargo vessel *Stena Alegra* dragged her anchor and grounded off the port of Karlskrona, southern Sweden in winds that exceeded 70 knots. She sustained hull damage and flooding to one void space but was able to be towed clear the following day. There were no injuries and there was no pollution.
9 Nov	The skipper of the fishing vessel *Horizon II* fell between the dockside and the vessel to which his was moored in Royal Quays Marina, North Shields. Although the alarm was raised and he was recovered to the shore, he did not survive.
19 Nov	A crew member caught his hand in a winch on the fishing vessel *Wanderer II* off the coast of Benbecula, Outer Hebrides. He sustained injuries that necessitated the amputation of his hand.
4 Dec	A fire on board the ro-ro cargo ship *Corona Seaways* caused serious damage. The vessel was on passage in the Kattegat and was able to reach the port of Helsingborg, Sweden. There were no injuries.
4 Dec	A single-handed angler fell overboard from his small boat *Amy Jane*. He was recovered by a survey vessel that was operating in the area and transferred to an RNLI lifeboat. He was subsequently evacuated by helicopter to hospital but could not be revived.
11 Dec	A collision occurred in the Dover Straits TSS between the UK-flagged general cargo vessel *Paula C* and the Hong Kong-flagged bulk carrier *Darya Gayatri*. Both vessels suffered serious material damage.
18 Dec	A crewman was pulled overboard from the Barbados-flagged general cargo vessel *Sea Melody*. He was swept away and despite an extensive search was not found.
20 Dec	The Gibraltar-flagged chemical tanker *Key Bora* sustained damage to her bulbous bow following a heavy contact with the jetty at Alexandra dock, Hull.

PART 2

RECOMMENDATIONS PUBLICATIONS

INVESTIGATIONS PUBLISHED IN 2013 INCLUDING RECOMMENDATIONS ISSUED

The following pages list the accident investigation reports and safety bulletins published by the MAIB during 2013. Where the MAIB has issued safety recommendations following an investigation, the current status of the recommendation and any applicable comments made by the MAIB accompany the entry*.

Recommendations from previous years that remain open are also included on the following pages.

In 2012 EU Directive 2009/18/EC was transposed into UK law by the Merchant Shipping (Accident Reporting and Investigation) Regulations 2012. A new marine accident reporting database was launched by the MAIB the same year to record accidents reported to the Branch in accordance with the new regulations. To identify recommendations that belong to cases started after the introduction of the new Regulations relevant recommendations have been assigned a '2..' number (Eg 2013/201). Recommendations that have been issued following an investigation started under the previous regulations continue to be represented by a '1..' number (Eg 2013/101).

For details of abbreviations, acronyms and terms used in this section please refer to the Glossary on page 88.

Background

Recommendations are a key element of MAIB investigations. They are issued to promulgate the lessons from accidents investigated by the MAIB, with the aim of improving the safety of life at sea and the avoidance of future accidents. The issue of a recommendation shall in no case create a presumption of blame or liability.

Following an investigation the MAIB will, normally, make a number of recommendations. These will be contained within the published report but will also be addressed in writing to the individuals or senior executives of organisations concerned. Urgent safety recommendations may also be made in Safety Bulletins that can be published at any stage of an investigation.

Recommendations are made to a variety of addressees who might have been involved in, or have an interest in, the accident. These may range from those organisations which have a wider role in the maritime community such as the Department for Transport (DfT), the Maritime and Coastguard Agency (MCA) or an international organisation, through to commercial operators and vessel owners/operators.

It is required by the Merchant Shipping (Accident Reporting and Investigation) Regulations 2012 that the person or organisation to whom a recommendation is addressed, consider the recommendation, and reply to the Chief Inspector within 30 days on the plans to implement the recommendation or, if it is not going to be implemented, provide an explanation as to why not. The Regulations also require the Chief Inspector "*to inform the Secretary of State of those matters*" annually, and to make the matters publicly available. This Annual Report to the Secretary of State for Transport fulfils this requirement.

*Status as of 1 June 2014.

RECOMMENDATION RESPONSE STATISTICS 2013

80 recommendations were issued to **90** addressees in 2013. Of these, the percentage of all recommendations that are either ***accepted*** or ***accepted yet to be implemented*** is **96.7%**.

Year	Total	Accepted Action		Partially Accepted	Rejected	No Response Received
		Implemented	Yet to be Implemented			
2013	90	56	31	1	1	-

1 recommendation has been withdrawn by the MAIB.

RECOMMENDATION RESPONSE STATISTICS 2004 to 2012

The following table shows the equivalent status of recommendations issued in 2004 to 2012 as published in the MAIB's previous Recommendations Annual Reports.

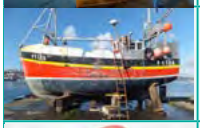
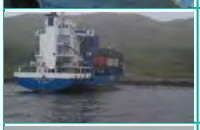
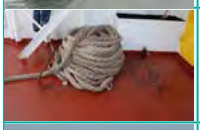
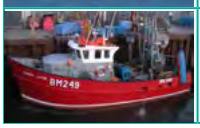
Year	Total	Accepted Action		Partially Accepted	Rejected	No Response Received
		Implemented	Yet to be Implemented			
2012	54	41	10	-	1	2
2011	57	33	21	2	-	1
2010	50	36	14	-	-	-
2009	117	74	29	7	-	7
2008	110	71	31	5	-	3
2007	136	109	23	1	1	2
2006	139	103	30	3	3	-
2005	140	122	14	1	1	2
2004	171	93	52	11	11	4

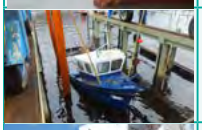
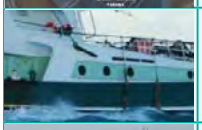
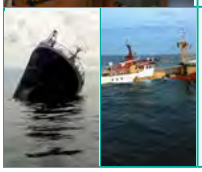
Of the **224** recommendations listed as ***accepted – yet to be implemented*** (at time of publication of relevant annual report):

89.7% have now been ***fully implemented***

10.3% remain **planned to be implemented**.

SUMMARY OF 2013 PUBLICATIONS

Vessel name(s)		Category	Publication date [2013]	Page
	*St Amant*	Very Serious Marine Casualty	9 January	16
	*Heather Anne*	Very Serious Marine Casualty	10 January	17
	*E.R. Athina*	Very Serious Marine Casualty	23 January	20
	*Zenith*	Very Serious Marine Casualty	24 January	20
	*Denarius*	Very Serious Marine Casualty	6 February	22
	*Betty G*	Very Serious Marine Casualty	7 February	23
	*Purbeck Isle*	Very Serious Marine Casualty	2 May	23
	*Milly* [Safety Bulletin]	Very Serious Marine Casualty	17 May	24
	*Carrier*	Very Serious Marine Casualty	22 May	25
	*Arniston* [Safety Bulletin]	Very Serious Marine Casualty	24 May	26
	*Coastal Isle*	Serious Marine Casualty	30 May	27
	*Alexander Tvardovskiy /UKD Bluefin/Wilson Hawk*	Serious Marine Casualty	31 May	28
	*Timberland*	Very Serious Marine Casualty	7 June	29
	*Swanland*	Very Serious Marine Casualty	12 June	30
	*Sarah Jayne*	Very Serious Marine Casualty	13 June	32

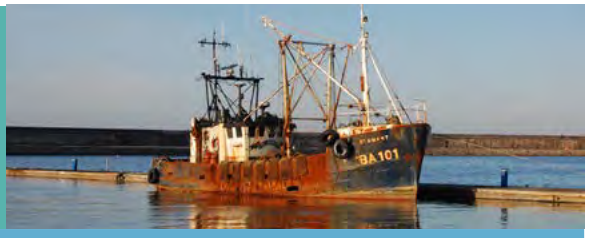
Vessel name(s)		Category	Publication date [2013]	Page
	*Beaumont*	Serious Marine Casualty	14 June	32
	*Hyundai Discovery/ACX Hibiscus*	Serious Marine Casualty	19 June	33
	*Vixen*	Very Serious Marine Casualty	20 June	34
	*Seagate/Timor Stream*	Serious Marine Casualty	26 June	36
	*Wah Shan*	Very Serious Marine Casualty	17 July	36
	*Vidar*	Very Serious Marine Casualty	16 August	37
	*Amy Harris III*	Serious Marine Casualty	23 August	37
	*Arklow Meadow*	Marine Incident	3 October	38
	*Amber*	Serious Marine Casualty	24 October	40
	*Wacker Quacker 1 /Cleopatra* [Combined Safety Bulletin]	Very Serious Marine Casualty/ Serious Marine Casualty	24 October	42
	*Windcat 9/Island Panther* [Combined Report]	Serious Marine Casualty/Serious Marine Casualty	20 November	43
	*Finnarrow*	Serious Marine Casualty	22 November	46
	*Jean Elaine*	Very Serious Marine Casualty	5 December	46
	*Fri Ocean*	Serious Marine Casualty	6 December	47
	*Audacious/Chloe T* [Combined Report]	Very Serious Marine Casualty/ Very Serious Marine Casualty	19 December	48

St Amant	**Report number:**	**1/2013**
Scallop dredger	Accident date:	13/01/2012

Loss of a crewman from a fishing vessel off the coast of North-West Wales

Safety Issues

- Poor housekeeping
- Wearing of lifejackets
- Trip hazards



No	Recommendation(s) to:	Vessel owner [Nightvalley Ltd] and skipper at time of accident

101 Improve safety on board this, and any other vessels they may own or operate, by reviewing the risk assessments and safety procedures, including:

- Consideration of the use of personal flotation devices (PFDs) and personal locator beacons (PLBs) for crew while they are on deck.
- The adoption of robust housekeeping procedures to minimise: the risk of trip hazards and clutter on deck.
- Conduct regular emergency drills on board in accordance with the requirements of the 15-24m Code and the guidance in MGN 430 (F).

Appropriate action implemented

No	Recommendation(s) to:	Maritime and Coastguard Agency

102 Ensure that its current policy of reviewing and deleting exemptions granted to fishing vessels that predate current regulatory requirements is applied robustly. As part of this process, the ambiguity between its Instructions to Surveyors and the 15-24m Code regarding the ongoing acceptance of standard exemptions should be resolved.

Appropriate action planned — 2014 DECEMBER 31

103 Provide guidance to the owners and skippers of fishing vessels which operate at sea for more than 24 hours on appropriate accommodation standards.

The guidance should also recommend consideration of hygiene and sanitation facilities in a vessel's risk assessments, and the application of appropriate control measures.

Appropriate action planned — 2014 JUNE 30

104 Introduce a policy and procedure for conducting inspections of fishing vessels following accidents that have resulted in a fatality, serious injury[1] or serious damage. The procedure should require examination of the factors that are relevant to the circumstances of the accident, including:

- Any relevant exemptions which were granted that predate current regulatory requirements.

[1] To be defined, but should include cases where a crewman has to be evacuated from sea for medical reasons, is admitted to hospital for more than 24 hours, or is unable to work for a significant period due to their injuries.

- That the working practices relevant to the circumstances of the accident were adequate and were consistent with existing rules and obligations.
- The risk assessments relevant to the circumstances of the accident. In particular, the quantification of the hazard and risk, and the effective implementation of the specified control measures, including the use of personal protective equipment.
- The effectiveness of the crews' response to the accident or emergency, including effective preparation and use of equipment.

Appropriate action implemented

105 Improve the management of fishing vessel surveys and inspections by ensuring that:

- Existing survey and inspection procedures and guidance are reviewed to improve the clarity of the guidance and ensure that it is consistent throughout.
- There is an effective and readily accessible system to record and provide information to surveyors on the status of all identified deficiencies.
- Existing instructions requiring a photographic record of a vessel's principal features are followed.

Appropriate action planned

Heather Anne

Report number: 2/2013

Ring netter | Accident date: 20/12/2011

Capsize and foundering resulting in the loss of one crewman in Gerrans Bay, Cornwall

Safety Issues

- Stability dangerously affected by catch size
- Vessel modifications unsuitable
- Lifejackets not worn
- Maintenance of emergency equipment

No	Recommendation(s) to:	Maritime and Coastguard Agency

106 Revise MGN 427 (F) in order to provide clearer and more comprehensive guidance to surveyors and fishermen on the methods available to assess small fishing vessel stability, taking into account, inter alia:

- The limitations of the alternatives to a full stability assessment.
- The suitability of the alternative stability assessments for small fishing vessels.
- A vessel's stability is dependent on several factors including her upright GM, freeboard and hull form.
- The need for skippers to be aware of the maximum loading of their vessels and the benefits of a freeboard mark.

- The impact of vessel modifications.
- Owners' and skippers' awareness of stability considerations while fishing.

Appropriate action planned

107 Expedite its development and promulgation of alternative small fishing vessel stability standards, which will ensure that all new fishing vessels under 15m (L) are subject to appropriate stability assessments, and which will eventually be included in the standards based on the Small Commercial Vessel and Pilot Boat Code scheduled for introduction in 2016.

Appropriate action planned

108 Specify the improvement in safety culture/behavioural change that it is seeking with respect to the voluntary wearing of personal flotation devices by individuals working on the decks of fishing vessels, and the timescale within which it is to be achieved; and

Make arrangements to rapidly introduce the compulsory wearing of personal flotation devices on the working decks of fishing vessels if the sought after changes are not delivered.

Partially accepted: Action planned

MCA response to recommendation 2013/108:
Introducing regulations to make wearing of PFDs mandatory remains and FISG agreed that the mandatory route should be invoked if it became clear that non-regulatory steps were failing to have the desired effect on behaviours. FISG will keep this under close review.

MAIB comment:
It is clear that the MCA and industry fully support the voluntary wearing of personal flotation devices by individuals working on deck, and are willing to mandate their use if necessary. However, the lack of metrics by which to measure the success of the current safety campaign remains of concern.

Nº	Recommendation(s) to:	Maritime and Coastguard Agency/ Marine Management Organisation

109 Work together to link the funding provided for modifications to small fishing vessels with a full assessment of the impact such modifications will have on such vessels' stability, particularly where the proposed modifications will substantially alter the method of fishing to be undertaken.

MCA: Appropriate action planned

MMO: Appropriate action planned

Nº	Recommendation(s) to:	Maritime and Coastguard Agency/ Marine Management Organisation/ Cornish Fish Producers Organisation
110	Work together to arrange trials of the 'Wolfson' mark on board a selection of Cornish fishing vessels under 15m (L) in order to gather sufficient data to enable the MCA to provide clear evidence on the mark's practicality, accuracy and usefulness.	

MCA: Appropriate action planned — 2014 DECEMBER 31

MMO: Appropriate action planned — 2014 JUNE 30

CFPO: Appropriate action planned — NO DATE GIVEN Update requested ?

Nº	Recommendation(s) to:	Vessel owner [at time of accident]
111	Take steps to ensure that any vessel he may own in the future is operated safely, taking into account the need to: • Accurately determine the vessel's maximum safe loading and be guided accordingly with regard to the size of catch that may be taken on board. • Re-apprise himself of the guidance available to fishermen regarding stability, particularly with regard to the stowage of cargo and free surface effect. • Carefully consider the impact on a vessel's stability before making any modifications. • Carry an EPIRB in order to enable a swift response by shore authorities in the event of vessel loss or abandonment. • Ensure that all persons working on a vessel's open deck wear PFDs while at sea. • Ensure that all crew have completed their mandatory safety training courses.	

Appropriate action implemented

E.R. Athina

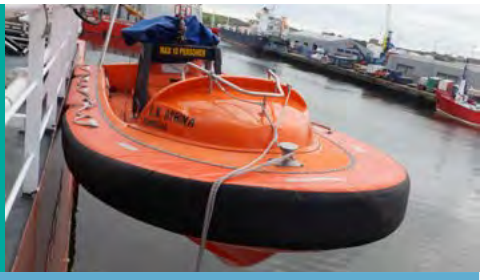
Report number: 3/2013

Platform supply vessel | Accident date: 10/06/2012

Fatal injury to a crew member while at anchor off Aberdeen

Safety Issues

- ▸ Suitability of the task not assessed
- ▸ Toolbox talk ineffective
- ▸ Severity of injury not recognised
- ▸ Emergency response inappropriate



Nº	Recommendation(s) to: E.R. Offshore GmbH
200	Provide specific guidance to its senior officers on: • The importance of completing onboard risk assessments before undertaking activities where the hazards and control measures have not been already identified; and • The advantages of immediately alerting shore authorities, such as the coastguard, as soon as a medical emergency occurs on board.

Appropriate action implemented

Zenith

Report number: 4/2013

Trawler | Accident date: 29/01/2012

Fatal manoverboard 29 miles south-east of Kilkeel

Safety Issues

- ▸ On board drills ▸ Working practices
- ▸ Personal Flotation Devices
- ▸ Communication between skipper and crew
- ▸ Complacency ▸ Risk Assessments

Nº	Recommendation(s) to: Vessel owner
112	Promote best working practices and improve the overall safety of their crews by: • Conducting emergency drills and training on board all their vessels as required by the 15-24m code.

- Ensuring suitable and sufficient risk assessments are conducted, recorded, shared with their crews and reviewed regularly.
- Verifying that all new crew members' mandatory safety training is appropriate and recorded accordingly.
- Insisting on the wearing of PFDs or safety harnesses when crew are working on external decks.

Appropriate action implemented

Nº	Recommendation(s) to:	Seafish Industry Authority
113	Work with the Fishing Industry Safety Group (FISG) to identify how the type of assistance with risk assessment offered by the Scottish Fishermen's Federation and the Anglo Northern Irish Fish Producers' Organisation to their members can be provided across the industry.	

Appropriate action implemented

Nº	Recommendation(s) to:	Maritime and Coastguard Agency
114	Strengthen its survey and inspection regime to ensure that effective emergency drills and crew training certificates are observed during renewal and intermediate surveys, as required by its internal guidance to surveyors and MGN 430 (F).	

Appropriate action implemented

Denarius

Report number: 5/2013

Twin rig trawler | Accident date: 09/07/2012

Fire and abandonment 83 miles NNE of Kinnaird Head

Safety Issues

- Engineering training/competence lacking
- Engine manufacturer's maintenance guidelines ignored
- Engine kept running despite obvious malfunction
- Communications with Coastguard not established in good time

Nº	Recommendation(s) to:	MB Denarius BF 804 LLP

202 Ensure the lessons learned from this accident are applied to its replacement vessel, and all future vessels it may own, and in particular:

- That engine manufacturers' maintenance instructions are understood and complied with.
- That fire drills include the methods and benefits of smoke and fire containment.
- That its "drivers" attend the Seafish 5 day diesel engine course.

Appropriate action implemented

Betty G

Report number: 6/2013

Fishing vessel | Accident date: 23/07/12

Capsize while beam trawling in Lyme Bay

Safety Issues

- Stability
- Trawl winch emergency release
- Liferaft carriage
- Wearing of lifejackets

Nº	Recommendation(s) to: Northwest Trawlers Ltd
201	With respect to any fishing vessels it may own or manage in the future, utilise available industry best practice guidance and advice to: • Conduct an assessment of the risks associated with the vessel's mode of fishing and, in particular, to identify and counter the risks associated with the recovery of fishing gear. • Ensure that procedures are established and drills conducted to train crews in the actions required to deal with foreseeable emergencies on board. Withdrawn

MAIB comment:
The owner of Northwest Trawlers Ltd has left the fishing industry and does not intend to return.

Purbeck Isle

Report number: 7/2013

Fishing vessel | Accident date: 17/05/2012

Foundering of fishing vessel 9 miles south of Portland Bill, England, resulting in the loss of her three crew

Safety Issues

- Material condition of vessel
- Watertight integrity
- Liferaft failure
- No PFDs
- No EPIRB/alarm not raised
- Safety culture

Nº	Recommendation(s) to: Maritime and Coastguard Agency
203	Take action to implement Recommendation 2008/173, issued in the MAIB's 1992-2006 Fishing Vessel Safety Study, specifically by: • Introducing a requirement for all fishing vessels of <15m (L) overall to carry EPIRBS. • Ensuring that the *Merchant Shipping and Fishing Vessels (Health and Safety at Work) Regulations 1997* apply in respect of all fishermen on board fishing vessels, irrespective of their contractual status. Appropriate action planned 2015 DECEMBER 31

204 Align its hull survey requirements for fishing vessels of <15m (L) overall with those applied to workboats under the *Harmonised Small Commercial Vessels Code*.

Appropriate action planned

2016 DECEMBER 31

205 Set minimum construction, performance and test standards for the liferafts currently mandated in MSN 1813 (F) *The Fishing Vessels Code of Practice of Small Fishing Vessels*, and any codes that supersede it.

Appropriate action implemented

Milly

Safety Bulletin number: 1/2013

Rigid Hulled Inflatable Boat | Accident date: 05/05/2013

EJECTION OF FAMILY OF SIX FROM A RHIB IN THE CAMEL ESTUARY LEADING TO TWO FATALITIES AND SERIOUS INJURIES TO TWO PEOPLE

Safety Issues

- Use of kill cords
- Suitability of training for vessel type
- Passenger safety when manoeuvring at speed

Carrier

Report number: 8/2013

General cargo vessel | Accident date: 03/04/2012

Grounding at Raynes Jetty in Llanddulas, North Wales

Safety Issues

- Not heeding adverse weather forecast
- Late decision to abort loading
- Incorrect manoeuvring during rough weather
- Unregulated status of jetties

No	Recommendation(s) to: Department for Transport
115	Engage with the MCA and the Port Marine Safety Code Steering Group to broaden the application and uptake of the *Port Marine Safety Code* by operators of non-statutory harbours.

Appropriate action implemented

No	Recommendation(s) to: Maritime and Coastguard Agency
116	Work with the UK Meteorological Office to review the terminology used in maritime weather forecasting to ensure that severe weather warning broadcasts are self-explanatory and explicit, with the aim of removing the potential need to consult other sources of information in order for users to fully understand the implications of such broadcasts.

Appropriate action implemented

Nº	Recommendation(s) to:	Cemex UK Materials Ltd
117	Establish better control of maritime operations at Raynes Jetty by developing and implementing a safety management system, which incorporates logical elements of the Port Marine Safety Code, and: • Provides support to jetty staff when making effective operational decisions about berthing and loading ships safely. • Delivers advice, or access to sources of advice, about maritime operations including weather forecasting, mooring arrangements and ship manoeuvring in the vicinity of the berth.	

Appropriate action planned

2014 MARCH 31

MAIB Comment:
An update on recommendation 2013/117's progress has been requested

Nº	Recommendation(s) to:	Reederei Erwin Strahlmann e.K.
118	Ensure masters of its vessels are better equipped to make well informed decisions by providing them with: • Advice on the different terminology used by national weather forecasting services. • Details about clauses in their charter-party agreements relating to bad weather. • Guidance and training on the most effective techniques for manoeuvring in severe weather conditions.	

Appropriate action implemented

Arniston

Safety Bulletin number: 2/2013

Bayliner 285 motor cruiser | Accident date: 01/04/2013

CARBON MONOXIDE POISONING RESULTING IN TWO FATALITIES

Safety Issues

- Use of a portable generator in an enclosed space
- DIY engine exhaust system failure
- Lack of carbon monoxide alarms

Coastal Isle

Report number:	**9/2013**	
Container vessel	Accident date:	02/07/2012

Grounding on the Island of Bute

Safety Issues

- Unattended bridge
- Bridge navigational watch alarm system
- Irregularity and fraudulence in the issuance of Certificates of Competency
- Inadequate annual performance tests on Voyage Data Recorder

Nº	Recommendation(s) to:	Antigua and Barbuda Department of Marine Services and Merchant Shipping/Germanischer Lloyd
206	Ensure that during vessel audits and surveys, Voyage Data Recorders are functioning and certificated in accordance with international regulations.	

Antigua and Barbuda Department of Marine Services and Merchant Shipping: Appropriate action implemented

Germanischer Lloyd: Appropriate action implemented

Nº	Recommendation(s) to:	Pasa International Technical Services
207	Issue specific instructions to its fleet that require data held on vessels' voyage data recorders to be saved in the event of an accident.	

Appropriate action implemented

208 Develop and adopt additional management controls designed to verify the authenticity of the certificates of competency held by seafarers employed by the company.

Appropriate action implemented

Alexander Tvardovskiy/UKD Bluefin/Wilson Hawk

Report number: 10/2013

Dry cargo vessel/Trailing suction hopper dredger/General cargo vessel

Accident date: 01/08/2012

Collision in the port of Immingham

Safety Issues

- Ineffective defect reporting
- Local shaft indication not fitted due to age of vessel
- Bridge procedures and master/pilot exchange ineffective

No	Recommendation(s) to:	Germanischer Lloyd
209	Propose to the International Association of Classification Societies that its members apply the SOLAS requirements regarding the provision of indication at propulsion control positions, particularly on vessels where only two methods of control are available, regardless of the vessel's age.	

Rejected

Germanischer Lloyd

GL's evaluation in the present case would not go so far as to support recommendation 2013/209. The 1996 built vessel was equipped with full propulsion control indication from at least two control stations (bridge and emergency control) – fully complying with the applicable regulations. It is not up to the members of IACS to retroactively apply a statutory requirement not prescribed in an international instrument without IMO member states having decided such application.

MAIB comment:

It is disappointing that Germanischer Lloyd has decided not to accept recommendation 2013/209. The MAIB's understanding of current guidance from the IMO is that grandfather rights may be waived where the safety benefits of more modern standards are self evident.

No	Recommendation(s) to:	UK Major Ports Group
210	Work with national pilot organisations to develop master/pilot exchange procedures in order to ensure: • The modes of propulsion control available and the mode of propulsion control in use on board vessels when entering and leaving United Kingdom ports, are clearly identified. • Appropriate control measures to be adopted are agreed in circumstances where the optimum method of control is either not available or not in use.	

Appropriate action implemented

Nº	Recommendation(s) to:	International Chamber of Shipping
211	At the next revision of its Bridge Procedures Guide, emphasise the importance of port pilots being notified of all defects which affect a vessel's manoeuvrability, and the potential consequences of failing to do so.	

Appropriate action planned

2014 DECEMBER 31

No	Recommendation(s) to:	JS North-Western Shipping Company
212	Take measures to ensure that the safety management of and on board its vessels is robust taking into account, inter alia: • The importance of the timely reporting and repair of defects to critical systems. • The risks and limitations of operating propulsion systems in manual control. • The need for comprehensive master/pilot exchanges. • The importance of bridge teamwork regarding briefing, monitoring of equipment and support to pilots.	

Appropriate action implemented

Timberland

Report number: 11/2013

General cargo vessel | Accident date: 25/11/2012

Man overboard in the North Sea

Safety Issues

- No heavy weather checklist
- Inadequate mooring rope stowage arrangements
- Underestimation of potential wave height
- Lack of procedures and equipment for sending crew on deck in heavy weather

▶ No recommendations made ◀

Swanland	**Report number:**	**12/2013**
General cargo vessel	Accident date:	27/11/2011

Structural failure and foundering in the Irish Sea with the loss of six crew

Safety Issues

- Cargo handling procedures
- Monitoring of structural condition
- Emergency preparedness and drills
- Suitability of life saving equipment

Nº	Recommendation(s) to:	Torbulk Ltd

119 With respect to vessels managed by the company, take action to ensure that the limits of structural strength are not exceeded at any time for vessels carrying high density cargoes, with particular regards to:

- the distribution of the cargo across the tank top;
- the carriage of the cargo being in accordance with the requirements of the IMSBC Code.

Appropriate action implemented

120 With respect to vessels managed by the company, take measures to ensure that:

- where applicable, classification society approval is gained prior to carrying high density cargoes;
- vessels do not sail in an overloaded condition;
- effective emergency drills are being conducted in accordance with the requirements of SOLAS and the company's SMM.

Appropriate action implemented

Nº	Recommendation(s) to:	International Naval Surveys Bureau

121 Review the conduct and auditing of structural surveys and inspections conducted on behalf of Flag States to ensure that the required standards are robustly applied. This review should take into account the experience, qualifications and training of the society's surveyors.

Appropriate action implemented

122 Review the society's Rules and Regulations to ensure that its requirements for in-service general dry cargo vessels employed in the carriage of high density cargoes in bulk are aligned with the standards applied by IACS societies for this type of vessel.

Appropriate action implemented

123 Ensure that future ISM audits of Torbulk and its vessels (where applicable) are thorough and robust and that the safety management deficiencies identified are properly addressed.

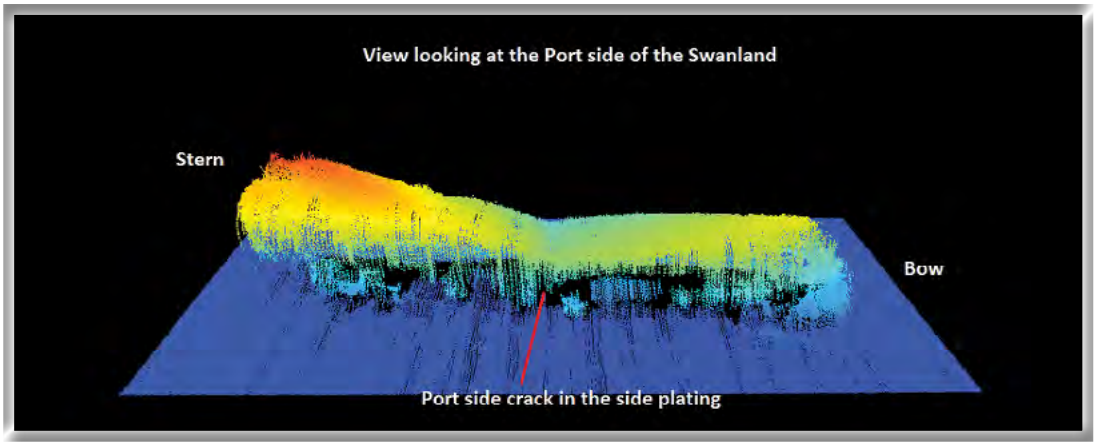
Appropriate action implemented

Nº	Recommendation(s) to:	Lloyd's Register

124 Propose to the International Association of Classification Societies (IACS) that it promulgates guidance to industry stakeholders highlighting:

- That the International Maritime Solid Bulk Cargoes Code (IMSBC Code) became mandatory for all vessels carrying solid bulk cargoes from January 2011.
- That the operators of all vessels carrying solid bulk cargoes must ensure that the cargoes are loaded and carried in accordance with the requirements of the IMSBC Code to maintain the structural integrity of the vessels at all times.
- The responsibility of cargo vessel operators to ensure that all cargoes are carried in accordance with the requirements of their classification society.

Appropriate action implemented



Sarah Jayne

Report number: 13/2013

Fishing vessel | Accident date: 11/09/2012

Capsize and foundering of fishing vessel 6nm east of Berry Head, Brixham resulting in the loss of one life

Safety Issues

- Watertight integrity
- Stability/loading limits
- Effects of vessel modifications

Nº	Recommendation(s) to:	Maritime and Coastguard Agency
213	As part of its intended development of new standards for small fishing vessels, review and include additional design and operational requirements as necessary to ensure that a vessel engaged in bulk fishing remains seaworthy throughout its intended loading procedure. Specific hazards that should be addressed include: • The increased risk of capsize from swamping if freeing ports are closed. • The risk of downflooding if flush deck scuttles and fish hold hatch covers are opened at sea.	

Appropriate action planned 2016 DECEMBER 31

Beaumont

Report number: 14/2013

Dry cargo vessel | Accident date: 12/12/2012

Grounding on Cabo Negro, Spain

Safety Issues

- Fatigue
- Bridge procedures
- Bridge navigational watch alarm system not used

► No recommendations made ◄

Hyundai Discovery/ACX Hibiscus

Report number: **15/2013**

Container vessels | Accident date: 11/12/2011

Collision in the approaches to the eastern Singapore Strait TSS

Safety Issues

- Use of VHF for collision avoidance
- Poor lookout/use of radar in reduced mobility
- Poor emergency response

Nº	Recommendation(s) to: Panama Maritime Authority
125	Take such measures as are necessary to ensure it is fully compliant with the IMO Casualty Investigation Code Mandatory sections, specifically Chapter 11. **Appropriate action implemented**
126	Take appropriate action with *ACX Hibiscus*'s owners to address the underlying causes of this accident. **Appropriate action implemented**

Nº	Recommendation(s) to: Zodiac Maritime Agencies Ltd
127	Develop its Safety Management System, training and audit programme to enhance its masters' and watchkeeping officers' understanding of: • The precautions to be taken in restricted visibility. • Emergency manoeuvring actions. • The obligation to offer assistance to any other vessels that their vessel might collide with. **Appropriate action implemented**

Vixen	**Report number:**	**16/2013**
Passenger ferry	Accident date:	19/09/2012

Foundering in Ardlui Marina, Loch Lomond

Safety Issues

- Hull condition
- Survey and standard
- Regulatory oversight

Nº	Recommendation(s) to:	Company partners

214 Take further action to ensure and enhance the safe operation of its ferry service between Ardlui and Ardleish by:

- Operating and maintaining any commercial ferries they may utilise, in accordance with The Inland Waters Small Passenger Boat Code.
- Obtaining an operating licence for any commercial ferries they may operate, as required by the Argyll and Bute Council.

Appropriate action implemented

Nº	Recommendation(s) to:	Argyll and Bute Council

215 Review and amend the requirements of its boat hire licensing scheme to:

- Adopt the Inland Waters Small Passenger Boat Code as the standard applied for small passenger boats carrying fewer than 12 passengers on categorised waters.
- Require such boats to be regularly surveyed by a competent person employed by a Certifying Authority or similar organisation as may be recommended by the Maritime and Coastguard Agency.

Appropriate action planned

2014 DECEMBER 31

Nº	Recommendation(s) to:	Stirling Council/ West Dunbartonshire Council

216 Take action to:

- Establish a boat licensing system for inland waters falling under the Council's area of responsibility and which adopts the Inland Waters Small Passenger Boat Code as the standard applied for small passenger boats carrying fewer than 12 passengers on its categorised waters.
- Require such boats to be regularly surveyed by a competent person employed by a Certifying Authority or similar organisation as may be recommended by the Maritime and Coastguard Agency.

Stirling Council: Appropriate action planned

2014 SEPTEMBER 30

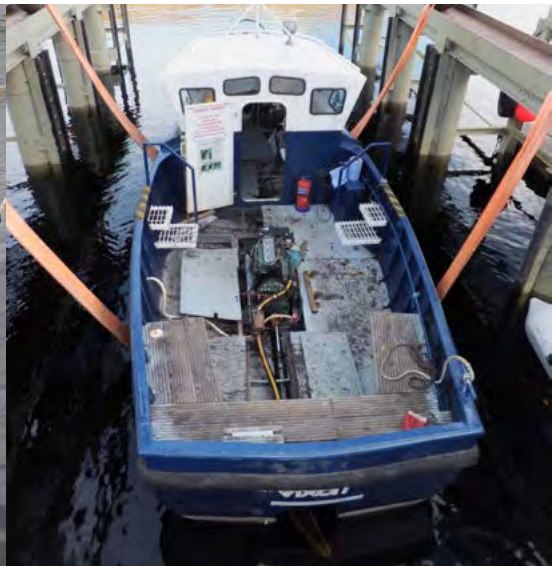
Dunbartonshire Council: Appropriate action planned

2014 DECEMBER 31

Nº	Recommendation(s) to:	Maritime and Coastguard Agency
217	Advise and work with the Argyll and Bute Council, the Stirling Council, the West Dunbartonshire Council and appropriate Certifying Authorities to: • Use the Inland Waters Small Passenger Boat Code as a basis for establishing robust licensing schemes on Loch Lomond. • Facilitate the effective survey of small passenger boats operating on Loch Lomond in accordance with the requirements of the Civic Government Act and the Inland Waters Small Passenger Boat Code. Appropriate action planned 2014 AUGUST 31	

Nº	Recommendation(s) to:	Loch Lomond and The Trossachs National Park Authority
218	Provide support to the Maritime and Coastguard Agency and local government authorities in efforts to improve the oversight, licensing and safety of small passenger vessels operating on Loch Lomond by: • Establishing proactive measures to enforce the requirement under existing byelaws for commercial vessels to display the correct registration renewal marks. • Developing protocols to enable Park Rangers' concerns about the licensing, safety or condition of small commercially operated vessels to be passed to the relevant authority for action. Appropriate action implemented	

Nº	Recommendation(s) to:	Transport Scotland
219	Use the lessons from this investigation to provide guidance and encouragement to councils in Scotland on the importance of establishing (where applicable) robust licensing regimes for small passenger vessels carrying fewer than 12 passengers on inland waters. Appropriate action planned 2014 JUNE 30	



Seagate/Timor Stream

Report number: **17/2013**

Geared bulk carrier/Refrigerated-cargo ship

Accident date: 10/03/2012

Collision 24 nautical miles north of the Dominican Republic

Safety Issues

- Failure to comply with COLREGs
- Poor watchkeeping/lookout
- Emergency response

▸ No recommendations made ◂

Wah Shan

Report number: **18/2013**

Bulk carrier

Accident date: 02/10/2012

Fatal injuries to a crewman while securing a tug's tow wire on the River Humber

Safety Issues

- Poor leadership and team work
- Lack of communication
- Poor design and layout of mooring deck

Nº	Recommendation(s) to:	Sincere Navigation Corporation
220	Improve the effectiveness of the safety management systems on board its managed vessels by: • Ensuring crew have the necessary technical competence to complete hazardous tasks. • Improving leadership and team-working skills among their crews. • Encouraging crew members to develop the habit of carrying out effective risk assessments before carrying out any hazardous tasks.	

Appropriate action implemented

Vidar

Report number: 19/2013

Fishing vessel | Accident date: 28/01/2013

Fatal man overboard off Milford Haven

Safety Issues

- Lack of lifejackets/lifelines
- Inefficient bridge watchkeeping practices
- Lack of manoverboard drills/risk assessment
- Delay in emergency reporting
- Use of recreational drugs on board

▸ No recommendations made ◂

Amy Harris III

Report number: 20/2013

Fishing vessel | Accident date: 16/01/2013

Engine room fire, South of Isle of Arran

Safety Issues

- Engineering system maintenance
- Emergency procedures
- Ship maintenance
- Vessel management/poor housekeeping

Nº	Recommendation(s) to:	The owner of *Amy Harris III*, Galbraith Trawlers Ltd
222	Improve the safety of its fishing vessels by taking measures to ensure that: • Fuel supply and other high-risk pipework is properly supported to prevent chafing and fatigue. • As far as practicable, electrical cabling insulation is protected against abrasion from sharp surfaces. • Monthly emergency drills are carried out and recorded. • Salvage pumps are regularly tested and maintained for immediate use, and associated petrol canisters are stowed in accordance with Section 5.1.8.8.4 of *The Code of Safe Working Practice for the Construction and Use of 15 Metre Length Overall to Less Than 24 Metre Registered Length Fishing Vessels*. • Risk assessments are undertaken and control measures applied. • The standard of housekeeping is improved to reduce the risk of fire and personal injury. • The MCA's publication - Fishermen's Safety Guide – is brought to the attention of skippers and crew.	Appropriate action implemented

Nº	Recommendation(s) to:	Vessel skipper
223	Attend a fire-fighting course to update his knowledge of fire-fighting techniques and equipment.	

Appropriate action implemented

Nº	Recommendation(s) to:	Seafish Industry Authority
224	Test students' knowledge of fixed fire-fighting systems in the assessment examination of its Basic Fire Fighting Course.	

Appropriate action implemented

Arklow Meadow

Report number: **21/2013**

General cargo vessel | Accident date: 05/12/2012

RELEASE OF PHOSPHINE GAS DURING CARGO DISCHARGE, WARRENPOINT, NORTHERN IRELAND

Safety Issues

- Crew training/familiarisation
- Incorrect surveyor employed
- Inadequate onboard procedures and guidance

Nº	Recommendation(s) to:	Maritime and Coastguard Agency
225	In consultation with the Health and Safety Executive, the Port Skills and Safety Organisation, and other industry bodies as appropriate, review, consolidate and reissue the guidance provided to UK stakeholders on the loading, carriage and discharge of fumigated cargoes to highlight the importance of: • The potential for a fumigant to remain active due to factors such as temperature, relative humidity, voyage length, and fumigant method.	

- The retention of suitably trained and qualified fumigators at both the load and discharge ports.
- Ships' crews being aware of their responsibilities.
- UK port authorities having robust procedures and contingency plans when receiving vessels with fumigated cargoes.

Appropriate action planned 2014 JULY 31

Nº	Recommendation(s) to:	UK Marine Ports Group/ British Ports Association

226 Through its Marine and Pilotage Working Group, develop a revision of the Guide to Good Practice on Port Marine Operations to reflect the revised guidance to be issued by the MCA, and in the meantime ensure that ports are aware of:

- The potential dangers posed by fumigants.
- The importance of suitably qualified fumigators certifying, where applicable, that the cargo can be safely discharged and that all fumigant has been removed and safely disposed of.
- The importance of developing procedures and emergency plans to cover the inadvertent or unexpected release of fumigant from a fumigated cargo.

UKMPG: Appropriate action planned 2014 JUNE 30

BPA: Appropriate action planned 2014 JUNE 30

Amber	**Report number:**	**22/2013**
Bulk carrier	Accident date:	15/11/2012

Contact and grounding at Gravesend Reach, River Thames

Safety Issues

- ▸ Bridge team management
- ▸ Master/pilot exchange
- ▸ Failure to report defects
- ▸ Perceived commercial pressures

Nº	Recommendation(s) to:	SC Corsena SRL

227 Ensure that its vessels comply fully with SOLAS requirements in respect of the carriage of operational 3GHz radar and ARPA.

Appropriate action implemented

228 Review its Safety Management System instructions relating to the performance of its vessels' bridge teams to ensure:

- Bridge equipment is tested in good time prior to departure from port.
- Bridge teams are familiar with all navigational and communications equipment on board, and understand the need to ensure that radars are set at optimum range scales and performance monitoring is used.
- The master/pilot information exchange checklist includes a requirement to clarify the roles and responsibilities of the master, pilot and other members of the bridge team.
- Bridge team members understand the need to communicate effectively in order to retain good situational awareness at all times.
- Bridge teams understand the importance of following checklists in emergency situations.

Appropriate action implemented

Nº	Recommendation(s) to:	Port of London Authority

229 Include in its pilot/master exchange form:

- Reference to the requirement to clarify the roles and responsibilities of the bridge team.
- Reference to the relative engine output power of the assisting tugs with that of the vessel being assisted.

Appropriate action implemented

230 Review its instructions to port controllers and VTS staff, aimed to ensure that:

- With respect to decisions taken regarding the movement of ships within the port, commercial considerations are not permitted to compromise safety.

- When vessels' movements are to take place in restricted visibility, appropriate risk mitigation measures are put in place, including making available a duty port controller to provide navigational assistance and setting clear minimum parameters that must be met. Such parameters could include: the number of pilots required and the requirement for all vessels to have a full suite of fully functioning radars and navigational equipment.
- A damage assessment is carried out on a grounded vessel before an attempt is made to refloat the vessel.

Appropriate action implemented

Nº	Recommendation(s) to:	Svitzer Marine Ltd
231	Review and, where appropriate, revise the roles and responsibilities of bridge teams when its vessels are towing in restricted visibility.	

Appropriate action planned — 2014 JULY 1

Nº	Recommendation(s) to:	International Chamber of Shipping
232	Include in the review of the Bridge Procedures Guide a reference to:	

- The need for bridge teams to be sufficiently resourced to provide assistance to embarked pilots through the operation of the vessel's navigational equipment when required.
- The need to compare the engine power of a vessel with that of the assisting tug(s), and for this to be discussed during the pilot/master exchange.

Appropriate action planned — 2014 DECEMBER 31

Wacker Quacker 1/Cleopatra

Safety Bulletin number: 3/2013

Passenger vessels Accident dates: 15/6 and 29/09 2013

THE SINKING OF THE DUKW AMPHIBIOUS VEHICLE *WACKER QUACKER 1* IN SALTHOUSE DOCK, LIVERPOOL ON 15 JUNE 2013

◀▶

THE FIRE ON BOARD THE DUKW AMPHIBIOUS VEHICLE *CLEOPATRA* ON THE RIVER THAMES, LONDON ON 29 SEPTEMBER 2013

Safety Issues

- ▸ Maintenance management
- ▸ Vessel survivability
- ▸ Stability
- ▸ Vessel evacuation
- ▸ Survey and Inspection

Nº	Recommendation(s) to:	Maritime and Coastguard Agency
221	Require operators of DUKW passenger vessels in the UK to demonstrate that they are able to provide 110% effective residual intact buoyancy in their vessels, and where buoyancy foam is fitted for this purpose, the quantity installed is measured by volume and the foam does not impede the operation or maintenance of key equipment.[2]	Appropriate action ongoing
S233	In addressing recommendation 2013/221, ensure that the means used by DUKW operators to achieve the required standard of buoyancy and stability for their vessels does not adversely impact on their safe operation. Furthermore, these vessels should not be permitted to operate until satisfactory levels of safety can be assured under all feasible operating conditions.	Appropriate action ongoing

[2] Recommendation 2013/221 issued prior to the publication of Safety Bulletin 3/2013 through a Chief Inspector letter to the MCA on 5 August 2013.

Windcat 9/Island Panther

Report[3] number: 23/2013

Catamarans | Accident date | 21/11/2012[4]

THE CONTACT WITH A FLOATING TARGET BY THE WIND FARM PASSENGER TRANSFER CATAMARAN *WINDCAT 9* WHILE TRANSITING DONNA NOOK AIR WEAPONS RANGE IN THE SOUTH-WEST APPROACHES TO THE RIVER HUMBER

◀▶

THE CONTACT OF ISLAND PANTHER WITH TURBINE I-6, IN SHERINGHAM SHOAL WIND FARM

Safety Issues

- ▶ Passage planning/monitoring
- ▶ Equipment familiarisation
- ▶ Training standards
- ▶ Defect reporting ▶ Audits
- ▶ Watchkeeping practice
- ▶ Weak knowledge of navigational aids

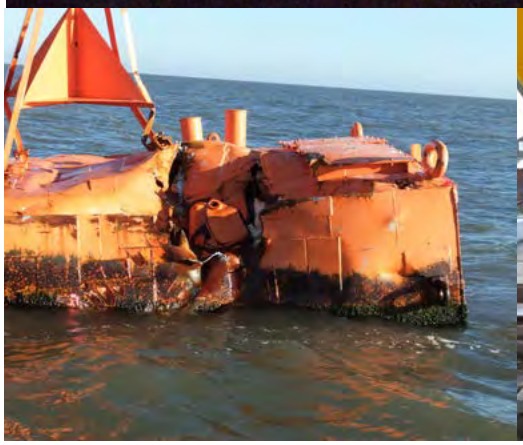
Nº	Recommendation(s) to: Windcat Workboats Ltd
234	With respect to operational navigational procedures, review and as necessary amend its Safety Management System and task-based risk assessments to provide guidance and instruction on: • The use and management of electronic navigation systems for passage planning and monitoring. • The role and crew in support of the master and the conduct of lookout duties while on passage. • The conduct of passages at night and in restricted visibility. **Appropriate action implemented**
235	Review its crew training, qualification and assessment procedures, together with their associated documentation, to ensure that: • Crews are correctly qualified and appropriately trained for their duties. • Appropriate records are maintained of all training and assessments undertaken. • Robust processes exist to periodically check an individual's competence. **Appropriate action implemented**
236	Take action to ensure its internal audits are undertaken in accordance with the company's Safety Management System and, specifically, that the audits are appropriately targeted and have robust assessment mechanisms. **Appropriate action implemented**

[3] Due to similiarities between the cases MAIB took the decision to publish its findings as a combined report.

[4] Both contacts occurred on 21 November 2012.

Nº	Recommendation(s) to:	Scira Offshore Energy Ltd
237	Review and amend its procedures to ensure: • A robust defect reporting system is established in combination with a means to issue navigational warnings when appropriate. • Liaison with the UK Coastguard to facilitate dissemination of navigation warnings to the marine community as a whole. **Appropriate action implemented**	

Nº	Recommendation(s) to:	Island Shipping Ltd
238	Amend its Safety Management System to include: • Instructions on passage planning and monitoring, including the use of electronic chart plotters in combination with paper charts. • The role of the crew as lookout to support the master effectively on passage. • Emergency procedure checklist(s) to assist the crew immediately after an accident. • A familiarisation/training schedule for new masters to follow during the induction period. • A system for updating and renewing paper charts. **Appropriate action implemented**	
239	Ensure masters are trained in the use of the electronic chart plotters fitted to its vessels and are able to employ them effectively for passage planning and monitoring. **Appropriate action implemented**	



Nº	Recommendation(s) to:	National Workboat Association/ International Marine Contractors Association
240	Review, develop and expand the National Workboat Association's *Best Practice Guide for Offshore Energy Service Crews*. In addition, develop a complementary document providing operational best practice guidance, specifically directed towards owners and managers of offshore renewable energy passenger transfer vessels.	

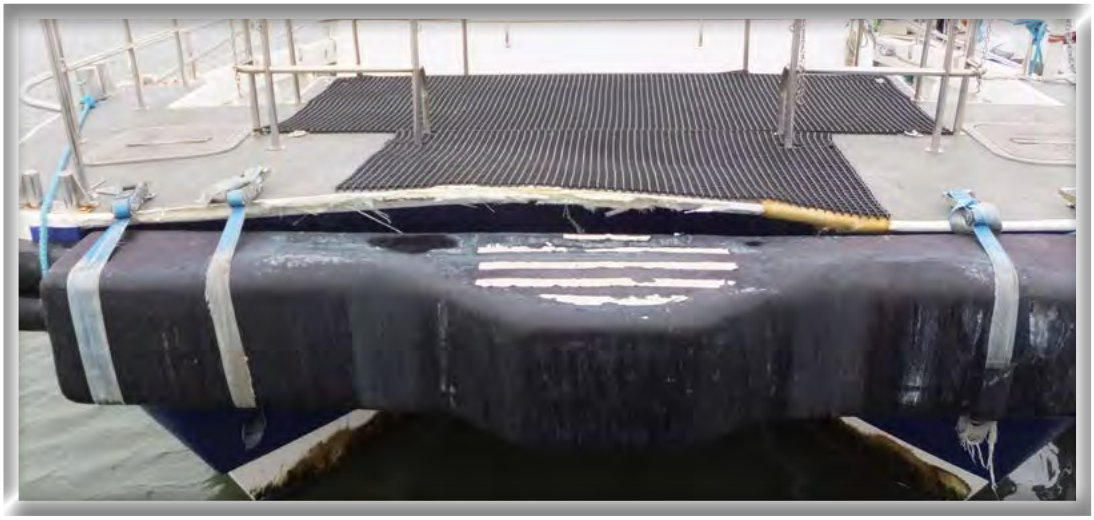
NWA: Appropriate action planned — 2014 JUNE 30

IMCA: Appropriate action planned — 2014 JUNE 30

241 Formulate a consolidated system to receive and promulgate safety issues and lessons to the offshore renewable energy sector.

NWA: Appropriate action implemented

IMCA: Appropriate action implemented



Finnarrow

Report number: 24/2013

Passenger/ro-ro cargo vessel | Accident date: 16/02/2013

Contact with the berth and subsequent flooding in Holyhead

Safety Issues

- Awareness of fatigue
- Emergency preparedness
- Effectiveness of audits

No	Recommendation(s) to:	Finnlines Ship Management
242	As part of the process of developing robust arrival procedures, ensure the status of the fin stabilisers has sufficient procedural and visual checks to prevent them being left deployed when the vessel enters port.	Appropriate action implemented
243	Review and amend emergency response procedures to ensure ship's staff are adequately supported during emergencies, and to require regular flooding drills to be conducted on board to enhance crew familiarisation.	Appropriate action implemented
244	Ensure robust project management procedures are used when changing flag and/or routes to capture the need for providing crews with: • Adequate vessel familiarisation. • Sufficient rest periods in accordance with the requirements of the International Convention on *Standards of Training, Certification and Watchkeeping for Seafarers 1978 (STCW)*.	Appropriate action implemented

Jean Elaine

Report number: 25/2013

Dive workboat | Accident date: 14/08/2012

Death of a recreational diver after a fall on board dive workboat, 15nm NW of Cape Wrath

Safety Issues

- Risk Assessment
- Trip hazards
- Effects of heavy dive gear

No	Recommendation(s) to:	Owner and skipper of vessel
245	Conduct a thorough review of the safety arrangements on this and any other vessels he may operate, to ensure that: • The risks involved in supporting recreational diving operations are formally and methodically assessed.	

- The employment of crew and positioning of physical supports are considered in order to minimise the risks to divers as they prepare to enter the water.

Appropriate action implemented

Nº	Recommendation(s) to:	British Diving Safety Group
246	Promulgate the lessons identified from this investigation to member organisations and encourage them to ensure that, as policy and guidance for recreational technical diving develops, the effects of specialist equipment on reducing mobility and increasing loads on divers while they are moving about on vessels are taken into account.	

Appropriate action implemented

Fri Ocean

Report number: 26/2013

General cargo vessel | Accident date: 14/06/2013

Grounding 2.5 miles south of Tobermory

Safety Issues

- ▶ Bridge design
- ▶ Lack of stimulation
- ▶ Lack of lookout
- ▶ Fatigue management

Nº	Recommendation(s) to:	Kopervik Ship Management AS
247	Improve its safety management system by: • Emphasising the value of lookouts, and to specifically require that a lookout is present on the bridge at night while the vessel is at sea. • Providing guidance on fatigue management and the effective use of crew. • Instructing masters to detail their own specific requirements with regard to passage planning and monitoring, including the extent to which particular electronic navigational aids should be used. • Providing instructions on when, and the manner in which, the BNWAS should be used while the vessel is at sea.	

Appropriate action implemented

248	Monitor the implementation and effectiveness of its navigational policy through an enhanced regime of auditing and verification.	

Appropriate action implemented

Audacious/Chloe T

Report[5] number: 27/2013

Fishing vessels | Accident dates: 10/8 and 01/09 2012

FLOODING AND FOUNDERING OF THE FISHING VESSEL *AUDACIOUS* 45 MILES EAST OF ABERDEEN ON 10 AUGUST 2012

◀▶

THE FLOODING AND FOUNDERING OF THE FISHING VESSEL *CHLOE T* 17 MILES SOUTH WEST OF BOLT HEAD, DEVON ON 1 SEPTEMBER 2012

Safety Issues - *Audacious*

- Inadequate on board maintenance
- Safety culture
- Safety training
- Survey and inspection
- Watertight doors

Safety Issues - *Chloe T*

- Survey and inspection
- Bilge alarms/salvage pumps
- Vessel system familiarity
- Stability

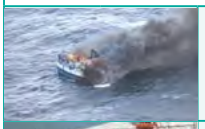
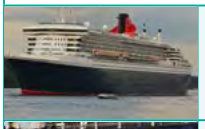
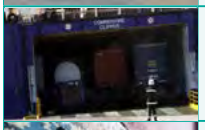
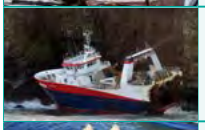
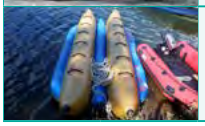
Nº	Recommendation(s) to: Maritime and Coastguard Agency
249	Review the conduct of its surveys and inspections of fishing vessels in order to ensure that: • The scope is credible and that it can be achieved in practice. • The whole scope is routinely applied. • Records are accurate and complete. Appropriate action planned 2014 DECEMBER 31
250	Implement a robust system to manage the scheduling of surveys and inspections on fishing vessels. Such a system should be capable of readily identifying vessels that are overdue for any surveys or inspections. Appropriate action planned 2014 DECEMBER 31

[5] Due to similiarities between the accidents MAIB took the decision to publish its findings as a combined report.

Nº	Recommendation(s) to:	Deveron Fishing Company [owner of *Audacious*]
251	Improve the safety of any other fishing vessels it operates by ensuring that: • Intermediate inspections are conducted. • Crew have completed mandatory training. • A continuous watch is maintained in the wheelhouse. **Appropriate action implemented**	

Nº	Recommendation(s) to:	Scottish Fishermen's Association/ National Federation of Fishermen's Organisations/Northern Ireland Fish Producers Organisation
252	Promulgate the lessons learned from these accidents to their members. Particular emphasis should be given to the need for fishing vessel operators to thoroughly inspect seawater pipework to identify corrosion/ erosion at an early stage. **SFA: Appropriate action implemented** **NFFO: Appropriate action implemented** **NIFPO: Appropriate action implemented**	

PROGRESS OF RECOMMENDATIONS FROM PREVIOUS YEARS

Vessel name(s)		Publication date	Page
2012 RECOMMENDATIONS - PROGRESS REPORT			52
	*Onward*	21 November 2012	52
	*Saga Sapphire*	8 November 2012	52
	*SD Nimble*	22 August 2012	52
	*Tombarra* [parts A and B]	19 July 2012	53
	*Chiefton*	23 May 2012	54
	*Karin Schepers*	17 May 2012	54
	*Saffier*	10 May 2012	55
	*Golden Promise*	1 March 2012	55
2011 RECOMMENDATIONS - PROGRESS REPORT			56
	*RMS Queen Mary 2*	22 December 2011	56
	*Commodore Clipper*	15 November 2011	56
	*Sapphire II/Silver Chord*	13 October 2011	57
	*Jack Abry II*	12 August 2012	57
	Princes Club	20 July 2012	57

2012 RECOMMENDATIONS - PROGRESS REPORT

Onward

Report number: 27/2012

Fishing vessel | Accident date: 11/02/2012

FIRE RESULTING IN LOSS OF THE VESSEL

Nº	Recommendation(s) to:	Mithcowie Fishing Company Ltd
2012/150	Ensure that the crews on board any vessels it may own in the future are fully prepared to effectively deal with emergency situations, taking into account, inter alia: • The requirement to conduct periodic emergency drills and the importance of emergency drills to a vessel's safety. • The need for all early warning devices such as fire detection systems and bilge alarms to be properly maintained and tested, and that crews fully understand their operation. • The need for crews to have a good knowledge of all onboard safety-related systems and equipment, and that routine safety precautions such as the closing of fire doors are taken at all times. Withdrawn	

MAIB comment:
Recommendation withdrawn as the company has been dissolved.

Saga Sapphire

Report number: 25/2012

Cruise ship | Accident date: 29/03/2012

TWO MEN OVERBOARD WHILE CONDUCTING A LIFEBOAT DRILL

Nº	Recommendation(s) to:	Acromas Shipping Ltd
2012/146	Seek formal approval from the Malta administration and the appropriate classification society in respect to: • The use of the welded bar modification, fitted to the tender lifting plates, as means of securing the bowsing tackle rope. • The use of the jackline safety harness tether, securing arrangements currently in use on *Saga Ruby*'s tenders. Appropriate action implemented	

SD Nimble

Report number: 23/2012

Tug | Accident date: 23/08/2011

ACCIDENTAL DISCHARGE OF CARBON DIOXIDE RESULTING IN SERIOUS INJURY

Nº	Recommendation(s) to:	Lloyd's Register
2012/141	Propose to IACS that UR Z17 be amended to reflect the importance of service suppliers' procedures being sufficiently robust to ensure that safe systems of work are agreed and implemented with ships' crews prior to commencing work on board vessels. Appropriate action implemented	

Tombarra	Report number:	19A ◊ 19B/2012
Car carrier	Accident date:	07/02/2011

Fatality to a rescue boat crewman, Royal Portbury Docks, Bristol

Report Part B - The failure of the fall wire

Nº	Recommendation(s) to: Maritime and Coastguard Agency
2012/135	Submit to the IMO proposals to amend MSC.1/Circ.1206/Rev.1 designed to require the annual weighing of rescue boats and lifeboats which use buoyancy foam within internal spaces, as soon as practicable.

Appropriate action planned

2012/134	Submit to the IMO proposals to amend the LSA Code designed to: • Ensure any water entering foam-filled buoyancy chambers within the enclosed hulls of rescue boats and lifeboats can be easily removed. • Require the actual weight of the rescue boat or lifeboat supplied to the vessel, rather than its prototype, to be provided in its certification.

Appropriate action ongoing

Report Part A - The weight of the rescue boat

Nº	Recommendation(s) to: Maritime and Coastguard Agency
2012/129	Submit to the IMO a proposal to mandate a maximum height of the davit head used in conjunction with rescue boats and survival craft fitted on board both cargo and passenger ships, based upon: • Recognition of the severe difficulties faced by the crews of high-sided vessels such as *Tombarra* when attempting to launch rescue boats in a seaway. • The increased hazards to which the crews of rescue boats and survival craft are exposed when operating at height. • The action taken by Wilhelmsen Lines Car Carriers Ltd to change the design of its future vessels to lower the height of the rescue boat davit head. • The maximum height of davit heads used in conjunction with survival craft already recommended for passenger vessels in SOLAS III/24; and, • The guidance provided in MSC Circ 1094 regarding the height of davit heads used for fast rescue boats on board passenger ships.

Appropriate action ongoing

2012/128	Submit to the IMO proposals for the LSA Code to: • Reflect a requirement for a 'system approach' to davit and winch installations with the aim of eliminating the possibility of any component being overstressed to the point of failure. • Provide clarification on the fitting and use of 'safety devices' on davit and winch systems, using a goal-based approach to their application.

Appropriate action ongoing

Chiefton

Report number:	12/2012
Tug	Accident date: 12/08/2011

COLLISION, CAPSIZE AND FOUNDERING WITH THE LOSS OF ONE CREW MEMBER

Nº	Recommendation(s) to: Maritime and Coastguard Agency
2012/117	Provide additional guidance relating to the following elements of combined push/pull towage operations: • Tug selection to ensure that bollard pull is appropriate for the intended operation. • The importance of effective communications to ensure control of towing operations at all stages. • The assessment and adjustment of tow length to avoid the risk of overrun, and, specifically, include these elements in the "Underpinning Knowledge" syllabi of the draft Marine Guidance Note – Towage Endorsements. **Appropriate action implemented**
2012/116	Advise Certifying Authorities to ensure their survey checklists reflect the content of Sub-section 25.2.2 of the Small Commercial Vessel and Pilot Boat Code, by including a requirement to check the efficient operation of the emergency release system from all operating positions. **Appropriate action implemented**

Karin Schepers

Report number	10/2012
Container vessel	Accident date: 03/08/2011

GROUNDING AT PENDEEN, CORNWALL, UK

Nº	Recommendation(s) to: Maritime and Coastguard Agency
2012/115	Assess the desirability of, and, where appropriate, develop operational guidelines for using Automatic Identification Systems (AIS) data to monitor marine traffic movements. Special consideration should be given to using AIS data to monitor marine traffic movement in areas of high traffic concentrations, including traffic separation schemes, where there is limited or no radar coverage. **Appropriate action planned** 

Saffier

Report number	09/2012
Cargo vessel	Accident date: 25/06/2011

Failure of the controllable pitch propellor

Nº	Recommendation(s) to:	Bureau Veritas
2012/113	Make a submission to IACS to introduce a unified requirement for controllable pitch propeller systems to be subjected to a full range of tests in both ahead and astern directions during commissioning trials of new and existing systems.	

Appropriate action implemented

Golden Promise

Report number	03/2012
Fishing vessel	Accident date: 07/09/2011

Grounding on the Isle of Stroma, North Scotland

Nº	Recommendation(s) to:	John MacAlister (Oban) Ltd
2012/103	Enhance the safety management of its vessels by: • Referring to and applying the best practice guidance for keeping a safe navigational watch on fishing vessels promoted in MGN 313 (F), including arrangements for ensuring the fitness for duty of watchkeepers and provision of an effective watch alarm. • Ensuring all crew members have completed all mandatory safety training courses.	

No response received: closed

MAIB comment:
Recommendation closed as no response from John MacAlister (Oban) Ltd since recommendation issued.

2011 RECOMMENDATIONS - PROGRESS REPORT

RMS Queen Mary 2

Report number: 28/2011

Cruise vessel | 23/09/2010

CATASTROPHIC FAILURE OF A CAPACITOR IN THE AFT HARMONIC FILTER ROOM WHILE APPROACHING BARCELONA

Nº	Recommendation(s) to: Lloyd's Register
2011/152	Review and clarify its rules on the installation of fixed water-based local application fire-fighting systems in compartments containing high voltage systems and, through IACS, propose the appropriate amendments to incorporate this guidance in the FSS Code.

Appropriate action implemented

Commodore Clipper

Report number: 24/2011

Ro-ro passenger ferry | Accident date: 16/06/2010

FIRE ON MAIN VEHICLE DECK WHILE ON PASSAGE TO PORTSMOUTH

Nº	Recommendation(s) to: Bahamas Maritime Authority
2011/144	Develop a joint paper with the Maritime and Coastguard Agency for submission to the IMO to consider a requirement for all vessels, whose principal means of access is via a single ramp to a vehicle, special category or ro-ro space, to assess how an alternative means of pedestrian access to shore could be provided in an emergency.

Appropriate action implemented

2011/143	Make a submission to the IMO to consider a requirement for all existing ro-ro passenger vessels to be fitted with, or have ready access to, means of determining the effect of damage or entrained water from fire-fighting on the vessel's stability.

Appropriate action implemented

Nº	Recommendation(s) to:	Maritime and Coastguard Agency
2011/140	Work with its stakeholders to produce industry guidelines for maritime emergency responders to consider when providing fire-fighting or other emergency support to ships in UK waters. The guidelines should include, inter alia: • Best practice command and control principles • Information gathering and liaison on scene • Safety of passengers and crew • Ship specific risks and considerations with particular emphasis on issues associated with passenger ro-ro vessels and vessels carrying hazardous cargoes • Factors to be considered in deciding whether to bring a vessel into port/alongside • Specialised equipment and other resources.	

Partially accepted: action implemented

MCA's response:
The Coastguard's Operation Management System has been updated and additional content has been added to provide enhanced guidance to Coastguard staff in order to enhance their ability to provide the best possible direction and co-ordination according to the nature of the incident. The MCA believes these guidelines will be effective even in a major incident, when other stakeholders such as Local Authorities may become involved.

MAIB comment:
While the MCA's actions in response to this recommendation are positive and welcome, it is disappointing that the opportunity has not been taken to coordinate this activity with harbour authorities and other stakeholders at local level.

Sapphire II/Silver Chord

Report number: 21/2011

Fishing vessels | Accident date: 1/12/2011

COLLISION RESULTING IN THE FOUNDERING OF *SAPPHIRE II*

Nº	Recommendation(s) to:	Maritime and Coastguard Agency
2011/134	Ensure its surveyors verify during survey and/or inspection that the field of visibility from fishing vessel wheelhouses complies with the criteria laid down in MGN 314 (F) and, where necessary, owners are directed to take action to ensure that adequate visibility is afforded.	

Appropriate action implemented

Jack Abry II

Report number: 14/2011

Fishing vessel | Accident date: 31/01/2011

GROUNDING ON THE ISLE OF RUM

Nº	Recommendation(s) to:	Scapêche SA
2011/126	Enhance the safety management of its vessels by: • Providing specific operational instructions and guidance with respect to: the management of hours of work and rest, taking into account travelling time when changing crew; watchkeeping	

best practice, including passage planning and the appropriate use of navigational equipment, watch alarms and lookouts; and the conduct and frequency of drills.
- Increasing onboard oversight to ensure compliance with its instructions and guidance, risk assessments, and statutory regulations.

Appropriate action implemented

Princes Club

Report number: 11/2011

Inflatable banana boat | Accident date: 11/09/2010

Fatal accident at Princes Club Water sports Park in Bedfont, Middlesex

No	Recommendation(s) to:	Maritime and Coastguard Agency
2011/121	Take appropriate action to improve the safety of towed inflatable rides by: • Considering the British Water Ski and Wakeboard Club Driver's Award as a standard for commercially operating boats towing inflatables, and including it in the list of suitable alternative qualifications to the Boatmaster's Licence. • At its next review, amending the '*Inland Waters Small Passenger Boat Code*' Annex 5, so that the guidance is relevant to boats operating on inland waters and not just beachcraft.	

Appropriate action planned

No	Recommendation(s) to:	Health and Safety Executive
2011/120	Include oversight of the activity of riding on towed inflatables into the arrangements that are currently being considered to replace the Adventure Activities Licensing Authority.	

Appropriate action ongoing

Yeoman Bontrup

Report number: 5/2011

Bulk carrier | Accident date: 02/07/2010

Fire and explosion on board

No	Recommendation(s) to:	Maritime and Coastguard Agency
2011/111	Improve its existing guidance on the stowage of ship's-use chemicals.	

Appropriate action implemented

No	Recommendation(s) to:	Bahamas Maritime Authority
2011/109	For self-unloading vessels: • Review and improve fire detection, containment and extinguishing standards for cargo handling areas. • Develop standards for conveyor belt fire resistance properties.	

Appropriate action implemented

Delta 8.5m RHIB

Report number: 1/2011

Rigid hullled inflatable boat

Accident date: 5/6/2010

INJURY TO A PASSENGER ON THE RIVER THAMES, LONDON

Nº	Recommendation(s) to:	Maritime and Coastguard Agency
2011/101	Prioritise and resource the revision of MGN 280 to ensure the updated code of practice for small commercial vessels is published as early as is possible.	

Appropriate action planned

2014 OCTOBER 31

2010 RECOMMENDATIONS - PROGRESS REPORT

Olivia Jean

Report number: 10/2010

Fishing vessel | Accident date: 10/10/2009

INJURY TO FISHERMAN

Nº	Recommendation(s) to:	Maritime and Coastguard Agency

2010/123 Consider the findings of this investigation when assisting the Department for Transport to address MAIB Recommendation 2010/112, including the need to improve fishing vessel standards and occupational safety by:

- Reviewing the application of LOLER, PUWER, risk assessment and working time regulations on board fishing vessels to ensure that they are suitable for the task of improving safety and reducing accidents; and,
- Providing clear and robust guidance to its surveyors and the fishing industry at large.
- Ensuring that accurate records are maintained such that surveyors are provided with the information required to survey fishing vessels effectively.
- Improving its recording of accidents on vessels' SIAS records to identify trends and act upon them.

Appropriate action planned — 2014 JUNE 30

Bro Arthur

Report number: 9/2010

Oil/chemical tanker | Accident date: 19/02/2010

FATALITY OF A SHORE WORKER IN NO 2 CARGO TANK WHILE ALONGSIDE AT CARGILL TERMINAL, HAMBURG

Nº	Recommendation(s) to:	International Chamber of Shipping

2010/120 Include guidance on the following in the respective International Chamber of Shipping publications during their next periodic review:

- TSGC - Management of contractors and sub-contractors with emphasis on the master's and other officers' and crew members' related health and safety responsibilities.
- TSGC and ISGOTT - The need for the provision of lightweight, portable casualty recovery equipment suitable for recovery from deep cargo tanks and for the crew to be fully trained in its use.

Appropriate action planned — 2014 DECEMBER 31

Nº	Recommendation(s) to:	Maritime and Coastguard Agency
2010/119	Provide additional guidance on the following: • Management of contractors and sub-contractors with emphasis on the master's and other officers' and crew members' related health and safety responsibilities. • The need for the provision of lightweight, portable casualty recovery equipment suitable for recovery from deep cargo tanks, and for the crew to be fully trained in its use.	

Appropriate action planned

Korenbloem/Optik/Osprey III

[Combined] Report number: 6/2010

Fishing vessels | Accident dates: November 2009

FATAL MANOVERBOARD ACCIDENTS

Nº	Recommendation(s) to:	Department for Transport
2010/112	Recognise the consistent and disproportionate rate of fatalities in the UK fishing industry and take urgent action to develop a comprehensive, timely and properly resourced plan to reduce that rate to a level commensurate with other UK occupations.	

Appropriate action ongoing

DfT comment:
Work is ongoing. An overall strategy to improve safety in the UK fishing industry has been developed by the MCA and has been approved by the Minister. The Fishing Industry Safety Group (FISG) has been reorganised and will be attended by Chief Executives of member organisations. FISG will then establish Project Teams that will address individual elements of the Strategy which were identified at a meeting of FISG members in December.

2009 RECOMMENDATIONS - PROGRESS REPORT

Jo Eik

Report number: **24/2009**

Chemical tanker | Accident date: 06/05/2009

TWO CREW CASUALTIES FROM RELEASE OF CARGO VAPOURS

Nº	Recommendation(s) to:	International Chamber of Shipping
2009/183	Include the following safety issues identified in this report in the next periodic review and amendment of the Tanker Safety Guide Chemicals: • Emphasise the need for the cargo specific MSDS to be held on board as supplied by the shipper. • That the cargo specific MSDS is promulgated to receivers (terminal or transhipment ships/barges) either directly from the ship or via the ship operator or agent so that risk control measures are based on accurate information. • That areas of the deck which fall into the IMO's definition of an Enclosed Space are identified, and that appropriate control measures are in place following risk assessment.	

Appropriate action implemented

Abigail H

Report number: **15/2009**

Grab hopper dredger | Accident date: 02/11/2008

FLOODING AND FOUNDERING IN THE PORT OF HEYSHAM

Nº	Recommendation(s) to:	Maritime and Coastguard Agency
2009/141	Introduce a mandatory requirement, for all vessels greater than 24m length and less than 500 gross tons, for the fitting of bilge alarms in engine rooms and other substantial compartments that could threaten the vessel's buoyancy and stability if flooded. These, and any other emergency alarms should sound in all accommodation spaces when the central control station is unmanned. In addition to functioning in the vessel's normal operational modes, alarms should be capable of operating when main power supplies are shut down, and be able to wake sleeping crew in sufficient time for them to react appropriately.	

Appropriate action planned 2014 SEPTEMBER 30

Celtic Pioneer

Report number:	**11/2009**	
Rigid Hullled Inflatable Boat	Accident date:	26/08/2008

INJURY TO A PASSENGER ON BOARD THE RHIB IN THE BRISTOL CHANNEL

Nº	Recommendation(s) to:	Local Authorities Co-Ordinators of Regulatory Service / Institute of Licensing
2009/128	When available, promulgate the approved code of practice for thrill-type boat operators, and strongly encourage local authorities within the United Kingdom to require operators to adhere to the code as a condition of licensing.	

LACORS: Appropriate action planned

Institute of Licensing: Appropriate action implemented

MAIB Comment:
The approved Code of Practice for thrill-type boat operators has been published. However, a response from LACORS to recommendation 2009/128 is still awaited.

Nº	Recommendation(s) to:	Maritime and Coastguard Agency
2009/126	Review and revise the deck manning and qualification requirements of the harmonised SCV Code taking into account the speed of craft and the type of activity intended in addition to the distance from shore and environmental conditions.	

Appropriate action planned — 2015 JUNE 30

2008 RECOMMENDATIONS - PROGRESS REPORT

Fishing Vessel Safety Study

Fishing vessels | Accident dates: 1992 to 2006

Analysis of UK Fishing Vessel Safety 1992 to 2006

Nº	Recommendation(s) to:	Maritime and Coastguard Agency
2008/177	Review the current requirements for safety training with particular reference to training assessment and refresher training.	

Appropriate action planned

Nº	Recommendation(s) to:	Department for Transport
2008/175	Work closely together and with fishing industry safety representatives, to ensure pragmatic safety concerns are integrated into conservation policy measures.	

Appropriate action planned

Nº	Recommendation(s) to:	Department for Transport/ Maritime and Coastguard Agency
2008/174	Agree the coherent resourced plan for reducing the fatality rate in the fishing industry (see recommendation 2008/173).	

DfT: Appropriate action planned

MCA: Appropriate action planned

Nº	Recommendation(s) to:	Maritime and Coastguard Agency
2008/173	In developing its plan to address the unacceptably high fatality rate in the fishing industry, identified in its study of statistics for the years 1996 to 2005, in addition to delivering the actions outlined at 6.2, the MCA is recommended to consider the findings of this safety study, and in particular to:	

- Clarify the requirement for risk assessments to include risks which imperil the vessel such as: environmental hazards; condition of the vessel; stability etc.
- Work towards progressively aligning the requirements of the *Small Fishing Vessel Code*, with the higher safety standards applicable under the Workboat Code.
- Clarify the requirements of *The Merchant Shipping and Fishing Vessels (Health and Safety at Work) Regulations 1997* to ensure that they apply in respect of all fishermen on board fishing vessels, irrespective of their contractual status.

- Ensure that the current mandatory training requirements for fishermen are strictly applied.
- Introduce a requirement for under 15m vessels to carry EPIRBs.
- Review international safety initiatives and transfer best practice to the UK fishing industry with particular reference to the use of PFDs and Personal Locator Beacons.
- Conduct research on the apparent improvement in safety in other hazardous industry sectors, such as agriculture, construction and offshore, with the objective of identifying and transferring best safety practice from those industries to the fishing industry.

Appropriate action planned

MSC Napoli

Report number: **09/2008**

Container vessel | Accident date: 18/01/2007

STRUCTURAL FAILURE

Nº	Recommendation(s) to: International Association of Classification Societies
2008/130	Research and review the technological aids available which would assist masters to measure hull stresses in port and at sea.

Appropriate action planned

2008/128 Review the contents of UR S11 (Longitudinal Strength Standard) to ensure:

- Hull girder strength and buckling checks are carried out on all critical sections along the entire length of the hull.
- An evaluation of the suitability of current UR S11 design wave bending moment criteria for vessels with low block coefficient is undertaken.
- Member societies use common methodologies when complying with the requirements of this rule.

Appropriate action planned

2007 RECOMMENDATIONS - PROGRESS REPORT

Thunder

Report number: 12/2007

General cargo | Accident date: 10/08/2006

GROUNDING AT THE APPROACHES TO THE DEE ESTUARY

Nº	Recommendation(s) to:	Department for Transport
2007/144	In considering his decisions on the Harbour Revision Orders submitted by the Environment Agency and Mostyn Docks Limited, take into account the need to clarify the status of the Mostyn Outer Channel, such that the responsible authority has the necessary powers to ensure the safety of navigation in the channel.	

Appropriate action planned

Danielle

Report number: 5/2007

Dredger | Accident date: 06/06/2006

MAJOR INJURIES SUSTAINED BY A DECKHAND

Nº	Recommendation(s) to:	Maritime and Coastguard Agency
2007/119	Amplify and expand on current advice contained in MSN 1768 (M&F) such that fishermen are reminded: • Medical scale requirements provide the minimum levels of medical stores only. Additional stores may be provided at the skipper's/owner's discretion. Such advice should also specify the need for skippers to consider the level of additional medical stores carried on individual vessels as part of the statutory risk assessment process.	

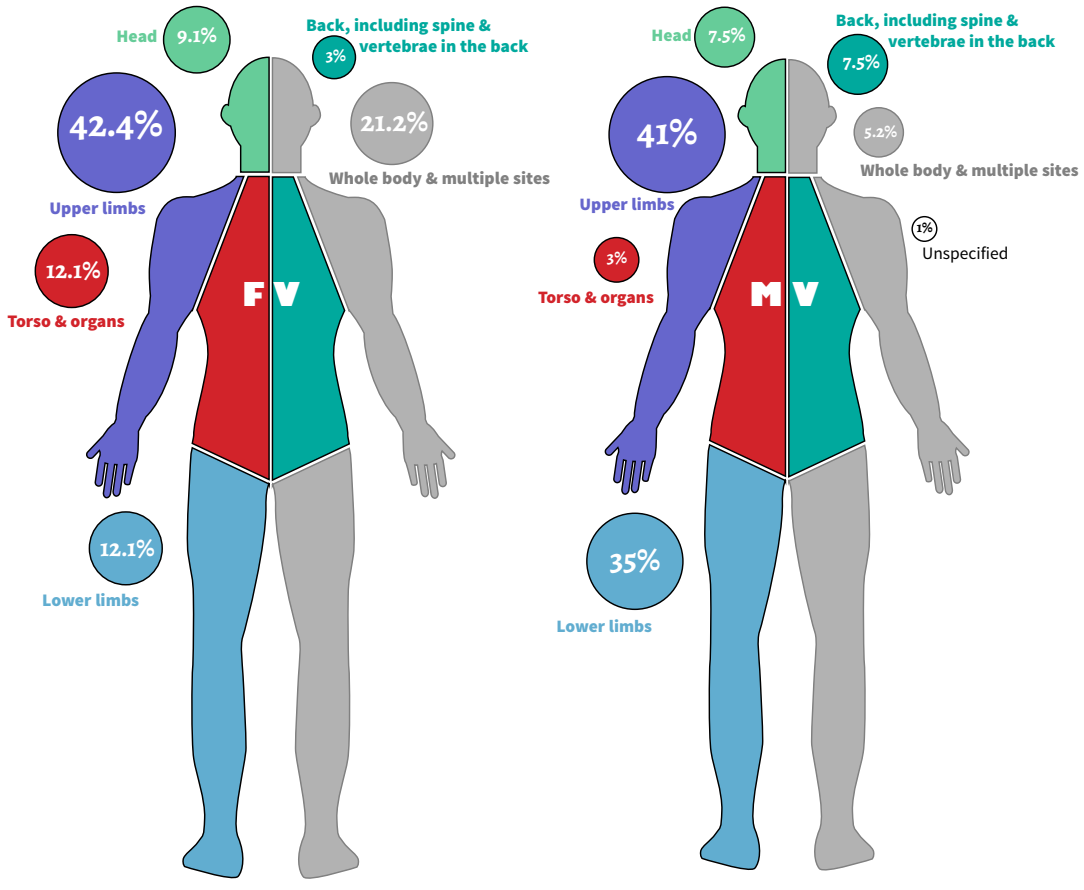
Partially accepted: action planned

PART 3: STATISTICS

STATISTICS

For details of reporting requirements and terms used in this section please see Annex - Statistics Coverage on page 87 and Glossary on page 88.

Deaths and Injuries of Merchant Vessel and Fishing Vessel Crew by Part of Body Injured



See Tables 8 and 20 for details

Table 1: UK vessel accidents involving loss of life

Date	Name of vessel	Type of vessel	Location	Accident
Merchant vessels 100gt and over				
15 May	*Tyrusland*	Cargo ro-ro	Tripoli, Libya.	Fatal injuries during cargo operations.
Merchant vessels under 100gt				
05 Feb	*Endurance*	Tug	3nm south of Beachy Head, East Sussex.	Crewman lost overboard while trying to recover a tow in rough seas.
Fishing vessels				
28 Jan	*JCK*	Gill netter	Tor Bay, Devon.	Foundering of small single-handed vessel in poor weather conditions.
21 Feb	*Achieve*	Creeler	6nm north-west of island of Taransay, West Scotland.	Foundering of vessel with three on board. The liferaft was deployed and two crew members were able to get inside. A third was separated for a time and although he was recovered to the liferaft he could not be revived.
25 Apr	*Speedwell*	Stern trawler	Firth of Lorn, south of Oban, West Scotland.	Foundering of single-handed vessel.
09 Nov	*Horizon II*	Stern trawler	Royal Quays Marina, North Shields, Tyne and Wear.	Skipper fell between dockside and vessel while returning on board and subsequently drowned.
Small craft				
1 Apr	*Arniston*	Cabin cruiser	Bowness-on-Windermere, Cumbria.	2 fatalities from carbon monoxide poisoning.
08 Apr	*Revel*	Sailing yacht	Dunstaffnage Marina near Oban, West Scotland.	Owner missing after leaving marina pontoon in small tender. The tender was later found with one oar missing.
19 Apr	-	Kayak	Off Holyhead, Anglesey.	Drowning following capsize.
05 May	*Milly*	RHIB	Padstow, Cornwall.	2 fatalities following the ejection of six occupants during a turn.
24 May	-	Gull class sailing dinghy	Firth of Forth, near Hound oil terminal, East Scotland.	Capsize involving single-handed sailor.
05 Jun	*Sylphida*	Sailing yacht	Wembury Bay, South Devon.	Person overboard during foredeck operation.
23 Sept	*Palamina*	Sailing yacht	English Channel on passage between Weymouth and Swanage.	Presumed person overboard.
12 Oct	*Pulau Tiga*	Sailing yacht (trimaran)	On passage between Methoni, Greece, and Syracuse, Sicily.	Vessel found with no-one on board and with catastrophic damage. 2 people missing.
16 Oct	-	Kayak	Off Budleigh Salterton, South Devon.	Drowning after capsize.
04 Dec	*Amy Jane*	Angling boat	Off Cadgwith, South Cornwall.	Person overboard.

UK MERCHANT VESSELS >= 100GT

Table 2: Merchant vessel total losses

There were no losses of UK merchant vessels reported to MAIB in 2013.

Table 3: Merchant vessel losses — 2003-2013

	Number lost	UK fleet size	Gross tons lost
2003	-	1343	-
2004	2	1406	832
2005	6	1443	1579
2006	-	1480	-
2007	5	1518	54304
2008	2	1578	645
2009	1	1564	274
2010	-	1520	-
2011	-	1521	-
2012	-	1450	-
2013	-	**1392**	-

Table 4: Merchant vessels in casualties by nature of casualty and vessel category❶

	Solid cargo	Liquid cargo	Passenger	Service ship	Commercial recreational	Total
Capsizing/listing	1	-	-	-	-	**1**
Collision	10	1	14	3	-	**28**
Contact	5	-	7	4	-	**16**
Damage to ship or equipment	4	-	3	7	-	**14**
Fire/explosion	2	-	1	1	-	**4**
Grounding	11	1	4	8	3	**27**
Hull failure	1	-	-	-	-	**1**
Loss of control	7	2	9	12	1	**31**
Total	**41**	**4**	**38**	**35**	**4**	**122**

❶ Vessel groups include vessels operating on inland waterways.
Note: 122 Casualties represents a rate of 88 Casualties per 1 000 vessels on the UK Fleet.

Table 5: Deaths and injuries to merchant vessel crew — 2003-2013❷

	Crew injured	Of which resulted in death
2003	289	3
2004	310	4
2005	246	2
2006	233	3
2007	243	12
2008	224	5
2009	199	6
2010	222	3
2011	185	5
2012	186	3
2013	**134**	**1**

❷ From 2012 this table excludes injuries/fatalities that were not in connection with the operation of a ship

Table 6: Deaths and injuries of merchant vessel crew by rank

Rank/specialism	Number of crew
Master/skipper	2
Officer, deck	12
Officer, engineering	22
Rating	41
Other crew	57
Total	**134**

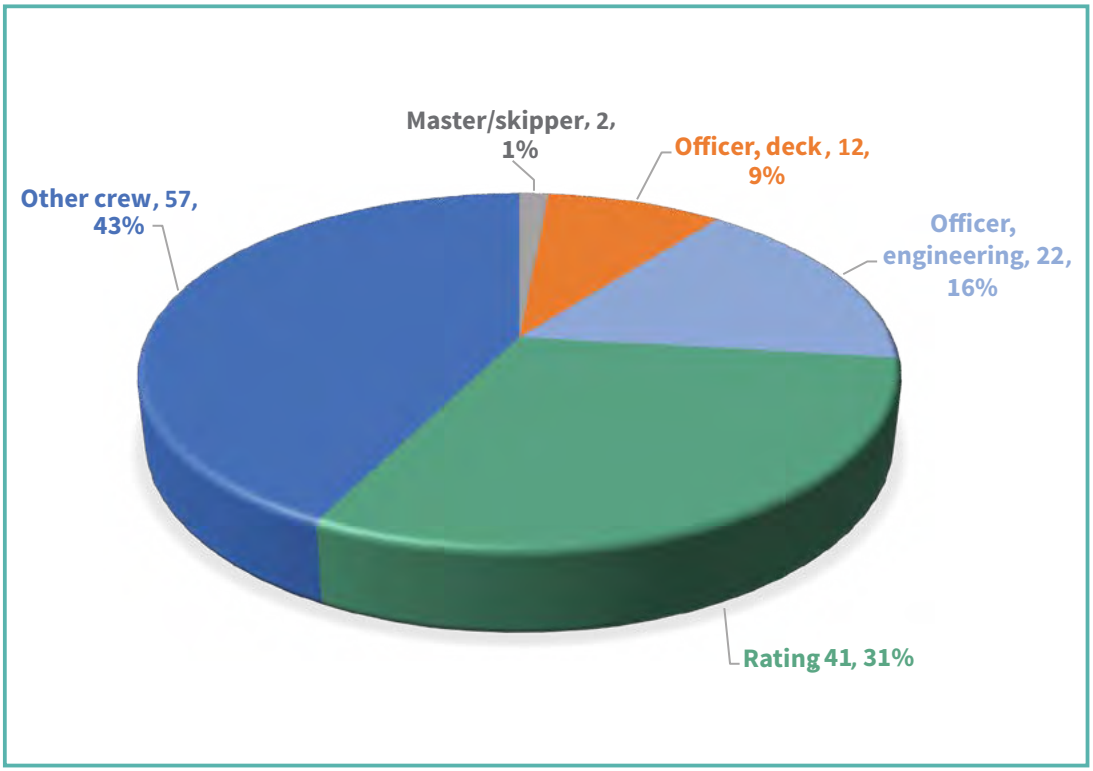


Table 7: Deaths and injuries of merchant vessel crew by place

Place		Number of crew
Accommodation	Accommodation	1
	Bathroom, shower, toilet	4
	Cabin space - crew	6
	Corridor	3
	Galley spaces	8
	Mess room, dayroom	4
	Theatre	1
	Provision room	2
	Stairway/ladders	8
	Other	4
Bridge | wheelhouse		3
Cargo & tank areas	Cargo hold	2
	Cargo tank	1
	Closed deck cargo space	2
	Open deck cargo space	4
	Ro-Ro vehicle deck ramp	1
	Vehicle cargo space	13
Engine department	Boiler room	1
	Control room	1
	Engine room	11
	Workshop/stores	2
	Other	3
Ship	Boat deck	7
	Forecastle deck	8
	Freeboard deck	14
	Gangway	1
	Over side	1
	Poop deck	1
	Stairs/ladders	12
	Superstructure deck	2
	Other	2
Unknown		1
Total		**134**

Table 8: Deaths and injuries of merchant vessel crew by part of body injured

Part of body injured		Number of crew
Whole body and multiple sites	Multiple sites of the body affected	6
	Whole body	1
Head	Eye(s)	2
	Facial area	4
	Brain and cranial nerves and vessels	1
	Multiple sites affected	1
	Other parts not mentioned above	2
Upper limbs	Arm, including elbow	11
	Finger(s)	17
	Hand	12
	Shoulder and shoulder joints	9
	Wrist	6
Back, including spine and vertebrae in the back		10
Torso and organs	Chest area including organs	1
	Pelvic and abdominal area including organs	1
	Rib cage, ribs including joints and shoulder blade	2
Lower limbs	Ankle	12
	Foot	8
	Hip and hip joint	1
	Leg, including knee	22
	Toe(s)	2
	Multiple sites affected	1
	Other parts not mentioned above	1
Not specified		1
Total		**134**

Table 9: Deaths and injuries of merchant vessel crew by deviation

Deviation		Number of crew
Body movement under or with physical stress (generally leading to an internal injury)	Lifting, carrying, standing up	6
	Pushing, pulling	3
	Putting down, bending down	4
	Treading badly, twisting leg or ankle, slipping without falling	3
	Twisting, turning	1
	Other	1
Body movement without any physical stress (generally leading to an external injury)	Being caught or carried away, by something or by momentum	10
	Kneeling on, sitting on, leaning against	1
	Unco-ordinated movements, spurious or untimely actions	4
Breakage, bursting, splitting, slipping, fall, collapse of Material Agent	Slip, fall, collapse of Material Agent - from above (falling on the victim)	1
	Slip, fall, collapse of Material Agent - on the same level	3
Deviation by overflow, overturn, leak, flow, vaporisation, emission	Gaseous state - vaporisation, aerosol formation, gas formation	2
	Liquid state - leaking, oozing, flowing, splashing, spraying	3
Loss of control (total or partial)	Of hand-held tool (motorised or not) or of the material being worked by the tool	3
	Of machine (including unwanted start-up) or of the material being worked by the machine	7
	Of means of transport or handling equipment, (motorised or not)	3
	Of object (being carried, moved, handled, etc)	17
Slipping - stumbling and falling - fall of persons	Fall of person - to a lower level	29
	Fall overboard of person	1
	Fall of person - on the same level	32
	Total	**134**

Table 10: Deaths and injuries of merchant vessel crew by injury

Main injury		Number of crew
Bone fractures	Closed fractures	43
	Open fractures	3
	Other types of bone fractures	1
Burns, scalds and frostbites	Burns and scalds (thermal)	3
	Chemical burns (corrosions)	1
Concussion and internal injuries	Concussion and intracranial injuries	2
	Internal injuries	8
Dislocations, sprains and strains	Dislocations and subluxations	9
	Other types of dislocations, sprains and strains	4
	Sprains and strains	26
Multiple injuries		2
Poisonings and infections	Acute poisonings	2
Traumatic amputations (Loss of body parts)		2
Wounds and superficial injuries	Open wounds	15
	Other types of wounds and superficial injuries	1
	Superficial injuries	9
Other specified injuries not included under other headings		2
Unknown or unspecified		1
Total		**134**

Table 11: Deaths and injuries to passengers — 2003-2013

	Number of passengers	Of which resulting in death
2003	186	-
2004	147	-
2005	110	1
2006	114	1
2007	106	-
2008	170	2
2009	115	1
2010	92	2
2011	109	1
2012	50	-
2013	**46**	**-**

❷ From 2012 this table excludes injuries/fatalities that were not in connection with the operation of a ship.

❸ Between 2009 and 2011 eight cruise ships left the UK flag.

Table 12: Deaths and injuries of passengers by injury

Main injury		Number of passengers
Bone fractures	Closed fractures	29
Concussion and internal injuries	Concussion and intracranial injuries	4
Dislocations, sprains and strains	Dislocations and subluxations	3
	Sprains and strains	1
Wounds and superficial injuries	Open wounds	6
	Superficial injuries	1
	Unknown or unspecified	2
	Total	**46**

UK MERCHANT VESSELS < 100GT

Table 13: Merchant vessels < 100gt - losses

	Date	Name Of vessel	Type of vessel	loa	Casualty event
*	15 Jun	*Wacker Quacker 1*	Inland waterway vessel | Passenger	10	Flooding
*	26 Aug	*Kingfisher*	Service ship | Other	10	Grounding

*Constructive total loss

Table 14: Merchant vessels < 100gt

	Inland waterway vessel	Passenger ship	Recreational craft | Motorboat	Recreational craft | Sailboat	Recreational craft | Other	Service ship | Offshore	Service ship | Special purpose ship	Service ship | Tug (Towing/Pushing)	Service ship | SAR craft	Service ship | Other	Total
Capsizing/ listing	-	-	-	1	-	-	1	-	-	1	**3**
Collision	11	1	-	16	1	-	6	2	2	6	**45**
Contact	2	-	-	1	-	1	2	-	-	1	**7**
Damage to ship or equipment	1	2	-	1	-	-	1	-	1	-	**6**
Fire/explosion	1	-	-	-	-	1	3	-	1	-	**6**
Flooding/ foundering	3	-	-	-	-	-	2	-	-	-	**5**
Grounding	5	1	1	2	-	-	5	2	-	9	**25**
Loss of control	5	1	-	4	1	1	5	-	1	9	**27**
Total casualties	**28**	**5**	**1**	**25**	**2**	**3**	**25**	**4**	**5**	**26**	**124**
Death	-	-	-	-	-	-	-	1	-	-	**1**
Injured	11	2	1	14	2	1	19	-	8	8	**66**

UK FISHING VESSELS

There were 5 774 UK registered fishing vessels at the end of 2013. During 2013, 248 Casualties to vessels involving these vessels were reported to the MAIB. Figures in the following tables show Casualties to vessels and injuries involving UK registered vessels that were reported to the MAIB in 2013.

Eighteen fishing vessels were reported lost (0.31% of the total fleet) and there were 4 fatalities to crew.

Table 15: Fishing vessel total losses

	Date	Name of vessel	Age	Gross tons	Casualty event	Occurrence severity
Under 15m length overall (loa)						
*	27 Jan	*Hunter*	35	13.18	Fire	Very serious
	28 Jan	*JCK*	26	1.71	Foundering	Very serious
	21 Feb	*Achieve*	34	10.67	Foundering	Very serious
	25 Apr	*Speedwell*	15	5.81	Foundering	Very serious
	06 Jun	*Millie G*	22	12.45	Capsizing	Very serious
	01 Jul	*Saint Peter*	20	2.89	Foundering	Very serious
	11 Jul	*Forget-Me-Not*	37	6.09	Flooding	Very serious
	08 Aug	*Mizpah*	Not known	0.57	Collision	Very serious
	12 Aug	*Magdalene Ann*	53	18.70	Collision	Very serious
	06 Sep	*Foxy Lady*	32	2.56	Flooding	Very serious
*	17 Sep	*Sally Jane*	23	18.06	Capsizing	Very serious
	17 Sep	*Nikki Lou*	39	6.4	Foundering	Very serious
	18 Sep	*Speedbird*	23	2.02	Foundering	Very serious
	03 Dec	*Laura K*	22	2.92	Flooding	Very serious
	07 Dec	*Southern Star*	24	9.47	Foundering	Very serious
15m length overall - under 24m registered length (reg)						
*	16 Jan	*Amy Harris III*	42	75.00	Fire	Serious
*	05 Aug	*Prospect*	17	169.00	Grounding	Very serious
*	17 Dec	*Grenaa Star*	45	46.00	Contact	Serious

* Constructive total loss

Table 16: Fishing vessel losses — 2003-2013❹

	Under 15m loa	15m loa to <24m reg	24m reg and over	Total lost	UK registered	% lost
2003	16	8	4	28	6 731	0.42
2004	16	9	-	25	6 693	0.37
2005	20	11	3	34	6 314	0.54
2006	11	7	1	19	6 346	0.30
2007	16	5	-	21	6 330	0.33
2008	14	4	3	21	6 763	0.31
2009	11	4	-	15	6 222	0.24
2010	11	3	-	14	5 902	0.24
2011	17	7	-	24	5 974	0.40
2012	5	4	-	9	5 834	0.15
2013	**15**	**3**	**-**	**18**	**5 774**	**0.31**

❹ From 2012 this table excludes losses that were not in connection with the operation of a ship.

Table 17: Casualties to fishing vessels

	Number of vessels involved	Incident rate per 1 000 vessels at risk (to one decimal place)
Capsizing/listing	3	0.5
Collision	12	2.1
Contact	3	0.5
Damage to ship or equipment	16	2.8
Fire/explosion	5	0.9
Flooding/foundering	22	3.8
Grounding	23	4.0
Loss of control	164	28.4
Total	**248**	**43.0**

Table 18: Fishing vessels in casualties — by nature of casualty

	Number of vessels involved	Incident rate per 1 000 vessels at risk (to one decimal place)
Under 15m length overall (loa) — vessels at risk: 5 114		
Capsizing/listing	3	0.6
Collision	9	1.8
Contact	1	0.2
Damage to ship or equipment	15	2.9
Fire/explosion	2	0.4
Flooding/foundering	21	4.1
Grounding	17	3.3
Loss of control	134	26.2
Total	**202**	**39.5**
15m loa - 24m registered length (reg) — vessels at risk: 502		
Collision	3	6.0
Contact	1	2.0
Damage to ship or equipment	1	2.0
Fire/explosion	2	4.0
Grounding	4	8.0
Loss of control	26	51.8
Total	**37**	**73.7**
24m reg and over — vessels at risk: 158		
Contact	1	6.3
Fire/explosion	1	6.3
Flooding/foundering	1	6.3
Grounding	2	12.7
Loss of control	4	25.3
Total	**9**	**57.0**
Fleet total	**248**	**43.0**

Table 19: Deaths and injuries to fishing vessel crew by injury

Main injury		Number of crew
Bone fractures	Closed fractures	7
	Open fractures	1
Burns, scalds and frostbites	Burns and scalds (thermal)	1
Concussion and internal injuries	Concussion and intracranial injuries	1
	Internal injuries	2
Drowning and asphyxiation	Drowning and non-fatal submersions	2
	Other types of drowning and asphyxiation	1
Effects of temperature extremes, light and radiation	Effects of reduced temperature	4
Poisonings and infections	Acute poisonings	2
Traumatic amputations (Loss of body parts)		9
Wounds and superficial injuries	Open wounds	1
	Superficial injuries	2
Total		**33**

Table 20: Deaths and injuries of fishing vessel crew by part of body injured

Part of body injured		Number of crew
Whole body and multiple sites	Whole body	7
Head	Eye(s)	1
	Facial area	1
	Brain and cranial nerves and vessels	1
Upper limbs	Arm, including elbow	2
	Finger(s)	8
	Hand	3
	Shoulder and shoulder joints	1
Back, including spine and vertebrae in the back		1
Torso and organs	Chest area including organs	2
	Pelvic and abdominal area including organs	1
	Torso, multiple sites affected	1
Lower Limbs	Ankle	1
	Hip and hip joint	1
	Leg, including knee	2
	Total	**33**

Table 21: Deaths and injuries of fishing vessel crew by deviation

Deviation		Number of crew
Body movement under or with physical stress (generally leading to an internal injury)	Lifting, carrying, standing up	1
Body movement without any physical stress (generally leading to an external injury)	Being caught or carried away, by something or by momentum	7
	Unco-ordinated movements, spurious or untimely actions	2
Deviation by overflow, overturn, leak, flow, vaporisation, emission	Liquid state - leaking, oozing, flowing, splashing, spraying	1
	Pulverulent material - smoke generation, dust/particles in suspension/emission of	2
Loss of control (total or partial)	Of hand-held tool (motorised or not) or of the material being worked by the tool	1
	Of machine (including unwanted start-up) or of the material being worked by the machine	6
	Of means of transport or handling equipment, (motorised or not)	2
	Of object (being carried, moved, handled, etc)	2
Slipping - stumbling and falling - fall of persons	Fall of person - to a lower level	1
	Fall overboard of person	8
	Total	**33**

Table 22: Deaths and injuries to fishing vessel crew by vessel length (of which, deaths shown in brackets) 2003-2013 ❷

	Under 15m loa		15m loa - under 24m reg		24m reg and over		Total	
2003	27	(8)	25	(2)	18	(1)	70	(11)
2004	27	(9)	20	(1)	23	-	70	(10)
2005	20	(3)	27	(3)	15	(3)	62	(9)
2006	21	(6)	30	(8)	18	(2)	69	(16)
2007	25	(4)	24	(3)	15	(1)	64	(8)
2008	19	(3)	22	(4)	19	(1)	60	(8)
2009	32	(5)	30	(7)	13	(1)	75	(13)
2010	22	(4)	10	-	13	(1)	45	(5)
2011	20	(7)	27	(1)	11	-	58	(8)
2012	21	(4)	22	(2)	7	-	50	(6)
2013	**13**	**(3)**	**13**	**(1)**	**7**	**-**	**33**	**(4)**

❷From 2012 this table excludes injuries/fatalities that were not in connection with the operation of a ship.

NON-UK COMMERCIAL VESSELS

Table 23: Non UK commercial vessels total losses in UK waters

There were no losses of non UK commercial vessels in UK waters reported to MAIB in 2013.

Table 24: Non UK commercial vessels in UK waters

	Cargo solid	Liquid cargo	Passenger	Service ship	Fishing vessel	Total
Collision	8	7	1	7	-	**23**
Contact	11	6	3	6	-	**26**
Damage to ship or equipment	-	-	3	1	-	**4**
Fire/explosion	1	-	-	-	-	**1**
Grounding	18	1	1	-	2	**22**
Loss of control	10	7	2	2	-	**21**
Total	**48**	**21**	**10**	**16**	**2**	**97**
Fatalities	1	1	-	-	1	**3**
Injuries	23	13	15	7	3	**61**

ANNEX - STATISTICS COVERAGE

1. Data is presented by the year in which the incident was reported to the MAIB. Historic data tables contain information from 2003.
2. Not all historical data can be found in this report. More data is contained in the 2012 Annual Report.
3. From July 2012 United Kingdom ships are required by the Merchant Shipping (Accident Reporting and Investigation) Regulations 2012[1] to report Accidents to the MAIB.
4. Accident has a new wider definition. In contrast to the 2005 Regulations, Accident incorporates the old Hazardous Incidents (which are now known as Marine Incidents). Accidents are now defined as being Marine Casualties or Marine Incidents, depending on the type of event(s) and the results of the event(s). See Casualty definitions[2] or MAIB's Regulations[1] for more information.
5. These new definitions mean that, although the overall numbers of Casualties are similar to the old number of Accidents (using the old definition), they are formed in a different manner. Eg previously a ship needed to be disabled for 12 hours or more before it would be considered a Machinery Accident, there is now no time limit for a disabled ship to be considered a Casualty. Another major change is that all Casualties need to be connected to the operation of a ship. Further details can be found in Changes to UK Casualty Event definitions[2].
6. Details of vessel types and groups used in this Annual Report can be found in the document: Vessel types used in MAIB Annual Report 2013[2].
7. Non-UK flagged vessels are not required to report accidents to the MAIB unless they are within a UK port/harbour or within UK 12 mile territorial waters and carrying passengers to or from a UK port. However, the MAIB will record details of, and may investigate, significant accidents notified to us by bodies such as H.M. Coastguard.
8. The Maritime and Coastguard Agency, harbour authorities and inland waterway authorities also have a duty to report accidents to the MAIB.
9. In addition to the above, the MAIB monitors news and other information sources for relevant Accidents.

[1] http://www.legislation.gov.uk/uksi/2012/1743/contents/made

[2] Supporting documents can be found on the MAIB website: http://www.maib.gov.uk/publications/annual_reports/annual_report_2013.cfm

GLOSSARY OF ABBREVIATIONS, ACRONYMS AND TERMS

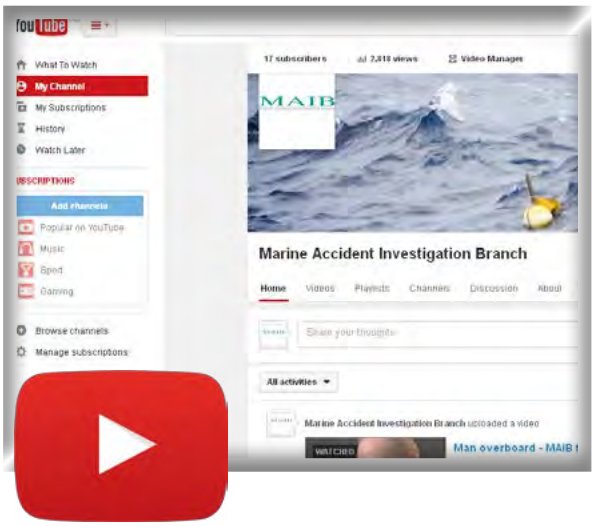
▶ Abbreviations and Acronyms ◀

AIS	-	Automatic Identification System
ARPA	-	Automatic Radar Plotting Aid
BNWAS	-	Bridge Navigational Watch Alarm System
BPA	-	British Ports Association
CFPO	-	Cornish Fish Producers Organisation
Circ	-	Circular
CO	-	Carbon Monoxide
COLREGs	-	International Regulations for Preventing Collisions at Sea 19S72, as amended
DfT	-	Department for Transport
DIY	-	Do-It-Yourself
EPIRB	-	Emergency Position Indicating Radio Beacon
EU	-	European Union
FISG	-	Fishing Industry Safety Group
FSS Code	-	International Code for Fire Safety Systems
FV	-	Fishing Vessel
FWBLAFF	-	Fixed water-based local application fire-fighting system
GHz	-	gigahertz
GL	-	Germanischer Lloyd
GM	-	Metacentric Height
GT	-	Gross Tonnage
IACS	-	International Association of Classification Societies
IMCA	-	International Marine Contractors Association
IMO	-	International Maritime Organization
IMSBC	-	International Maritime Solid Bulk Cargoes Code
ISGOTT	-	International Safety Guide for Oil Tankers and Terminals
ISM	-	International Safety Management Code
(L)	-	Length
LACORS	-	Local Authority Coordinators of Regulatory Services
LLP	-	Limited Liability Partnership
LOA	-	Length overall
LOLER	-	Lifting Operations and Lifting Equipment Regulations
LR	-	Lloyd's Register
LSA	-	Life Saving Appliance
LTD	-	Limited

m	-	metre
MCA	-	Maritime and Coastguard Agency
MGN	-	Marine Guidance Note
MMO	-	Marine Management Organisation
MSC	-	Maritime Safety Committee
MSDS	-	Material Safety Data Sheet
MSN	-	Merchant Shipping Notice
MV	-	Merchant Vessel
NFFO	-	National Federation of Fishermen's Organisations
NIFPO	-	Northern Ireland Fish Producers Organisation
nm	-	nautical mile
NW	-	North west
NWA	-	National Workboat Association
PFD	-	Personal Flotation Device
PLB	-	Personal Locator Beacon
PUWER	-	Provision and Use of Work Equipment Regulations (1998)
UK	-	United Kingdom
UR	-	Unified Requirements
VTS	-	Vessel Traffic Services
Reg	-	Registered Length
Rev	-	Revision
RHIB	-	Rigid Hulled Inflatable Boat
RNLI	-	Royal National Lifeboat Institution
Ro-ro	-	Roll on, Roll off vessel
SAR	-	Search and Rescue
SCV Code	-	Small Commercial Vessel Code
SFA	-	Scottish Fishermen's Association
SIAS	-	Ship Inspections and Surveys
SMM	-	Safety Management Manual
SMS	-	Safety Management System
SOLAS	-	Safety of Life at Sea
STCW	-	International Convention on Standards of Training, Certification and Watchkeeping for Seafarers 1978
TSGC	-	Tanker Safety Guide (Chemicals)
TSS	-	Traffic Separation Scheme
UKMPG	-	The United Kingdom Major Ports Group Limited

Grandfather rights	-	The 'grandfather clause' is the practice of permitting existing vessels to operate to the standards applicable at the time they were built or as otherwise stated.
Deviation	-	The last event differing from the normal working process and leading to an injury/fatality.
DUKW	-	A DUKW (Pronounced "duck") is an amphibious landing vehicle that was designed to transport military personnel and supplies for the US Army during World War 2. The acronym DUKW indicates that it was designed in 1942 (D), it is an amphibious (U) vehicle and has both front-wheel and rear-wheel drive capability (K and W, respectively).
Material Agent	-	A tool object or instrument.
Subluxation	-	Incomplete, or partial dislocation.
Superficial injuries	-	Bruises, abrasions, blisters etc.

MAIB ONLINE RESOURCES



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MAIB Annual Report

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