SYNOPSIS

On 21 July 2000, HM Coastguard and SOSREP informed the MAIB that the container-feeder vessel *Coastal Bay* had grounded off Anglesey, Wales. An investigation began three days later.

Coastal Bay was on passage from Dublin to Liverpool. Her planned route was via The Skerries Traffic Separation Scheme (TSS). Shortly before 2300 on 20 July, the chief officer relieved the master on the bridge; about thirty minutes later he fell asleep. A planned alteration of course taking the vessel into the north-east bound lane of the TSS was missed, and the vessel ran aground at 0020 the next day.

The investigation highlighted three key factors:

1. The chief officer fell asleep through fatigue.

2. The chief officer was alone on the bridge.

3. The bridge watch alarm was not in use.

These factors were the result of serious shortcomings in the management of *Coastal Bay*, and the failure to comply with the requirements of STCW 95, regarding watchkeeping arrangements and bridge manning at night.

Recommendations to the MCA and the Antigua and Barbuda administration are aimed at ensuring the requirements of STCW 95, regarding watchkeeping arrangements and bridge manning at night, are understood by all vessels operating in UK waters. Others, to the vessel's management company, aim to improve watchkeeping arrangements and vessel management.