

2018







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

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July 2019

MARINE ACCIDENT INVESTIGATION BRANCH

ANNUAL REPORT 2018 TO THE SECRETARY OF STATE FOR TRANSPORT

The Marine Accident Investigation Branch (MAIB) examines and investigates all types of marine accidents to or on board UK vessels worldwide, and other vessels in UK territorial waters.

Located in offices in Southampton, the MAIB is a separate, independent branch within the Department for Transport (DfT). The head of the MAIB, the Chief Inspector of Marine Accidents, reports directly to the Secretary of State for Transport.

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Front cover yacht image: Greg Baillie

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CHIEF INSPECTOR'S REPORT

COMMENTARY ON THE STATISTICS

2018 was a challenging year for the MAIB, though to some extent it was business as usual. The year saw 1227 accidents reported, just a few less than the previous year; and 23 investigations started, up from 21 in 2017 but still lower than 2016 when the Branch started 29 investigations. In fact, it looked like being a very quiet year for investigations until December when in the space of 4 days we commenced five investigations, three of which can be attributed to the heavy weather hitting the UK at that time.

For the ninth successive year there were no UK merchant vessels of >100gt lost. The overall accident rate for UK merchant vessels >100gt continues to fall at 64 per 1000 vessels, down from 75 per 1000 vessels in 2017. There was no loss of life to crew or passengers due to accidents on board UK merchant vessels >100gt during 2018. Three UK registered small commercial vessels were lost in 2018. There were two reported deaths of crew working on foreign flag vessels while in UK ports: one fell through an open hatch cover, the other was working under an unsecured hatch cover that fell on him.

Eight commercial fishing vessels were lost in 2018 compared with six in 2017. The loss rate of fishing vessels remains low at 0.14% of the fleet. Six fishermen lost their lives in 2018 compared with five lives lost in 2017. But more of this below.

The investigations started were the usual mixed bag. Merchant vessel accident investigations included four groundings and five collisions, but notable this year was the number of catastrophic failures of propulsion machinery. Two investigations, involving propulsion failures on Wight Link ferries in the latter part of the year caused us to review some previous investigation reports and to widen the scope of the investigation to encompass everything from design and installation to maintenance and operation. While this is taking some time, what has been heartening is the way that the manufacturers, operators, regulators and Class have collaborated with the Branch to identify the underlying safety issues.

FISHING SAFETY

The MAIB annual report provides an opportunity for the Chief Inspector to raise concerns and make some general observations about marine safety. My predecessor regularly raised concerns about fishing safety, and it would be remiss of me not to do the same as investigating fatal fishing vessel accidents has accounted for 25% of the Branch's work this year.

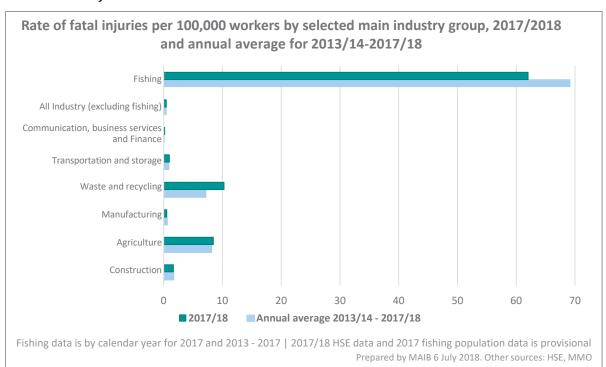
In 2018, tragically, another six fishermen lost their lives: three due to their vessels capsizing; two from falling overboard; and one from a noxious atmosphere in a fish hold. Since 2010, an average of 6.44 fishermen have lost their lives each year, and the figures bear out that the fatality rate has been fairly steady. When considered against deaths on the roads, these figures seem small. However, when adjusted to show deaths per 100,000 workers, the figures tell a different story. When the Health and Safety Executive (HSE) posted its figures for the most dangerous profession in the UK, top of the list was the recycling industry. The HSE's figures did not include commercial fishing. Had they done so, commercial fishing would have been shown to be the most dangerous occupation, by

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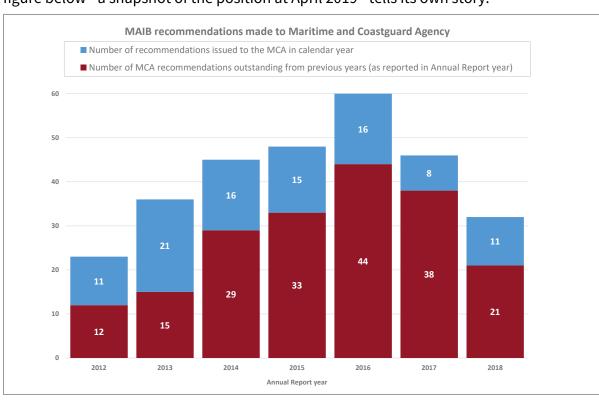
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a factor of 10. There is no silver bullet that will alter this picture, but small fishing vessel stability and lifejacket wear stand out as areas where improvements could significantly enhance safety.



RECOMMENDATIONS

On a more positive note, there has been a significant increase in the rate at which the Maritime and Coastguard Agency has been completing actions to deliver on MAIB recommendations. My predecessor raised his concerns on a number of occasions about the time it was taking the Agency to deliver on recommendations it had accepted. Some of the success in this area can be linked to the UK ratifying ILO 188, which has helped resolve a number of recommendations relating to commercial fishing vessels, but the figure below - a snapshot of the position at April 2019 - tells its own story.



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INTERNAL MATTERS

The retirement of my predecessor, Steve Clinch, coupled with other retirements, has resulted in a number of internal promotions and external recruitments. The training overhead for personnel new to role or new to the Branch, and legacy work have all impacted on the speed with which investigations have been completed, and a handful of investigations have been put on the back burner to allow higher priority work to progress. While this has increased the average time the Branch has taken to complete investigations, the impact on future safety has been minimised through stakeholder engagement and increased use of Safety Bulletins and targeted recommendations. Nonetheless, reducing the overall time taken to deliver investigation reports in the year ahead is a high priority.

The other 'higher priority' work referred to above has, by necessity, included preparing for the UK to leave the EU. Some years ago, the decision was taken to avoid duplication and to dispense with a separate national database for marine accident statistics as all the UK's marine accident data had to be input to the European Marine Casualty Investigation Platform (EMCIP). With the UK's future relationship with Europe unclear, the Branch has had to create a national database and repatriate 41,000 or so accident records so the UK's national data can again be held separately. The database was ready to use, with all data verified as correct by 29 March 2019, but the staff effort to achieve this was drawn from other tasks and this had an impact on outputs

FINANCE

The annual report deals principally with the calendar year 2018. However, for ease of reference, the figures below are for the financial year 2018/19, which ended on 31 March 2019. The MAIB's funding from the Department for Transport is provided on this basis, and this complies with the Government's business planning programme.

A separate Capital budget was allocated in 2018/19 to cover the cost of developing a case management system for all three DfT accident investigation branches, and the national database referred to above, aimed at addressing disruption to data access as a result of the UK leaving the European Union.

£ 000s	2018/19 Budget	2018/19 Outturn
Costs – Pay	2939	2736
Costs – Non Pay	1188	1097
Totals	4127	3833
Capital	936	756

Captain Andrew Moll

Chief Inspector of Marine Accidents

de PRU

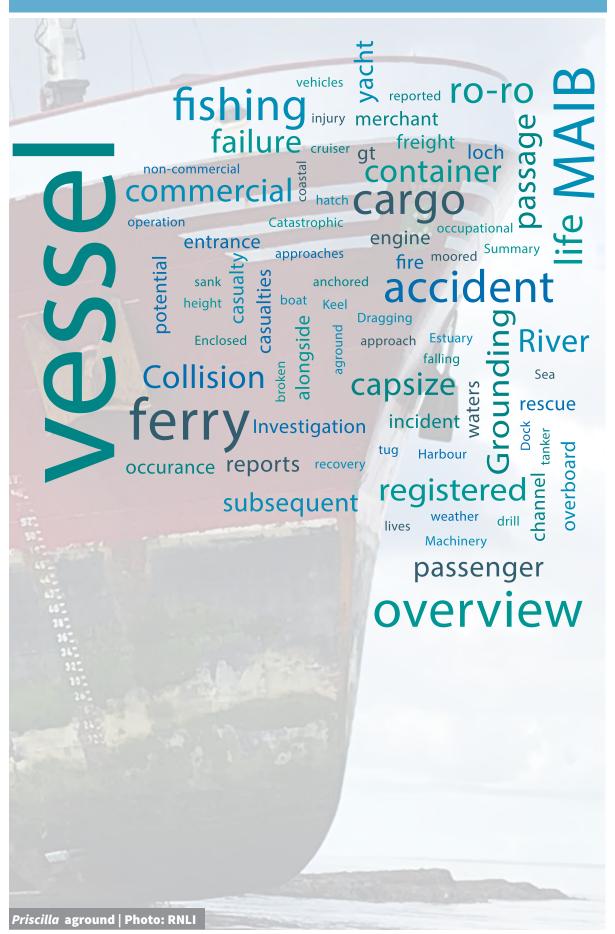
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PART 1: 2018 OVERVIEW



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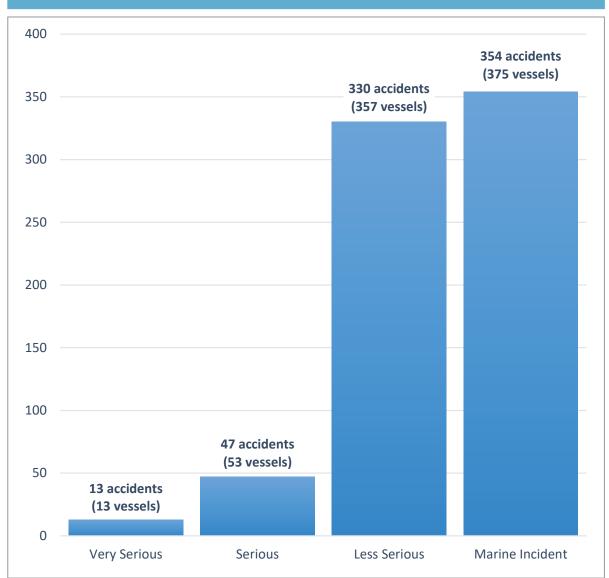
2018: OVERVIEW OF CASUALTY REPORTS TO MAIB

In 2018, 1227 accidents (casualties and incidents¹) to UK vessels or in UK coastal waters were reported to the MAIB. These involved 1339 vessels.

27 of these accidents involved only non-commercial vessels, 456 were occupational accidents that did not involve any actual or potential casualty to a vessel.

There were 744 accidents involving 798 commercial vessels that involved actual or potential casualties to vessels. These are broken down in the following overview:

Chart 1: UK accidents - commercial vessels



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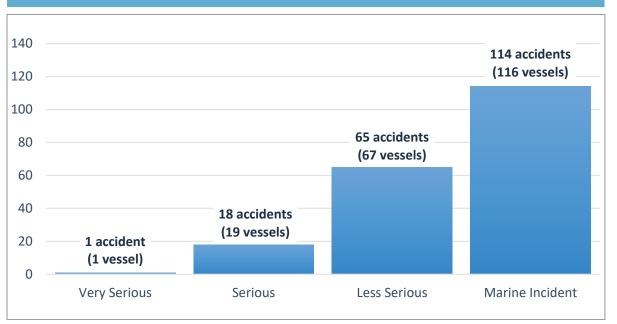
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¹ As defined in Annex B on page 92.

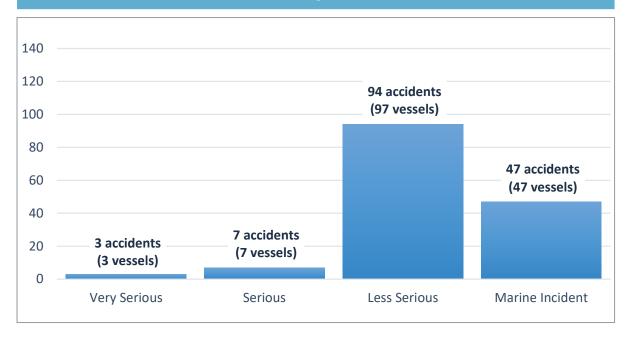




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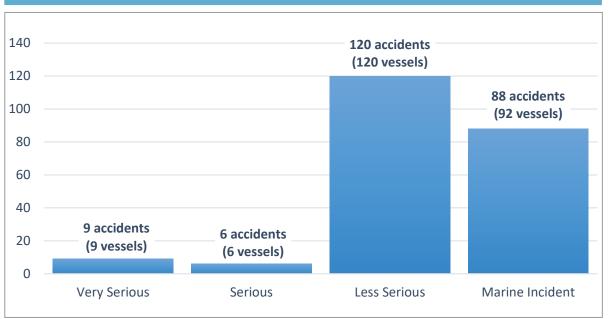
Chart 3: UK merchant vessels of under 100gt



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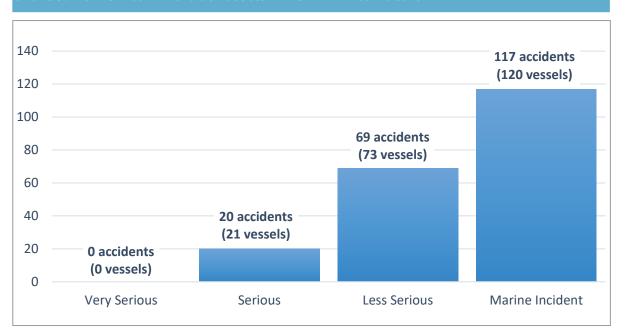




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Chart 5: Non-UK commercial vessels - in UK 12 mile waters



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2018: SUMMARY OF INVESTIGATIONS STARTED

Date of occurrence	Occurrence details
18 Jan	Capsize of the UK registered fishing vessel <i>Nancy Glen</i> (TT100) in Lower Loch Fyne, Scotland with the loss of two lives.
20 Jan	Loss of containers from the UK registered container vessel CMA CGM G.Washington in the North Pacific Ocean, while on passage from Xiamen, China to Los Angeles, USA.
1 Feb	A crewman from the Liberian registered general cargo vessel, SMN Explorer , died when he was crushed by a falling hatch cover while alongside at Alexandra Dock, King's Lynn, England.
5 Feb	Man overboard from the UK registered fishing vessel <i>North Star</i> (WK 623), 16nm north of Cape Wrath, Scotland with loss of one life.
7 Dec 2017*	Keel failure and capsize of the UK registered commercial yacht <i>Tyger of London</i> while on passage from La Gomera to Tenerife. *Investigation started on 19 February 2018
1 Mar	Dragging anchor by the general cargo vessel <i>Celtic Spirit</i> and subsequent collisions with anchored vessels <i>Atlantic Explorer</i> and <i>Celtic Warrior</i> on the River Humber, England.
24 Mar	Failure of a throw bag rescue line during a boat capsize rescue drill in a swimming pool at Warrington Rowing Club, Widnes, England.
27 Mar	Grounding of the Bahamas registered general cargo vessel Celtica Hav on a stone training wall in the approach channel to the River Neath, Wales.
16 Apr	Engine failure and subsequent fire causing injury to one crewman on board the Lithuanian registered ro-ro cargo vessel <i>Finlandia Seaways</i> while on passage 11 miles east of Lowestoft, England.
7 May	Capsize of the UK registered fishing vessel <i>Laura Jane</i> (SE80) in Plymouth Sound, England with the loss of one life.
18 Jul	Grounding of the Netherlands registered general cargo vessel <i>Priscilla</i> in the Pentland Firth, Scotland.
4 Aug	Collision between the UK registered container vessel ANL Wyong and the Italian registered LPG tanker King Arthur approximately 4 miles south east of Gibraltar.
7 Aug	Man overboard from the UK registered fishing vessel <i>Fram of Shieldaig</i> (BD679) off Ardheslaig, Scotland with the loss of one life.

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Date of occurrence	Occurrence details
14 Aug	Enclosed space accident on board the UK registered fishing vessel Sunbeam (FR487) while alongside at Fraserburgh, Scotland with the loss of one life.
26 Aug	Catastrophic main engine failure on board the UK registered ro-ro passenger ferry Wight Sky at the entrance to Lymington River, England.
29 Sep	Collision between the UK registered ro-ro passenger ferry <i>Red Falcon</i> and the motor cruiser <i>Phoenix</i> in the Thorn Channel, Southampton, England.
21 Oct	Collision between the UK registered ro-ro passenger ferry <i>Red Falcon</i> and the moored yacht <i>Greylag</i> in Cowes Harbour, Isle of Wight, England. The ferry subsequently ran aground and the yacht sank.
6 Nov	Close quarters incident between the UK registered ro-ro ferry Stena Superfast VII and a submerged Royal Navy submarine in the Irish Sea.
14 Dec	Machinery space fire on board the UK registered ro-ro passenger ferry Wight Sky at the entrance to Lymington River, England.
15 Dec	Grounding of the Cyprus registered container feeder vessel <i>Thea II</i> in the approaches to the Humber Estuary, England and the subsequent grounding of the UK registered tug <i>Svitzer Josephine</i> during the recovery operation.
17 Dec	Fall from height on board the Cyprus registered ro-ro freight ferry Seatruck Pace while alongside in Liverpool, England with the loss of one life.
18 Dec	Grounding of the Russia registered bulk carrier <i>Kuzma Minin</i> off Falmouth, England.
18 Dec	Cargo shift of freight vehicles on the Bahamas registered ro-ro passenger ferry <i>European Causeway</i> during heavy weather while on passage from Larne, Northern Ireland, to Cairnryan, Scotland.

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PART 2: RECOMMENDATIONS AND PUBLICATIONS

Recommendation



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INVESTIGATIONS PUBLISHED IN 2018 INCLUDING RECOMMENDATIONS ISSUED

The following pages list the accident investigation reports and safety bulletins published by the MAIB during 2018. 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.

For details of abbreviations, acronyms and terms used in this section please refer to the Glossary on page 97.

***Status as of 31 May 2019**

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 that 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.

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RECOMMENDATION RESPONSE STATISTICS 2018

36 recommendations were issued to **41** addressees in 2018. The percentage of all recommendations that are either *accepted and implemented* or *accepted yet to be implemented* is **85.4%**.

		Accepted Action				
Year	Total*	Implemented	Yet to be Implemented		Rejected	No Response Received
2018	41	28	7	5	0	1

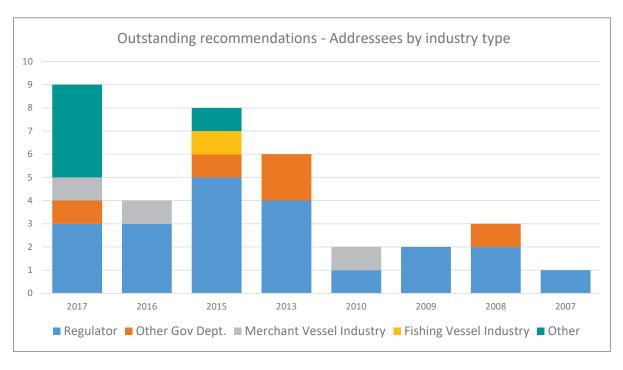
*Total number of addressees

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RECOMMENDATION RESPONSE STATISTICS 2007 TO 2017

The chart below shows the number of recommendations issued under the closed-loop system that remain outstanding as of May 2019. There are no outstanding recommendations from 2004-2006, 2011-2012 and 2014.



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SUMMARY OF 2018 PUBLICATIONS AND RECOMMENDATIONS ISSUED

	Vessel name(s)	Category	Publication date (2018) and report number	Page
	CV30①	Very Serious Marine Casualty	9 January - Safety Bulletin (No <u>SB1/2018</u>)	15
	Windcat 8	Serious Marine Casualty	28 February (No <u>1/2018</u>)	15
	Vertrouwen/James 2	Very Serious Marine Casualties	7 March (No <u>2/2018</u>)	16
<u> </u>	Saga Sky/Stema Barge II	Serious Marine Casualty	15 March (No <u>3/2018</u>)	17
	Constant Friend	Very Serious Marine Casualty	21 March (No <u>4/2018</u>)	18
	Enterprise	Very Serious Marine Casualty	10 April (No <u>5/2018</u>)	19
	Formula 4 powerboats	Serious Marine Casualty	12 April (No <u>6/2018</u>)	20
MOKING	Huayang Endeavour /Seafrontier	Serious Marine Casualty	25 April (No <u>7/2018</u>)	20
AVI:	Ocean Prefect	Serious Marine Casualty	10 July (No <u>8/2018</u>)	21
	Islay Trader	Serious Marine Casualty	9 May (No <u>9/2018</u>)	21
	Ocean Way	Very Serious Marine Casualty	24 May (No <u>10/2018</u>)	22
(Q)	Throw bag rescue lines②	Marine Incident	1 June - Safety Bulletin (No <u>SB2/2018</u>)	23
	Ruyter	Serious Marine Casualty	20 June (No <u>11/2018</u>)	23
	CV24	Very Serious Marine Casualty	28 June (No <u>12/2018</u>)	24
	Veruna	Very Serious Marine Casualty	4 July (No <u>13/2018</u>)	26
	Tyger of London [®]	Very Serious Marine Casualty	n/a, recommendation issued pre-publication by letter	25

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Vessel name(s)	Category	Publication date (2018) and report number	Page
Wight Sky	Serious Marine Casualty	18 July (No <u>14/2018</u>)	26
Tyger of London®	Very Serious Marine Casualty	1 August - Safety Bulletin (No <u>SB3/2018</u>)	27
Illustris	Very Serious Marine Casualty	9 August (No <u>15/2018</u>)	28
Eddystone and Red Eagle	Marine Incidents	12 September (No <u>16/2018</u>)	28
CMA CGM Centaurus	Serious Marine Casualty	18 October (No <u>17/2018</u>)	29
Sunbeam [®]	Very Serious Marine Casualty	19 October - Safety Bulletin (No <u>SB4/2018</u>)	31
Celtic Spirit	Serious Marine Casualty	31 October (No <u>18/2018</u>)	31
North Star	Very Serious Marine Casualty	8 November (No <u>19/2018</u>)	32
Solstice	Very Serious Marine Casualty	6 December (No <u>20/2018</u>)	33
SMN Explorer	Very Serious Marine Casualty	13 December (No <u>21/2018</u>)	34

- ① Report published on 20 June 2019.
- ② Report published on 31 January 2019.
- ③ *Tyger of London* is under investigation.
- 4 Sunbeam is under investigation.

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CV30

Safety Bulletin number: SB1/2018

Commercial racing yacht

Accident date:

18/11/2017

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Man overboard in the Indian Ocean with the loss of 1 life

Safety Issue

► Tether hook entanglement with securing point

The bulletin was intended to raise awareness of the need to prevent lateral loading of safety tether hooks.

No recommendations were made.



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Windcat 8

Report number:

1/2018

Windfarm crew transfer vessel

Accident date:

7/9/2017

Catastrophic engine failure resulting in a fire off the Lincolnshire coast

Safety Issues

- ► Fire following catastrophic engine failure
- ► Engine warning alarm not thoroughly investigated
- Fixed fire-fighting system ineffective because engine space vents were left open



No Recommendation(s) to:

Windcat Workboats BV Ltd

Provide training and guidance on the action to be taken for all critical propulsion alarms, and to introduce measures to ensure its crews understand the principles of the installed fixed fire-fighting systems and are fully familiar with procedures for their operation.

Appropriate action implemented



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Vertrouwen/James 2

Fishing vessel (DS11)/Motor cruiser

Report number:

Accident date:

2/2018

6/8/2017

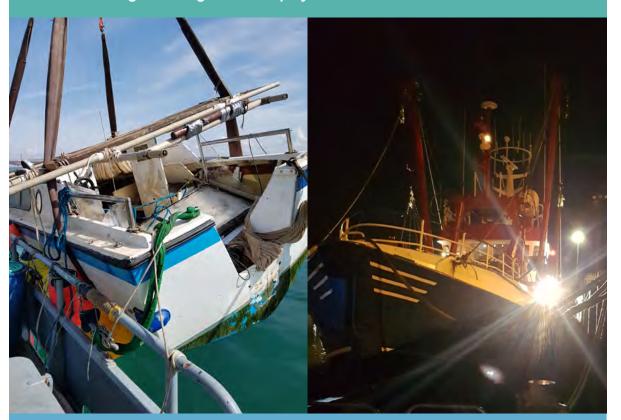
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Collision resulting in the sinking of the motor cruiser James 2 in Sussex Bay, Shoreham-by-Sea, with the loss of 3 lives

Safety Issues

- No effective lookout on either vessel
- Fishing vessel watchkeeper distracted by mobile phone and laptop
- Personal flotation devices not worn by sea anglers
- Correct navigational lights not displayed



Recommendation(s) to: No

Macduff Shellfish (Scotland) Ltd

Provide guidance within its safety management system regarding the keeping of 102 a safe navigational watch, and to promulgate MGN 313(F) to all its skippers and crews.

Appropriate action implemented

103 Provide guidance within its safety management system to skippers with regard to the completion of E-log departure reports to ensure that it does not impact on the ability to maintain a safe navigational watch.

Appropriate action implemented (



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Saga Sky/Stema Barge II

General cargo vessel/Rock carrying barge

Report number:

3/2018

Accident date: 20/11/2016

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Collision resulting damage to subsea power cables off the Kent coast

Safety Issues

- Delayed use of anchors
- ► Admiralty chart out of date
- Weather forecast not considered in passage planning



No Recommendation(s) to:

Maritime and Coastguard Agency

104 Commission a study to review the full range of emergency response assets available in the Dover Strait area, including a reassessment of the need for a dedicated emergency towing capability.

Appropriate action planned:

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No Recommendation(s) to: Marine Management Organisation

105 Improve its marine licence application process by:

- Highlighting precisely what activities the particular marine licence is to cover, including any specified risks to be assessed in the submission.
- Clearly stipulating a requirement that the latest nautical publications are referred to in the submission.
- Ensuring that its primary advisors are clear on the objectives of their respective reviews and the elements of the application they are required to assess.

Appropriate action implemented (





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No Recommendation(s) to: United Kingdom Hydrographic Office

Adopt the International Hydrographic Organization's recommendation for responsible authorities to set a minimum distance, nominally 0.25nm, from submarine cables, within which ships should avoid anchoring or conducting other underwater activities.

Appropriate action implemented **(**



No Recommendation(s) to: Maritime and Coastguard Agency/United Kingdom Hydrographic Office

Justify the need for regulatory powers which could be applied, where appropriate, to ensure vessels comply with International Hydrographic Organization recommendations made with respect to anchoring in the vicinity of submarine cables.

MCA: Appropriate action planned:

2019 DECEMBER 31

DECEMBER 31

UKHO: Appropriate action planned:

No Recommendation(s) to: Anglo-Eastern Ship Management Ltd

108 Enhance its shipboard procedures by developing vessel-specific guidance that its masters can refer to in order to estimate the effect forecast heavy weather conditions could have on their ships' manoeuvrability.

Appropriate action implemented



Constant Friend

Report number: 4/2018

Stern trawler (N83) Accident date: 23/9/2017

Fatal man overboard in Kilkeel Harbour

Safety Issues

- ► Alcohol consumption
- ► Climbing over the guardrails to cross between boats
- ► No risk assessment for means of access
- ► No manoverboard recovery device



No Recommendation(s) to: Maritime and Coastguard Agency

109 Review and amend MGN 337(M+F) – Provision of Safe Means of Access to Fishing and Other Small Vessels – to highlight the need for risk assessments to specifically include the hazards associated with crew members proceeding to and from the shore for recreational activities. The guidance should include suggested control measures such as the provision of guardrail gates and a formal arrangement for a nominated crewman to monitor and assist individuals boarding the boat.

Appropriate action implemented 🗸



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110 Review and amend MGN 413(F) – Voluntary Code of Practice for Employment of non-European Economic Area (EEA) Fishing Crew – to clarify the requirement, or otherwise, to seek Border Force authorisation before allowing non-EEA fishing crew to proceed ashore for local leave.

Appropriate action planned:

Owner of Constant Friend

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Appropriate action implemented

Develop a contact card and procedure to enable crew to directly and immediately 112 alert the emergency services (when in port).

the provision of guardrail gates and a formal arrangement for a nominated

crewman to monitor and assist individuals boarding the boat.

Review Constant Friend's risk assessment relating to boarding and leaving the boat. The risk assessment should include the hazards associated with crew

members proceeding to and from the shore for recreational activities, and take

into account the increased risk of a crew member falling in as a result of adverse environmental conditions. Suggested control measures for consideration include

Appropriate action implemented



Enterprise

No

111

Report number: 5/2018

Potting fishing vessel (SH323)

Recommendation(s) to:

Accident date: 6/4/2017

Fatal man overboard while 6 miles off Scarborough

Safety Issue

Deckhand entangled in potting gear

Following the accident, the owner/skipper fitted a closed-circuit television system to enable the working deck to be monitored from inside the wheelhouse. He also retired from fishing and put the vessel up for sale.

Due to the actions taken, no recommendations were made.



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Formula 4 powerboats

Racing powerboats Accident date: 2/7/2017

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Collision on Stewartby Lake, Bedfordshire resulting in 1 person injured

Safety Issues

- Collision following loss of control of F4 powerboat
- Driver trapped in upturned boat
- ► Insufficient emergency air supply



Report number:

No Recommendation(s) to: Royal Yachting Association

113 Review the escape protocols taught by its approved driver immersion test centres to ensure they are in accordance with UIM guidance and include lessons learnt from this accident, such as the importance of the emergency air supply, access to harness release buckles and the carriage and use of a rescue knife.

Appropriate action implemented (



6/2018

Huayang Endeavour/Seafrontier Report number: 7/2018

Bulk carrier/oil tanker Accident date: 1/7/2017

Collision between bulk carrier and oil tanker in the Dover Strait

Safety Issues

- ► Inappropriate use of VHF
- ➤ Seafrontier's bridge team did not monitor Huayang Endeavour and were unaware of the bulk carrier's position before manoeuvring
- ► Failure to comply with COLREGs

Following an internal investigation *Huayang Endeavour*'s manager amended its procedures for the use of VHF for collision avoidance, and promulgated the lessons learned from this accident to its fleet. The manager of *Seafrontier*

also completed an internal investigation and took a number of steps to train its personnel in bridge and crew resource management, review its procedures, and promulgated the lessons from this accident to its fleet.

Due to the actions taken, no recommendations were made.

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Ocean Prefect

Report number:

8/2018

Bulk carrier Accident date: 10/7/2017

CHIEF INSPECTOR'S REPORT

Two groundings at Ahmed Bin Rashid Port, Umm Al Qaywayn, United Arab Emirates

Safety Issues

- ► Pilot's lack of local knowledge
- Effects of tidal stream not fully appreciated
- Potentially misleading navigation marks



In December 2017, the Chief Inspector of Marine Accidents presented the safety issues identified in the investigation to the United Arab Emirates' Federal Transport Authority. The Federal Transport Authority liaised with the Ahmed Bin Rashid Port and Free Zone Authority to introduce measures to improve the safety of navigation in Umm Al Qaywayn. In addition, *Ocean Prefect*'s manager promulgated the lessons learned from the vessel's groundings to its fleet.

Due to the actions taken, no recommendations were made.

Islay Trader

General cargo vessel

Report number: 9/2018

Accident date: 8/10/2017

Grounding at Margate

Safety Issues

- Navigational practices compromised by bridge manning levels
- Position of ship not monitored by crew, so unaware of the vessel dragging its anchor
- Insufficent length of anchor cable used



No Recommendation(s) to:

Faversham Ships Ltd

- Take measures to help ensure that navigation and bridge watchkeeping practices on board its vessels are maintained to an acceptable standard, focusing on, inter alia:
 - The impact of operational pressures and demands on board vessels with only two bridge watchkeepers.
 - The conduct of anchorage planning and anchor watches.
 - The recognition of circumstances warranting the master's input and oversight.

Appropriate action implemented (



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Ocean Way

Report number:

10/2018

Stern trawler (LK207)

Accident date:

3/3/2017

CHIEF INSPECTOR'S REPORT

Flooding and sinking off Lerwick

Safety Issues

- ► No bilge suction in flooded compartment
- ► Emergency drills not regularly conducted



No Recommendation(s) to:

Maritime and Coastguard Agency

- Update the Fishermen's Safety Guide to include guidance on the emergency preparation and emergency response for flooding emergencies, including stability considerations.
 - Review and, where appropriate, update its guidance to the fishing industry and its marine surveyors on:
 - the maintenance of watertight integrity in fishing vessels where drain valves are fitted through watertight bulkheads.
 - the construction standards of 15 24m fishing vessels to ensure that all watertight compartments are fitted with a dedicated bilge suction. A clearer definition of peak compartments should also be considered.

Appropriate action planned:





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Throw bag rescue lines

Safety Bulletin number: SB2/2018

Accident date: 24/03/2018

CHIEF INSPECTOR'S REPORT

Failure of a throw bag rescue line during a boat capsize rescue drill

Safety Issues

n/a

- ► Failure of a throw bag rescue line
- ► Throw line weakened by fused connections
- Poor manufacturing technique and quality control



This safety bulletin was issued to highlight a safety issue concerning the possibility of the rescue lines having weak points that could fail under load in a rescue situation.

No recommendations were made.

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Ruyter

General cargo vessel

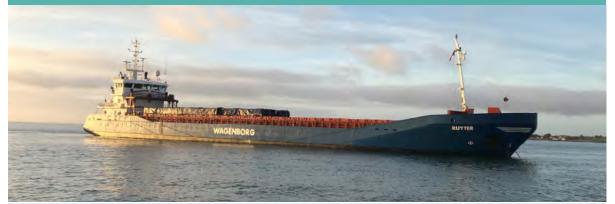
Report number: 11/2018

Accident date: 10/10/2017

Grounding on Rathlin Island off the coast of County Antrim

Safety Issues

- ▶ Bridge navigational watch alarm system was switched off
- ► Excessive alcohol consumption
- ▶ Alcohol consumption not challenged by other crew members



The ship's manager took action, including the introduction of random alcohol testing and the empowerment of its crews to notify the company whenever there are concerns relating to the safe operation of their vessels.

Due to the action taken, no recommendations were made.

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CV24

12/2018 **Report number:**

Commercial racing yacht

Accident date:

31/10/2017

Grounding and loss of yacht at Cape Peninsula, South Africa

Safety Issues

- ► Insufficient supervision of inexperienced crew
- Ineffective passage planning



Recommendation(s) to: No

Maritime and Coastguard Agency

Provide guidance and direction on safety management to Clipper Ventures plc in 116 order to assure the safe operation of the company's yachts in accordance with the Small Commercial Vessel Code.

Appropriate action planned:

STATISTICS

Clipper Ventures plc No **Recommendation(s) to:**

- Review and improve company safety management procedures in co-operation 117 with the Maritime and Coastguard Agency and aligned with the guidance proposed in MAIB recommendation 2018/116 above. This review should ensure that:
 - Risk assessments for on-water operations identify all hazards and set out appropriate mitigating measures.
 - Accidents and incidents are thoroughly investigated so that causal factors and lessons are identified in order that, where necessary, changes are made to company procedures to minimise the risk of recurrence.
 - There is guidance and terms of reference for members of staff with responsibility for safety management.

Partially accepted: NO DATE



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- 118 Update procedures for the safe navigation of its vessels at all times when underway, including:
 - Defining the role, responsibility, training and experience necessary of a nominated navigator.
 - Ensuring that thorough passage plans are prepared, taking into account guidance identified in this report.
 - Ensuring that procedures include instructions when the nav station should be manned and navigation reporting policies between the nav and helm stations.
 - Provision of training and guidance for all crew who may have navigation duties in the use of electronic navigational systems and how to identify hazards ahead within the determined fixing interval.

Partially accepted: NO DATE

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MAIB comment:

Clipper Ventures plc initially indicated its intention to implement elements of the above recommendations. Following the publication of MAIB report 7/2019 (CV30) the company's position has become less clear, and clarification is being sought.

Tyger of London

Recommendation issued pre-publication by letter

Commercial sailing yacht

Accident date:

7/12/2017

Update requested

GIVEN

Keel failure and capsize off Punta Rasca, Tenerife

Safety Issues

- ► Keel failure due to poor construction
- ► Inability to identify failure point



No Recommendation(s) to:

British Marine

Propose to the International Organization for Standardisation that the requirement for 'information connected with the risk of flooding and stability', detailed in ISO 10240 (Small craft-Owner's manual), be enhanced to include advice to owners of sailing vessels on the construction of the craft's keel; and the occasions for, and methods of, inspection designed to verify its structural integrity.

Appropriate action implemented (

Varuna

Report number: 13/2018

Creel fishing vessel (BRD684)

Accident date:

20/11/2018

Fatal man overboard west of Camusterrach in the Scottish Highlands

Safety Issues

- ▶ No PFD worn and no PLB carried
- Shooting gate not closed when not in use
- ► Single-handed fisherman



The MAIB formally responded to the consultation on the implementation of ILO 188 emphasising the need for the impending legislation to address the safety issues identified in this report.

Due to the action taken, no recommendations were made.

Wight Sky

Report number:

14/2018

Ro-ro passenger ferry

Accident date:

12/9/2017

Catastrophic engine failure and fire off Yarmouth, Isle of Wight

Safety Issues

- ► Fire following catastrophic engine failure
- ► Maintainance management and quality control issues during engine assembly
- ► Fixed fire-fighting system not ready for immediate use



No Recommendation(s) to:

Volvo Group (UK) Ltd

120 Consider offering wear particle detection technology for Volvo Penta marine engines that cannot be easily serviced on board.

Appropriate action implemented **(**



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Tyger of London

Safety Bulletin number: SB3/2018

Commercial sailing yacht

Accident date:

7/12/2017

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Keel failure and capsize off Punta Rasca, Tenerife

Safety Issues

- ► Keel failure due to poor construction
- ► Inability to identify failure point

The bulletin was issued to highlight a safety concern about yachts with keels fabricated in a similar manner to the 'shallow draught lead keel' fitted to Tyger of London.



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No recommendations were made in this bulletin. However, a recommendation was issued pre-publication by letter from the Chief Inspector to British Marine (see recommendation no 119/2018 on page 25).

Finlandia Seaways

Recommendation issued pre-publication by letter

Ro-ro cargo vessel

Accident date:

16/4/2018

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Engine failure and fire off Lowestoft resulting in injury to a crewman

Safety Issues

- ► Fire following catastrophic engine failure
- Maintainance management and quality control issues at service agent's workshop
- ► Failure to comply with manufacturer's maintenance instructions



No Recommendation(s) to: MAN Diesel & Turbo SE / Lloyd's Register EMEA (Klaipėda branch)

Provide technical advice to AB DFDS Seaways on the actions the company should 121 take to minimise the risk of a similar catastrophic engine failure on board Botnia Seaways, and any other vessel operators whose MAN engines might have been subject to similar maintenance practices.

MAN Diesel & Turbo SE: Appropriate action implemented



Lloyd's Register EMEA: Appropriate action implemented **V**



PART 3 **STATISTICS**

Illustris

15/2018 **Report number:**

Stern trawler (B119) Accident date: 12/11/2017

Fatal man overboard at Royal Quays Marina, North Shields

Safety Issues

- ► Alcohol consumption
- Means of access to fishing vessel
- Alarm not raised



No **Recommendation(s) to:** **Sagittarius Fishing Co Ltd**

- Take account of the hazards associated with crew members proceeding to and 122 from shore for recreational activities by:
 - Reviewing and enhancing Illustris's risk assessment relating to boarding and leaving the vessel, including the need for a nominated crewman to monitor and assist individuals board the vessel.
 - Establishing a formal drug and alcohol policy that will apply to the crew at all times when living or working on board.
 - Ensuring crew members attend all of the mandatory safety training courses.

Appropriate action implemented (



Eddystone/Red Eagle

Ro-ro cargo vessel/ro-ro passenger ferry

Report number: 16/2018 Accident dates: 8/6/2016 and 17/7/2017

Unintentional release of carbon dioxide from fixed fire-extinguishing systems in the southern Red Sea and in The Solent

Safety Issues

- ► Inadequate maintenance of fire-extinguishing
- Insufficient industry guidance for maintaining fixed fire-extinguishing equipment



Recommendation(s) to: No

Maritime and Coastguard Agency

Ensure that surveys check that all safety devices fitted to CO₂ fixed fire-123 extinguishing systems are appropriately maintained and surveyed.

Appropriate action implemented **(**



124 Seek clarification from the IMO of the maximum permitted periodicity between hydrostatic tests of individual high pressure cylinders, as detailed in MSC.1/ Circ.1318 ANNEX B 6.1.2.

Appropriate action implemented **(**



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No Recommendation(s) to:

Det Norske Veritas – Germanischer Lloyd/ Lloyd's Register

Propose to the International Association of Classification Societies that an investigation be carried out into the application of Procedural Requirements for Service Suppliers, UR Z17. This should take into consideration the finding of this report, that the level of service provided by approved service suppliers regularly fails to maintain the safety of CO₂ based fixed fire-extinguishing systems on ships.

Det Norske Veritas – Germanischer Lloyd: Appropriate action implemented



Lloyd's Register: Appropriate action implemented



No Recommendation(s) to: Red Funnel

Review the design of the CO₂ fixed fire-extinguishing systems fitted to its vessels where the leakage of a single cylinder valve causes the entire system to discharge.

Appropriate action implemented (



MAIB comment:

It was disappointing that the review carried out by the vessel operator did not result in design change following cost/benefit analysis.

CMA CGM Centaurus

Report number:

17/2018

Container vessel

Accident date:

4/5/2017

Heavy contact with the quay and two shore cranes at the Port of Jebel Ali, United Arab Emirates

Safety Issues

- ► Ineffective master/pilot exchange
- ► No detailed pilotage plan
- **▶** Commercial pressures
- Ineffective bridge resource management



No Recommendation(s) to:

DP World UAE Region

- Review and improve its management of pilotage and berthing operations in respect of large container ship movements within the port of Jebel Ali, with particular regard to the following:
 - Development of approved pilotage and manoeuvring plans, including optimum use of tugs and ensuring ships do not commit to the buoyed channel until completion of a detailed and effective master/pilot information exchange.
 - Provision of approved pilotage and manoeuvring plans to a visiting ship as soon as practicable prior to the pilot boarding.

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- Provision of Bridge Resource Management training specifically tailored to meet the needs of pilots.
- Removal of Key Performance Indicators that potentially create inappropriate performance bias towards efficiency against safety.

Appropriate action planned: NO DATE



No Recommendation(s) to:

International Chamber of Shipping/
International Maritime Pilots' Association/
International Harbour Masters' Association

- 128 Conduct a joint campaign of information for ships' bridge teams, pilots and port authorities designed to:
 - Promote the benefits of adhering to effective bridge resource management procedures during acts of pilotage.
 - Endorse the BRM-P course as an effective means of providing pilots with the necessary skills to best utilise the resources available during acts of pilotage.

ICS - partially accepted: NO DATE



IMPA - partially accepted: NO DATE



IHMA - partially accepted: NO DATE



MAIB comment:

ICS, IMPA and IHMA did not agree that a joint campaign was appropriate given the circumstances of this accident. However, ICS and IMPA have agreeed to review their guidance on the master/pilot relationship at the next change, with a view to removing any potential scope for ambiguity. ICS and IMPA have also agreed to circulate to their members the forthcoming IHMA guidance that will set out expectations for the conduct of pilotage in harbour authority areas.



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Sunbeam

Safety Bulletin number: SB4/2018

Pelagic trawler (FR487)

Accident date:

14/08/2018

CHIEF INSPECTOR'S REPORT

Fatal enclosed space accident when working in a refrigerated salt water tank alongside at Fraserburgh

Safety Issues

- Entry into an enclosed space where the atmosphere would not support life
- Enclosed space entry procedures and lone working
- ► Lack of enclosed space rescue equipment



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No Recommendation(s) to:

Sunbeam's owners

S129 Conduct risk assessments specifically for entering and working in RSW tanks and provide safe operating procedures for its crew to follow and appropriate levels of safety equipment to use.

Appropriate action implemented (



Celtic Spirit

Report number:

18/2018

General cargo vessel

Accident date:

1/3/2018

Dragging anchor and subsequent collisions with two anchored vessels on the River Humber

Safety Issues

- ► Detailed anchorage plan not carried out
- ► Scope of anchor cable insufficient
- Anchor position not monitored
- ► Engines not at immediate readiness

Celtic Spirit's owner took action, with its fleet, to raise the standards of anchor watchkeeping and to clarify the term 'main engine stand-by'. ABP Humber completed an

anchorage review and implemented measures designed to mitigate the risk factors identified during the investigation.

Due to the actions taken, no recommendations were made.

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North Star

Report number:

19/2018

Creel fishing vessel (WK 673)

Accident date:

5/2/2018

Fatal man overboard off Cape Wrath

Safety Issues

- The vessel's documented risk controls did not reflect the operational practice on board
- Crewman entangled in back rope and dragged overboard
- ► No barrier between crewman and potting gear
- Owners were not experienced in fishing vessel management



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Recommendation(s) to: No

Scrabster Seafoods Limited

- Improve the overall safety of its crews by ensuring that: 130
 - Documented risk assessments remain appropriate to the vessel's fishing operation and reflect industry best practice.
 - Annual self-certification is conducted, risk assessments are reviewed at least annually, and crew training and certification remain valid.
 - Mandatory vessel surveys and inspections are applied for at the required times.
 - Practical emergency drills are conducted at least monthly and in accordance with industry best practice.
 - Skippers are clear on their delegated responsibilities in implementing the vessel's health and safety policy.

Appropriate action implemented



No **Recommendation(s) to:**

Maritime and Coastguard Agency

- Improve its support to commercial fishing vessel owners by: 131
 - Providing new owners of fishing vessels with guidance on the applicable regulatory requirements and published best practice.
 - Conducting a safety inspection following a change of fishing vessel ownership.
 - Providing timely reminders to fishing vessel owners of the need to apply for due surveys and inspections.

Appropriate action implemented (



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GLOSSARY RESOURCES Solstice

Report number: 20/2018

Scalloper/trawler (PH119)

Accident date:

26/9/2017

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Capsize and sinking off Plymouth with loss of 1 life

Safety Issues

- ▶ Crew attempted to lift heavy catch on board over the stern from a high point
- ► Stability assessment not carried out following vessel modifications and change in fishing methods
- ▶ PFDs not worn on deck
- ► SAR efforts hampered by lack of AIS, EPIRB and/or PLBs



132 Commission an independent review of UK SAR operational capability and HMCG network functionality to assess the effectiveness of the actions taken as a result of the lessons identified in the MAIB and Irish Coast Guard *Solstice* investigation reports.

Appropriate action planned:





133 Conduct a thorough review of SAR IT systems to ensure a reliable network function with accessible information exchange between CGOCs and the NMOC, identifying areas for improvement within the SAR IT systems infrastructure.

Appropriate action implemented 🗸



SMN Explorer

General cargo vessel

Report number:

Accident date:

21/2018

1/2/2018

Uncontrolled closure of a hatch cover at Alexandra Dock, King's Lynn

with the loss of 1 life

Safety Issues

- ► Planning and supervision of deck operations
- ► No risk assessments or safe system of work
- Weak safety culture onboard vessel



No Recommendation(s) to:

Sky Mare Navigation Co

Take appropriate action to remove the need for deck crew to climb onto the stowage hatch coamings and cover, and walk across uneven surfaces to routinely attach and disconnect the foremast crane hook.

Appropriate action implemented



Ensure that *SMN Explorer* and all its managed vessels have systems in place to manage and record the maintenance of lifting appliances.

Appropriate action implemented **(**



Take appropriate actions to improve the level of safety culture on board *SMN Explorer* and its other managed vessels.

Appropriate action implemented **(**





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	Toby Wallace	1 February 2017 (No <u>2/2017</u>)	38
	CV21	12 April 2017 (No <u>7/2017</u>)	39
	Pauline Mary	4 May 2017 (No <u>8/2017</u>)	39
	Love for Lydia	11 May 2017 (No <u>9/2017</u>)	40
Marketine (Osprey/Osprey II	18 May 2017 (No <u>10/2017</u>)	40
	Zarga	15 June 2017 (No <u>13/2017</u>)	41
	Surprise	29 June 2017 (No <u>14/2017</u>)	43
	Louisa	27 July 2017 (No <u>17/2017</u>)	44
	Sunmi/Patrol	12 October 2017 (No <u>21/2017</u>)	44
	Typhoon Clipper/Alison	2 November 2017 (No <u>24/2017</u>)	45
anna V	CV24	n/a, recommendation issued pre- publication by letter	46
	Nortrader	7 December 2017 (No <u>26/2017</u>)	46
2016 RECOM	MENDATIONS - PROGRES	S REPORT	47
1	Hoegh Osaka	17 March 2016 (No <u>6/2016</u>)	47
11	Cemfjord	21 April 2016 (No <u>8/2016</u>)	48
4570	Asterix	12 May 2016 (No <u>10/2016</u>)	49
1	Carol Anne	9 June 2016 (No <u>11/2016</u>)	49

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	JMT	7 July 2016 (No <u>15/2016</u>)	50
HE SAFE MARKET	Arco Avon	1 September 2016 (No <u>17/2016</u>)	51
N	Aquarius	6 October 2016 (No <u>18/2016</u>)	51
To apply	Annie T	3 November 2016 (No <u>21/2016</u>)	52
	Daroja Erin Wood	22 December 2016 (No <u>27/2016</u>)	52
2015 RECOM	MENDATIONS - PROGRESS F	REPORT	53
	Cheeki Rafiki	29 April 2015 (No <u>8/2015</u>)	53
	Commodore Clipper	6 August 2015 (No <u>18/2015</u>)	54
	Beryl	2 December 2015 (No <u>26/2015</u>)	56
	Stella Maris	10 December 2015 (No <u>29/2015</u>)	55
2014 RECOM	MENDATIONS - PROGRESS F	REPORT	57
	Danio	2 April 2014 (No <u>8/2014</u>)	57
	Eshcol	11 June 2014 (No <u>14/2014</u>)	57
	Wacker Quacker 1/Cleopatra	17 December 2014 (No <u>32/2014</u>)	58
2013 RECOM	MENDATIONS - PROGRESS F	REPORT	59
	St Amant	9 January 2013 (No <u>1/2013</u>)	59
	Heather Anne	10 January 2013 (No <u>2/2013</u>)	59
OHIG4	Purbeck Isle	2 May 2013 (No <u>7/2013</u>)	60

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ONZ40	Sarah Jayne	13 June 2013 (No <u>13/2013</u>)	61
	Vixen	20 June 2013 (No <u>16/2013</u>)	61
4	Audacious/Chloe T (combined report)	19 December 2013 (No <u>27/2013</u>)	62
2012 RECOM	MENDATIONS - PROGRESS F	REPORT	62
No recomme	ndations outstanding for 2012		
2011 RECOM	MENDATIONS - PROGRESS F	REPORT	62
No recomme	ndations outstanding for 2011		
2010 RECOM	MENDATIONS - PROGRESS F	REPORT	63
A DE	Bro Arthur	19 August 2010 (No <u>9/2010</u>)	63
	Olivia Jean	26 August 2010 (No <u>10/2010</u>)	63
2009 RECOM	MENDATIONS - PROGRESS F	REPORT	64
	Celtic Pioneer	21 May 2009 (No <u>11/2009</u>)	64
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4	Danielle	29 March 2007 (No <u>5/2007</u>)	66

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*Status as of 31 May 2019

Toby Wallace Report number: 2/2017 Accident date: Ocean rowing boat 14/2/2016

Fatal man overboard in the North Atlantic Ocean

No **Recommendation(s) to: British Rowing/ Maritime and Coastguard Agency** Work together in order to assess the feasibility of developing means by 2017/101 which commercially operated ocean rowing boats can demonstrate equivalent safety standards to those required of other small vessels in commercial use for sport or pleasure.

British Rowing: Appropriate action implemented

MCA: Appropriate action implemented

MAIB comment

Following review of inherit characteristics of ocean rowing, both MCA and British Rowing concluded that ocean rowing boats could not meet equivilent safety standards to those vessels in commercial use for sport or pleasure.

No **Recommendation(s) to: British Rowing** 2017/102 Liaise with stakeholders to develop and promulgate a best practice guide or a code of practice for ocean rowing, taking into account, inter alia: · Boat design, construction and stability Minimum training requirements Minimum equipment requirements Onboard procedures

Shore-based and seaborne support.

Appropriate action implemented





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No	Recommendation(s) to: Oceanus Rowing Limited
2017/103	Review its risk assessments for the conduct of future ocean crossings and take measures as necessary to ensure its crews are appropriately fit, trained and competent, and the necessary equipment, training and procedures are in place to reduce the risk of rowers coming to harm to as low as reasonably practicable.

Withdrawn

MAIB comment:

Oceanus Rowing Limited is no longer involved in ocean rowing events.

CV21 Report number: 7/2017
Commercial racing yacht Accident dates: 4/9/2015 and 1/4/2016

Combined report on the investigations of the fatal accident while

122nm west of Porto, Portugal on 4 September 2015 and the fatal person overboard in the mid-Pacific Ocean on 1 April 2016

No Recommendation(s) to: Royal Yachting Association/
World Sailing/British Marine

2017/109 Work together to develop and promulgate detailed advice on the use and limitations of different rope types commonly used, including HMPE, in order to inform recreational and professional yachtsmen and encourage them to consider carefully the type of rope used for specific tasks on board their vessels.



World Sailing: Appropriate action implemented 🗸



British Marine: Appropriate action planned:



Pauline MaryReport number:8/2017Potting fishing vessel (WY845)Accident date:2/9/2016

Fatal man overboard east of Hartlepool

No	Recommendation(s) to: Maritime and Coastguard Agency
2017/111	Provide updated guidance on the carriage of passengers or guests on board commercial fishing vessels during operations.
	Appropriate action implemented ©

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Love for Lydia

Report number:

9/2017

Motor cruiser

Accident date: Between 7 and 9/6/2016

INSPECTOR'S REPORT

Carbon monoxide poisoning on Wroxham Broad resulting in two fatalities

No	Recommendation(s) to: British Marine
2017/113	Seek clarification from the Recreational Craft Sectoral Group concerning whether a requirement to install carbon monoxide detection systems falls within the scope of the RCD's essential requirements, particularly requirement 5.1.1.

Appropriate action implemented

MAIB comment:

While British Marine has satisfactorily completed the recommendation and Recreational Craft Sectoral Group's response resolves any ambiguity over the requirement to fit CO detector devices, the response does not improve future safety.

•	, , ,
No	Recommendation(s) to: Boat Safety Scheme
2017/114	Make the installation of carbon monoxide alarms a requirement for recreational craft participating in the Boat Safety Scheme, taking into account, among other things, the:
	 Potential risk posed to other boat users by carbon monoxide-rich engine emissions.
	Various sources of carbon monoxide on board recreational craft.
	 Number of recent deaths of recreational boaters caused by carbon monoxide poisoning.
	Relatively low cost of carbon monoxide alarms.
	Appropriate action implemented 🐓

Osprey/Osprey II **Report number:** 10/2017 RIBs Accident date: 19/7/2016

> Collision between two rigid inflatable boats resulting in serious injuries to one passenger on Firth of Forth

No	Recommendation(s) to: Maritime and Coastguard Agency
2017/115	Include in its forthcoming Recreational Craft Code with respect to commercially operated passenger carrying RIBs:
	 A requirement for the certificated maximum number of passengers to be limited to the number of suitable seats designated for passengers.
	 Guidance on its interpretation of "suitable" with respect to passenger seating.

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 A requirement for passengers not to be seated on a RIB's inflatable tubes unless otherwise authorised by the Certifying Authority and endorsed on the RIB's compliance certificate with specified conditions to be met for a particular activity.

Appropriate action planned:

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No Recommendation(s) to: Royal Yachting Association/ Passenger Boat Association

2017/116

Review the content of the two documents 'Passenger Safety on Small Commercial High Speed Craft' and 'Small Passenger Craft High Speed Experience Rides'. In particular, any ambiguity with respect to seating arrangements for high speed craft should be removed and measures taken to ensure that these documents are updated and remain in line with current thinking and good practice.

RYA: Appropriate action implemented



PBA: Appropriate action implemented 🍑



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ZargaReport number:13/2017LNG carrierAccident date:2/3/2015

Failure of a mooring line while alongside the South Hook Liquefied Natural Gas terminal, Milford Haven resulting in serious injury to an officer

No	Recommendation(s) to: Bridon International Ltd
2017/117	Review and enhance its guidance and instructions for the monitoring, maintenance and discard of HMSF mooring ropes, and bring this to the attention of its customers. The revised guidance should emphasise the importance of:
	Deck fitting and rope D:d ratios.
	Applying appropriate safety factors for given applications.

- Understanding the causes of kinking and the potential impact of axial compression fatigue on the working life of HMSF rope.
- Rope fibre examination and testing as part of the assessment of fibre fatigue degradation and discard.

Appropriate action planned:



2017/118 Conduct whole rope break tests, where practicable, to establish accurate realisation factors for its HMSF ropes.

Recommendation(s) to:

Recommendation(s) to:

No

Appropriate action planned:

Shell International Trading and



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	Recon	mendacion(s) to.	Shipping Company Ltd
201	7/120		ne procurement criteria to ensure rope ndations on safety factors and D:d ratios are
			Appropriate action implemented
201	7/121	Provide its ships' crews wi HMSF mooring ropes.	th comprehensive guidance on the inspection of
			Appropriate action implemented
201	7/122	rope mooring lines with th	onitoring the through-life condition of HMSF ne aim of ensuring ropes are retired and replaced gth drops below their expected working load

Appropriate action implemented

Oil Companies International Marine



Forum
17/123 Consider the safety issues identified in this report during the revision of its Mooring Equipment Guidelines, in particular:
The complex nature of meering rope chan back, and actions that

- The complex nature of mooring rope snap-back, and actions that can be taken to mitigate injury to the crew.
- Factors such as axial compression, cyclic loading, creep, flexing and twisting that will contribute to the loss of strength in HMSF ropes over time.
- Adoption of a safe minimum D:d ratio for all deck fittings using HMSF mooring ropes.
- Through-life monitoring of HMSF mooring rope operating conditions and maintenance to achieve managed discard timescales.

Appropriate action implemented



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2017/125	When updating its OCIMF/SIGTTO guide on purchasing high modulus synthetic fibre mooring lines, ensure the limitations of the tests contained within its "Guidelines for the Purchasing and Testing of SPM Hawsers" are recognised, and that rope performance tests verify an HMSF rope meets a prescribed safe working life.
	Appropriate action implemented

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No **Recommendation(s) to: EUROCORD**

2017/126

Consider the inclusion of the following criteria during the next revision of ISO 2307:2010:

- Full load break tests to be applied to all new rope designs/ constructions and when the molecular properties of fibre material have been significantly altered.
- Clarification that yarn break testing and the resultant realisation factors, as a means of determining rope strength, be treated only as supporting evidence to full rope break testing.
- Indicative realisation factors for HMSF.
- The effects of yarn twist levels on rope strength and fatigue life under varying operating conditions.

Appropriate action planned:



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Surprise 14/2017 **Report number:** Domestic passenger vessel Accident date: 15/5/2016

Grounding and evacuation of vessel at Western Rocks, Isles of Scilly

No	Recommendation(s) to:	Council of the Isles of Scilly
2017/127	Boatman's licences. The re	he examination and issue of Local Authority view should consider the applicability of the rance of examination standards.
		Appropriate action planned: NO DATE





Louisa

Report number:

17/2017

Vivier creel boat (SY30)

Accident date:

9/4/2016

Foundering while at anchor off the Isle of Mingulay in the Outer Hebrides resulting in three fatalities

Urgently conduct research to confirm or otherwise the effectiveness of SOLAS lifejacket water performance test requirements to ensure approved lifejackets will satisfactorily turn a face-down, unconscious person onto their back with sufficient orientation and buoyancy to maintain their airway clear of the water. Any shortcomings in the water performance test requirements that may be identified should be brought to the attention of the International Maritime Organization for action.

Appropriate action planned:

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2017/131

Update and enhance its response to satellite distress beacon alerts, particularly with regard to GNSS enabled EPIRBs, in respect of:

- HMCG's standard operating procedure.
- Staff training, in terms of both Cospas-Sarsat system knowledge and HMCG's operational requirements, including the definition of standard terminology in relation to beacon alerts.
- Network functionality, reliability, supporting interactivity and resource, in terms of both manpower and equipment.

Appropriate action implemented V



Sunmi/Patrol

Report number:

21/2017

General cargo vessel/pilot launch

Accident date:

5/10/2016

Fatal accident during pilot transfer on the River Thames, London

No	Recommendation(s) to: International Maritime Pilots' Association
2017/139	Promulgate the requirements for gateways in vessels' rails or bulwarks intended for pilot boarding operations by updating its <i>Required Boarding Arrangements For Pilot</i> poster to include the amendments contained in IMO Resolution A.1108(29).
	Appropriate action implemented

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Typhoon Clipper/Alison

High-speed passenger catamaran/workboat

Report number:

24/2017

Accident date: 5/

5/12/2016

Collision between the high-speed passenger catamaran Typhoon Clipper and the workboat Alison adjacent to Tower Millennium Pier, River Thames, London

No Recommendation(s) to: Port of London Authority

2017/147 Review and, as necessary, clarify the application of:

 General Direction 28 requiring posting of a lookout or a suitable technical means of maintaining an effective lookout in any vessel with limited visibility.

 Byelaw 43 requiring the use of sound signals for vessels intending to enter the fairway; this should include consideration of vessels departing from a pier.

Appropriate action planned:

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CV24

Recommendation issued pre-publication by letter

Commercial racing yacht

Accident date:

31/10/2017

Grounding and loss of yacht at Cape Peninsula, South Africa

No	Recommendation(s) to: Clipper Ventures plc
2017/151	Take urgent action designed to improve the ability of its skippers and watch leaders to maintain positional awareness while on deck in pilotage and coastal waters. Consideration should be given to:
	 The provision of a navigation/chart display on deck by the helm position;
	 More effective use of onboard navigational equipment to avoid danger, including a means for rapid communication between the navigation station and the helm;
	More clearly defining the duties of the watch navigator.
	Partially accepted: NO DATE GIVEN

Nortrader

Report number:

26/2017

General cargo vessel

Accident date:

13/1/2017

Explosion of gas released from a cargo of unprocessed incinerator bottom ash while at anchorage in Plymouth Sound

No	Recommendation(s) to: Maritime and Coastguard Agency/ Environment Agency
2017/153	Work collaboratively to identify reliable methods and protocols for testing non-homogeneous solid bulk cargoes for the property of evolving flammable gases when wet. MCA: Appropriate action implemented EA: Appropriate action implemented
No	Recommendation(s) to: Maritime and Coastguard Agency
2017/154	Update The Merchant Shipping (Carriage of Cargoes) Regulations 1999 with appropriate references to the IMSBC Code. Appropriate action planned:

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Hoegh Osaka

Report number:

6/2016

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Car carrier

Accident date:

03/01/2015

Listing, flooding and grounding of a car carrier on Bramble Bank, The Solent

No **Recommendation(s) to:** **Maritime and Coastguard Agency**

2016/110

Promulgate the amended version of IMO Resolution A.581(14) in respect of the minimum MSL of lashings to be used when securing road vehicles:

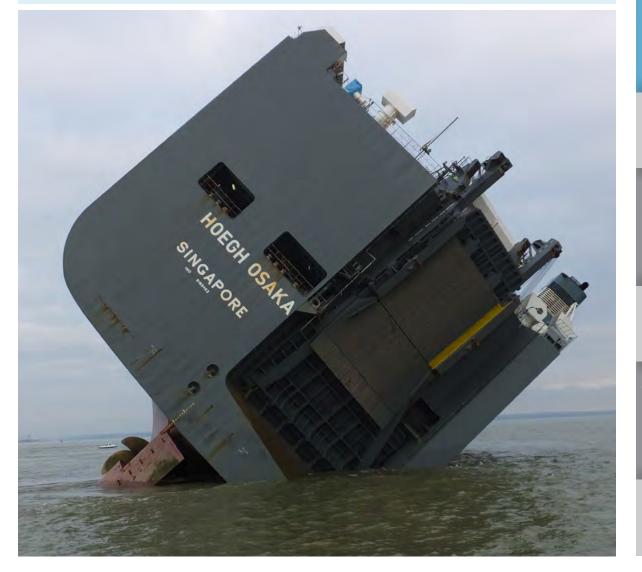
- Through its forthcoming Marine Guidance Note, providing guidance on the safe stowage and securing of specialised vehicles; and
- Within the next edition of its publication Roll-on/Roll-off Ships -Stowage and Securing of Vehicles - Code of Practice.

Appropriate action planned:



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Cemfjord

Report number:

8/2016

Cement carrier

Accident date:

02/01/2015

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Capsize and sinking of a cement carrier in the Pentland Firth with the loss of all eight crew

Maritime and Coastguard Agency No Recommendation(s) to:

2016/115

Review the arrangements for the safety of shipping in the Pentland Firth, giving particular consideration to:

- Defining the purpose of the Pentland Firth voluntary reporting scheme. This should include the information to be provided by vessels in the area and the subsequent use of that information by the coastguard.
- The potential benefits of making the Pentland Firth voluntary reporting scheme compulsory.
- Identifying the level of surveillance and monitoring required of vessels operating in the Pentland Firth. In particular, establishing operational routines for the use of AIS information and operator procedures to monitor AIS tracks and respond to loss of AIS contact.
- Whether, given the frequent and extreme local sea conditions, advisory information should be broadcast to ships in addition to routine maritime safety information.

Appropriate action implemented V





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Asterix

10/2016 **Report number:**

Mooring launch

Accident date:

30/03/2015

Girting and capsize of a mooring launch at Fawley Marine Terminal, Southampton

Maritime and Coastguard Agency No Recommendation(s) to: 2016/120 Inform tug operators and port authorities of the importance of ensuring that masters engaged in towing operations have the necessary knowledge and skills.

Appropriate action implemented \bigvee



Carol Anne

Report number:

11/2016

Workboat

Accident date:

30/04/2015

Collapse of a crane on board a workboat resulting in one fatality on Loch Spelve, Isle of Mull

No **Recommendation(s) to: Association of Lorry Loader Manufacturers** and Importers 2016/123 Work with the Maritime and Coastguard Agency to ensure that the maritime requirements and regulation covering the inspection and testing of shipborne lorry loader cranes is included in its training syllabi and examiners' manuals. **Progress Ongoing** Appropriate action planned: NO DATE

Recommendation(s) to:

Maritime and Coastguard Agency



2016/124

No

Instruct certifying authorities to ensure that their procedures for the agreement of the fitting or modification of lifting appliances on board workboats take into account, inter alia, the importance of assessing the suitability of installation arrangements and the impact on vessel stability.

Appropriate action implemented



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JMT

Report number:

15/2016

Fishing vessel

Accident date:

09/07/2015

Capsize and foundering of a small fishing vessel resulting in two fatalities 3.8nm off Rame Head, English Channel

Maritime and Coastguard Agency No Recommendation(s) to: 2016/130 Include in its intended new legislation introducing stability criteria for all new and significantly modified decked fishing vessels of under 15m in length a requirement for the stability of new open decked vessels, and all existing vessels of under 15m to be marked using the Wolfson Method or assessed by use of another acceptable method. DECEMBER **Appropriate action planned:** 2016/131 Require skippers of under 16.5m fishing vessels to complete stability awareness training. Appropriate action planned:

Recommendation(s) to: No

Sea Fish Industry Authority

2016/132

Amend its construction standards to include a requirement for new fishing vessels and vessels joining the UK fishing vessel register to be fitted with a Wolfson freeboard mark.





MAIB comment

Seafish does not intend to include the Wolfson Mark in its construction standards.

NO	Recommendation(s) to:	Sea Fish Industry Authority	
2016/133	vessels against the Seafish	at the inspection regime for assessing existing Construction Standards is consistently robust of the condition of each vessel at the time of	

MCA - Appropriate action implemented



Seafish - Partially accepted: closed

MAIB comment

In November 2017 Seafish stopped providing registration surveys for existing fishing vessels built before 16 July 2007. From 1 December 2017, such vessels are surveyed against the Seafish Construction Standards by independant surveyors approved by the MCA.

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No	Recommendation(s) to:	Maritime and Coastguard Agency/ Sea Fish Industry Authority/ Scottish Fishermen's Federation/ National Federation of Fishermen's Organisations
2016/134	explore ways to encourage are engaged in trawling, sc	e Fishing Industry Safety Group, collectively owners of fishing vessels of under 15m LOA that alloping and bulk fishing to affix a Wolfson Mark e them in accordance with the stability guidance

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MCA - Appropriate action implemented

Seafish - Appropriate action implemented

SFF - Appropriate action implemented



NFFO - Appropriate action implemented

Arco Avon

provided.

Report number: 17/2016

Dredger

Accident date: 18/08/2015

Engine room fire on a suction dredger, 12 miles off the coast of Great Yarmouth with loss of one life

No	Recommendation(s) to: Maritime and Coastguard Agency
2016/136	Review International Maritime Organization circular MSC.1/Circ.1321 – Guidelines for measures to prevent fires in engine-rooms and cargo pumprooms, and, as appropriate, promulgate its contents to the shipping industry.

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Appropriate action implemented V

Aquarius

Report number:

18/2016

Fishing vessel Accident date: 17/08/2015

> Fatal man overboard from the fishing vessel 2 miles east of Aberdeen harbour

No	Recommendation(s) to: Maritime and Coastguard Agency
2016/140	Review its monitoring and enforcement of "The Working Time: Sea Fishermen Regulations 2004" to ensure that fishermen, and in particular foreign fishermen living on board their vessels, are achieving the statutory levels of rest and annual leave.
	Appropriate action implemented 🐓

Annie T

Report number: 21/2016

04/10/2015

Fishing vessel

Accident date: 04/10/2

Man overboard from a creel fishing vessel with the loss of one life in the Sound of Mingulay

No Recommendation(s) to: Maritime and Coastguard Agency

2016/146 Prioritise the introduction of legislation that will require the compulsory wearing of personal flotation devices on the working decks of all fishing

vessels while at sea.

Appropriate action implemented

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Daroja/Erin Wood

Cargo ship/oil bunker barge

Report number: 27/2016

Accident date: 29/08/2015

Collision between a general cargo ship and an oil bunker barge, 4 nautical miles south-east of Peterhead

No Recommendation(s) to: The St Kitts and Nevis International
Shipping Registry

2016/155

Ensure that, for vessels applying to join the Registry:

- A Flag State inspection of the vessel takes place to review compliance with relevant regulations.
- Manning negotiations with owners/managers take into account all relevant factors set out in the IMO Principles of Safe Manning.

Appropriate action implemented





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*Status as of 31 May 2019

Cheeki Rafiki

Report number:

8/2015

Sailing yacht

Accident date:

16/05/2014

Loss of a yacht and its four crew in the Atlantic Ocean, approximately 720 miles east-south-east of Nova Scotia, Canada

No Recommendation(s) to:

British Marine Federation²

2015/117

Co-operate with certifying authorities, manufacturers and repairers with the aim of developing best practice industry-wide guidance on the inspection and repair of yachts where a GRP matrix and hull have been bonded together.

Appropriate action planned:

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No Recommendation(s) to: Maritime and Coastguard Agency

2015/119

Issue operational guidance to owners, operators and managers of small commercial sailing vessels, including:

- The circumstances in which a small vessel is required to comply with the provisions of the SCV Code and those in which it is exempt from compliance.
- Management responsibilities and best practice with regard to:
 - Vessel structural inspection and planned maintenance by competent personnel, particularly prior to long ocean passages,
 - Passage planning and execution, including weather routing,
 - The provision of appropriate lifesaving equipment, including liferafts, EPIRBs and PLBs, and the extent to which they should be float-free and/or readily available, and
 - The provision of onboard procedures, including the action to be taken on discovering water ingress.
- The need for an inspection following any grounding, taking into account the danger of potential unseen damage, particularly where a GRP matrix and hull have been bonded together.

Appropriate action planned:

31

2015/120

Include in the SCV Code a requirement that vessels operating commercially under ISAF OSR should undergo a full inspection to the extent otherwise required for vessels complying with the SCV Code.

Appropriate action planned:

31

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² British Marine Federation now known as British Marine.

Commodore Clipper

Ro-ro passenger ferry

Report number:

18/2015

Accident date: 14/07/2014 CHIEF INSPECTOR'S REPORT

Grounding and flooding in the approaches to St Peter Port, Guernsey

No	Recommendation(s) to: Government of Guernsey
2015/145	Improve the standard of vessel traffic services within the Guernsey Ordnance statutory pilotage area by implementation of an information level service to shipping as guided by the applicable elements of the Maritime and Coastguard Agency's Marine Guidance Note 401.
	Appropriate action implemented 🍑
2015/146	Implement measures designed to provide assurance that, post- qualification, its Special Pilotage Licence holders continue to demonstrate the required level of proficiency when conducting acts of pilotage.
	Appropriate action planned: 31

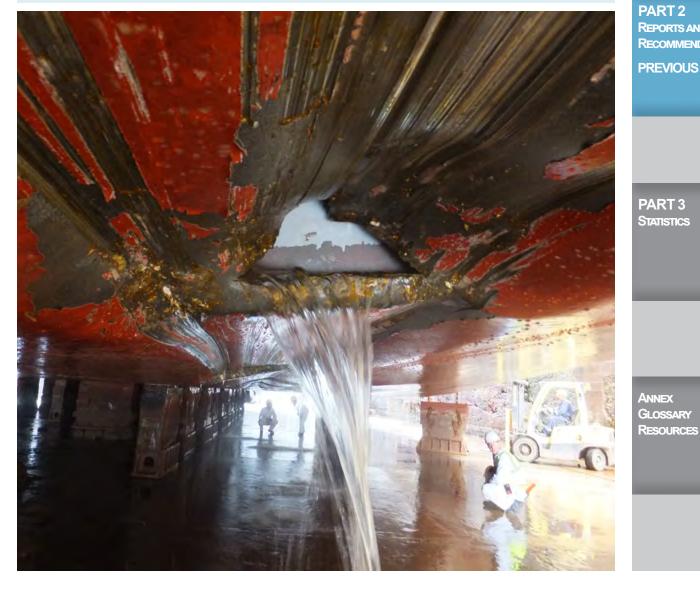
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GLOSSARY



Beryl **Report number:** 26/2015 Fishing vessel Accident date: 10/02/2015 Fatal person overboard west of the Shetland Islands **Maritime and Coastguard Agency/** No **Recommendation(s) to:** Scottish Fishermen's Federation/ **National Federation of Fishermen's Organisations/Sea Fish Industry Authority** Through membership of the Fishing Industry Safety Group, collectively 2015/156 explore ways of: Ensuring fishermen conduct regular emergency drills as required by statute

change and develop robust safety cultures.

Procuring rescue dummies which could be made available to the

owners/skippers of fishing vessels to facilitate realistic manoverboard

Using the results of onboard risk assessments to promote behavioural

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MCA - Appropriate action implemented

SFF - Partially accepted: closed³

NFFO: Appropriate action implemented:



Seafish - Appropriate action implemented:

No	Recommendation(s) to:	Sea Fish Industry Authority
2015/158	use on board fishing vessels	anoverboard recovery systems suitable for and promulgate advice on the systems to the eir suitability, capabilities and limitations.

Partially accepted: closed

MAIB comment

drills

There is no dedicated research planned, but Seafish will continue to work with stakeholders.

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³ Refer to page 46 of 2015 MAIB Annual Report for MAIB comment: www.gov.uk/government/uploads/system/uploads/attachment_data/file/541432/MAIB_AnnualReport2015.pdf

Stella Maris

Report number:

29/2015

Fishing vessel

Accident date:

28/07/2014

Capsize and foundering 14 miles east of Sunderland

No	Recommendation(s) to: Maritime and Coastguard Agency
2015/165	Introduce intact stability criteria for all new and significantly modified decked fishing vessels of under 15m in length. Appropriate action planned:
2015/166	Revise as necessary and re-issue its guidance to fishing vessel owners and skippers on the application to fishing vessels of:
	 The Merchant Shipping (Provision and Use of Work Equipment) Regulations 2006, and
	The Merchant Shipping (Lifting Operations and Lifting Equipment)

Appropriate action planned:

31

No Recommendation(s) to: Sea Fish Industry Authority

Regulations 2006.

2015/167

Amend its construction standards for new registered vessels to increase the angle at which downflooding occurs by reviewing the placement of ventilation ducts in or adjacent to the bulwarks.

Appropriate action planned:

остовек **31**

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

2015/171

Work together to ensure European Commission funded modifications are fully reviewed for their impact on vessel stability and safety by agreeing the remit of such reviews and setting realistic target times to enable such co-operation.

MCA: Appropriate action planned:

30

MMO: Appropriate action implemented

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Danio **Report number:** 8/2014 General cargo vessel Accident date: 16/03/2013

Grounding off Longstone, Farne Islands

No	Recommendation(s) to: Maritime and Coastguard Agency
2014/110	Working closely with the European Commission and EU member states, make a proposal to the International Maritime Organization that all vessels engaged in short sea trades be required to carry a minimum of two watchkeepers in addition to the master.

Appropriate action implemented



MAIB comment

A proposal has been made by the MCA to the EU, however the proposal has not been accepted.

Eshcol 14/2014 **Report number:** Fishing vessel Accident date: 15/01/2014

> Carbon monoxide poisoning on board fishing vessel in Whitby, resulting in two fatalities

No	Recommendation(s) to: Maritime and Coastguard Agency
2014/121	In developing a Code of Practice for the Safety of Small Fishing Vessels based on the Small Commercial Vessel and Pilot Boat Code, and in implementing the requirements of International Labour Organization Convention C188 in national regulations (when in force), take into account the circumstances of this accident, including, inter alia:
	 The disparity in the requirements for Liquid Petroleum Gas installations on board small fishing vessels and other small commercial craft and larger fishing vessels.
	 The need for suitable accommodation to be provided when crew are expected or required to stay on board overnight.
	 The operating patterns of small fishing vessels and the need to protect fishermen from fatigue.
	Appropriate action implemented 🍑

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Wacker Quacker 1/Cleopatra

Report number:

32/2014

Amphibious passenger vehicles

2014/153

Accident dates: 15/06/2013 and 29/09/2013

Combined report on the investigations of the sinking and abandonment of the DUKW amphibious passenger vehicle Wacker Quacker 1 in

Driver and Vehicle Standards Agency Identify single points of contact for amphibious vehicle issues and put processes in place to allow them to work together, in consultation with the

conflicts and agree a coherent approach to the survey and certification of new and existing amphibious passenger vehicles.

industry, to explore potential cross agency synergies, identify regulatory



DVSA: Appropriate action implemented



No	Recommendation(s) to:	Maritime and Coastguard Agency
2014/154	Provide amphibious vehicle surveyors.	e survey guidance and instructions to its
		Appropriate action implemented



Work with industry to develop an amphibious vehicle operators' code of 2014/155 practice.





2014/156 Ensure that measures to reduce the risk of passenger entrapment and improve the levels of passenger survivability are included in its proposed technical standard for amphibious passenger vehicles.

Appropriate action implemented





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*Status as of 31 May 2019

St AmantReport number:1/2013Fishing vessel (BA101)Accident date:13/01/2012

Loss of a crewman from fishing vessel off the coast of north-west Wales

No	Recommendation(s) to: Maritime and Coastguard Agency
2013/103	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 implemented V
2013/105	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. 2019 DECEMBER
	Appropriate action planned:

Heather AnneReport number:2/2013Fishing vessel (FY 126)Accident date:20/12/2011

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

No	Recommendation(s) to: Maritime and Coastguard Agency
2013/106	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.

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- A vessel's stability is dependent on several factors including its 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 implemented 🗸



2013/108

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.

Appropriate action implemented \bigvee



MAIB comment:

As a result of the ratification of ILO 188, the wearing of PDFs on working decks of fishing vessels is now manditory whenever there is a risk of falling or dragged overboard.

Purbeck Isle **Report number:** 7/2013 Fishing vessel (PH 104) Accident date: 17/05/2012

> Foundering of fishing vessel 9 miles south of Portland Bill with the loss of three lives

No	Recommendation(s) to: Maritime and Coastguard Agency
2013/203	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 length overall to carry EPIRBS.
	• Ensuring that the <i>Merchant Shipping and Fishing Vessels (Health and Safety at Work) Regulations 1997</i> apply in respect of all fishermen on board fishing vessels, irrespective of their contractual status.
	Appropriate action implemented
2013/204	Align its hull survey requirements for fishing vessels of <15m length overall with those applied to workboats under the <i>Harmonised Small Commercial Vessels Code</i> .
	Appropriate action planned: 31

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Sarah Jayne

Fishing vessel (BM 249)

Report number:

Accident date:

13/2013

11/09/2012

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

No Recommendation(s) to: Maritime and Coastguard Agency

2013/213

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:

31

Vixen

Report number:

16/2013

Passenger ferry

Accident date:

19/09/2012

Foundering in Ardlui Marina, Loch Lomond

No Recommendation(s) to: Stirling Council/

West Dunbartonshire Council

2013/216

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: NO DATE

Update requested
NO DATE
GIVEN

West Dunbartonshire Council: Appropriate action planned: NO DATE

Update requested
NO DATE
GIVEN

MAIB comment:

It is disappointing that it is taking such a long time to implement a recommendation that was issued and accepted over 5 years ago.

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Audacious/Chloe T

Fishing vessels (BF 83/PZ1186)

Report⁴ number:

27/2013

Accident dates: 10/8/2012 and 1/09 2012

Flooding and foundering of fishing vessel Audacious 45 miles east of Aberdeen on 10 August 2012 and the Flooding and foundering of fishing vessel *Chloe T* 17 miles south-west of Bolt Head, Devon on 1 September 2012

No Recommendation(s) to: **Maritime and Coastguard Agency**

2013/249

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 implemented



2013/250

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:



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2012 RECOMMENDATIONS - PROGRESS REPORT

There are no outstanding recommendations for 2012.

2011 RECOMMENDATIONS - PROGRESS REPORT

There are no outstanding recommendations for 2011.

PART 3 **STATISTICS**

GLOSSARY RESOURCES

⁴ Due to similarities between the accidents MAIB took the decision to publish its findings as a combined report.

*Status as of 31 May 2019

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:

2019 DECEMBER 31

Olivia Jean

Report number: 10/2010

Fishing vessel (TN35) Accident date: 10/10/2009

Injury to fisherman, 17nm south south east of Beachy Head

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.
- 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:

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*Status as of 31 May 2019

11/2009

Celtic Pioneer Report number:

RIB Accident date: 26/08/2008

Injury to a passenger during a boat trip in the Bristol Channel

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:

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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:

PART 3
STATISTICS

*Status as of 31 May 2019

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

2008/173

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:

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Annex Glossary <u>Resour</u>ces

No	Recommendation(s) to:	Department for Transport/ Maritime and Coastguard Agency
2008/174	Agree the coherent resourc fishing industry (see recom	red plan for reducing the fatality rate in the amendation 2008/173). DfT: Appropriate action planned:
		MCA: Appropriate action planned:
No	Recommendation(s) to:	Maritime and Coastguard Agency

Review the current requirements for safety training with particular

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2007 RECOMMENDATIONS - PROGRESS REPORT*

reference to training assessment and refresher training.

2008/177

*Status as of 31 May 2019

Appropriate action implemented

DanielleReport number:5/2007Fishing vessel (BM 478)Accident date:06/06/2006

Major injuries sustained by a deckhand, 7 miles south-south-east of Falmouth

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:

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PART 3: STATISTICS

Ship reported 94 2 \$\frac{1}{29} 8 \frac{1}{29} fatalities affected 41 area losses

| Shing 136 injury | Shi commercial vesse

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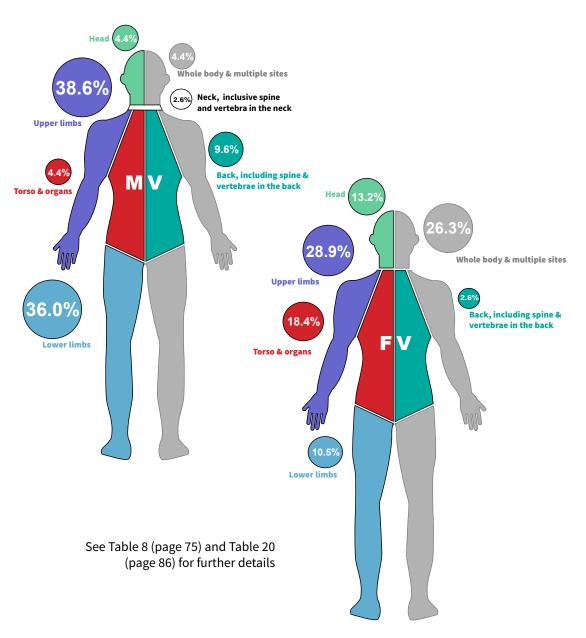
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UK vessel accidents involving loss of life	69
UK merchant vessels >= 100gt	71
UK merchant vessels < 100gt	80
UK fishing vessels	81
Non-UK commercial vessels	90

For details of reporting requirements and terms used in this section please see Annex - Statistics Coverage on page 91 and Glossary on page 97.

Charts 6 and 7: Deaths and injuries of merchant vessel and fishing vessel crew by part of body injured



Note: Rates may not add up to 100% due to rounding

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UK VESSELS: ACCIDENTS INVOLVING LOSS OF LIFE

Table 1: Loss of life in 2018 reported to the MAIB

Date Name of vessel Type of Location Accident

Merchant vessels 100gt and over

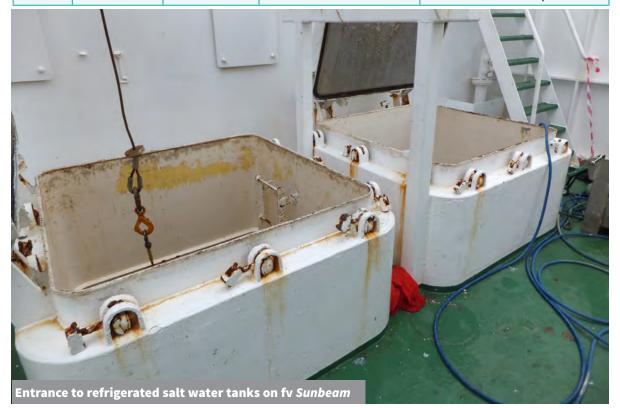
None reported to the MAIB in 2018

Merchant vessels under 100gt (excluding commercial recreational)

None reported to the MAIB in 2018

Fishing vessels

18 Jan	Nancy Glen (TT100)	Stern trawler	Loch Fyne, Argyll and Bute, Scotland	Capsize and foundering resulting in the deaths of two of the three crew.
5 Feb	North Star (WK673)	Creeler	16nm north of Cape Wrath, Scotland	A crewman was dragged overboard by fishing gear. He was recovered on board but was unable to be resuscitated.
7 May	Laura Jane (SE80)	Gill netter/ potter	Plymouth Sound, England	A single-handed fisherman drowned when his vessel capsized and he was trapped in the wheelhouse.
7 Aug	Fram of Sheildaig (BRD679)	Potter	Loch Torridon off Ardheslaig, Scotland	Fatal person overboard when a deckhand was manoeuvring a small tender alongside the moored fishing vessel.
14 Aug	Sunbeam (FR487)	Pelagic trawler	Fraserburgh, Scotland	A crewman died in a drained refrigerated salt water tank that contained an unbreathable atmosphere.



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Date	Name of vessel	Type of vessel	Location	Accident	
Recreati	Recreational craft (including commercial recreational)				
22 Feb	Jemima	Narrowboat	Trent and Mersey Canal, Stone, Staffordshire, England	A woman died after fire broke out as a result of embers falling from a fuel burner.	
12 Apr	Katniss	Sailing yacht	North Atlantic, off the coast of Portugal	The body of a single-handed yachtsman was found following a PLB EPIRB alert. His yacht was found 200nm from the position that his body was found.	
25 May	Timanfaya	Cabin cruiser	Sharpness Docks, Gloucestershire, England	A man was found deceased in the vessel following a fire while moored.	
24 Jun	Y Knot	Racing powerboat	Off West Bay, Dorset, England	The owner/driver died following a collision with another competitor that resulted in his boat overturning.	
3 Aug	-	5.5m speedboat	River Blackwater, Essex, England	The speedboat was towing a water-skier when it collided with a moored sailing yacht, as a result of which the driver of the speedboat died.	
10 Aug	Legs Eleven	RS Elite racing keelboat	The Solent, near Cowes, Isle of Wight, England	A crewmember drowned after falling overboard and becoming entangled with a spinnaker sheet.	
6 Oct	-	Outrigger kayak	Off the Dorset coast, England	A competitor in a race failed to return to the finish and was later found 22nm south of the Purbeck coast.	
21 Oct	Our W	Diving support boat	19nm east of Beachy Head, English Channel	While attempting to reboard the boat, a diver fell back into the water and was lost.	
21 Dec	Crow's Nest	Sailing yacht	Beaumaris, Anglesey, Wales	The owner was found deceased in the water after apparently having fallen overboard while moored.	

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UK MERCHANT VESSELS >= 100GT

Table 2: Merchant vessel total losses

There were no losses of UK merchant vessels reported to the MAIB in 2018 $\,$

CHIEF INSPECTOR'S REPORT

Table 3: Merchant vessel losses — 2009-2018

	Number lost	UK fleet size	Gross tonnage lost
2009	1	1 564	274
2010	-	1 520	-
2011	-	1 521	-
2012	-	1 450	-
2013	-	1 392	-
2014	-	1 361	-
2015	-	1 385	-
2016	-	1 365	-
2017	-	1 356	-
2018	-	1 332	-

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

	Solid cargo	Liquid cargo	Passenger	Service ship	Commercial recreational	Total
Collision	8	-	8	14	-	30
Contact	6	-	5	4	-	15
Damage to ship or equipment	5	-	2	5	-	12
Fire/explosion	-	-	2	1	-	3
Flooding/foundering	1	-	-	-	-	1
Grounding	4	3	-	7	1	15
Loss of control	-	-	4	5	-	9
Total	24	3	21	36	1	85

O Vessel groups include vessels operating on inland waterways.

Note: 85 casualties represents a rate of 64 casualties per 1000 vessels on the UK Fleet.

Table 5: Deaths and injuries to merchant vessel crew — 2009-2018 ❷

	Crew injured	Of which resulted in death
2009	199	6
2010	222	3
2011	185	5
2012	186	3
2013	134	1
2014	142	-
2015	141	2
2016	133	2
2017	153	-
2018	114	-

② From 2012 this table excludes injuries/fatalities that were not in connection with the operation of a ship.

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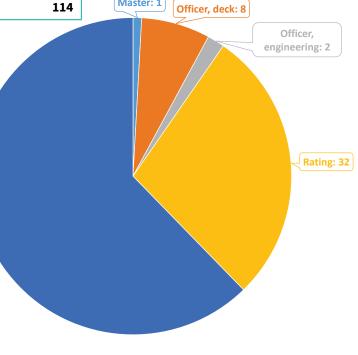
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Table 6: Deaths and injuries of merchant vessel crew by rank

Rank/specialism	Number of crew
Master	1
Officer, deck	8
Officer, engineering	2
Rating	32
Other crew	71
Total	114

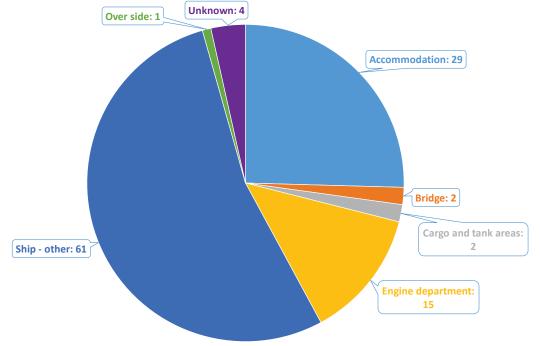
Chart 8: Deaths and injuries of merchant vessel crew by rank



Master: 1

Chart 9: Deaths and injuries of merchant vessel crew by place

Other crew: 71



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UK merchant vessels >= 100gt

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

Place		Number of crew
	Accommodation, other	1
	Alleyway	1
	Bathroom, shower, toilet	2
	Cabin space - crew	3
ation	Galley spaces	6
Accommodation	Gymnasium	1
Accor	Hospital/clinic	1
	Laundry	1
	Restaurant/bar	2
	Stairway/ladders	7
	Theatre	4
	Bridge	2
go nnk aas	Cargo hold	1
Cargo & tanl areas	Vehicle cargo space	1
ent	Engine department, other	4
ingine artm	Engine room	10
dep	Pump room	1

Place		Number of crew
	Aloft	1
	Boat deck	15
	Bridge deck	1
	Forecastle	3
	Forecastle deck	3
Ship	Freeboard deck	5
S	Gangway	1
	Main deck	2
	Poop deck	5
	Ship, other	17
	Stairs/ladders	7
	Open deck (other)	1
	Over side	
	Unknown	4
	Total	114

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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	5
	Ear(s)	1
	Eye(s)	1
Head	Head, brain and cranial nerves and vessels	1
	Head, other	2
	Neck, inclusive spine and vertebra in the neck	3
	Arm, including elbow	7
	Finger(s)	22
	Hand	6
Upper limbs	Shoulder and shoulder joints	4
	Upper extremities, multiple sites affected	2
	Wrist	3
	Back, including spine and vertebrae in the back	11
	Pelvic and abdominal area including organs	1
Torso and organs	Rib cage, ribs including joints and shoulder blade	3
	Torso, other	1
	Ankle	14
Lower limbs	Foot	4
	Leg, including knee	23
	Total	114

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

Deviation*		Number of crew
	Body movement under/with physical stress, other	3
Body movement under	Lifting, carrying, standing up	7
or with physical stress (generally leading to an internal injury)	Treading badly, twisting leg or ankle, slipping without falling	4
	Twisting, turning	4
	Being caught or carried away, by something or by momentum	19
Body movement without	Body movement without physical stress, other	1
any physical stress (generally leading to an	Kneeling on, sitting on, leaning against	2
external injury)	Uncoordinated movements, spurious or untimely actions	5
	Walking on a sharp object	1
Deviation* by overflow,	Liquid state - leaking, oozing, flowing, splashing, spraying	1
overturn, leak, flow, vaporisation, emission	Pulverulent material - smoke generation, dust/ particles in suspension/emission of	1
Deviation due to electrical problems, explosion, fire	problems, Explosion	
	Of hand-held tool (motorised or not) or of the material being worked by the tool	6
Loss of control (total or	Of machine (including unwanted start-up) or of the material being worked by the machine	1
partial)	Of means of transport or handling equipment, (motorised or not)	1
	Of object (being carried, moved, handled, etc.)	5
Slipping - stumbling and	Fall of person - to a lower level	24
falling - fall of persons	Fall of person - on the same level	18
	Deviation, no information	1
	Deviation, other	9
	Total	114

^{*}See "Terms" on page 99

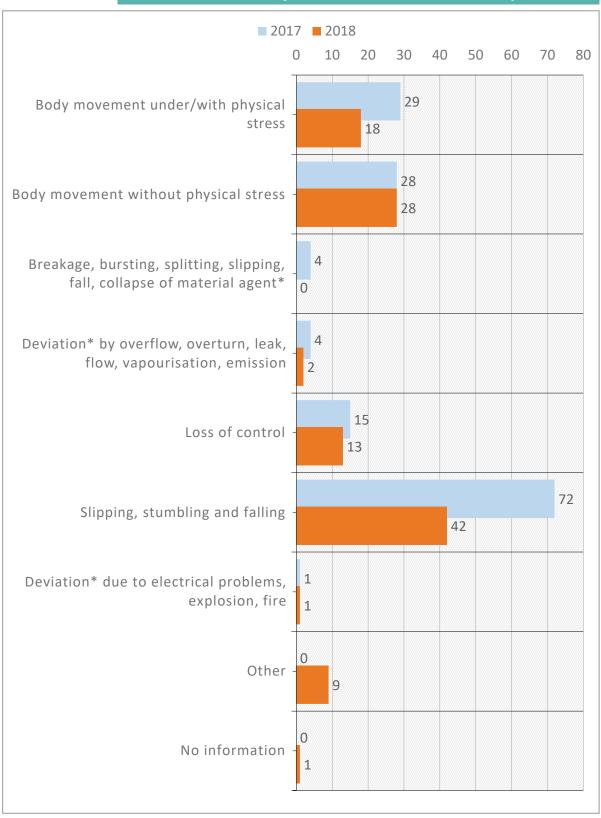
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Chart 10: Deaths and injuries of merchant vessel crew by deviation*



^{*}See "Terms" on page 99

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UK merchant vessels >= 100gt

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

Main injury		Number of crew
Bone fractures	Closed fractures	29
Bone tractures	Open fractures	4
Burns, scalds and	Burns and scalds (thermal)	1
frostbites	Chemical burns (corrosions)	1
Concussion and internal	Concussion and intracranial injuries	1
injuries	Internal injuries	1
Dislocations, sprains and	Dislocations and subluxations*	12
strains	Sprains and strains	31
Effects of sound, vibration and pressure		1
Effect	Effects of temperature extremes, light and radiation	
Wounds and superficial	Open wounds	6
injuries*	Superficial injuries*	10
	Traumatic amputations (loss of body parts)	6
Other specified injuries not included under other headings		7
Multiple injuries		1
Unknown or unspecified		2
Total 114		114

^{*}See "Terms" on page 99

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Table 11: Deaths and injuries to passengers — 2009-2018 ❸

	Number of passengers	Of which resulted in death
2009	115	1
2010	92	2
2011	109	1
2012	50	-
2013	46	-
2014	56	1
2015	55	1
2016	51	1
2017	26	-
2018	81	-

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

Table 12: Deaths and injuries of passengers by injury

Main injury		Number of passengers
Dana fuartuura	Closed fractures	64
Bone fractures	Open fractures	2
	2	
	Dislocations and subluxations*	6
Dislocations, sprains and strains	Sprains and strains	3
Wounds and superficial injuries*	Open wounds	1
	3	
	Total	81

^{*}See "Terms" on page 99

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UK MERCHANT VESSELS < 100GT

Table 13: Merchant vessels < 100gt - losses

Date	Name of vessel	Type of vessel	loa	Casualty event
21 Apr	Nisida of Hamble	Sailing yacht	15.85m	Foundering
28 Jul	European	Crew transfer vessel	6.36m	Flooding
19 Oct	Adelaide	Angling boat	7.00m	Loss of directional control (steering failure resulting in contact with a pier)

Table 14: Merchant vessels < 100gt

	Cargo ship Solid cargo	Passenger ship	Recreational craft Power	Recreational craft Sail	Service ship Offshore	Service ship Seach and Rescue (SAR) craft	Service ship Tug (Towing/Pushing)	Service ship Other	Total
Capsizing/listing	-	-	1	-	-	-	-	-	1
Collision	1	6	2	4	2	2	1	9	27
Contact	-	1	-	-	-	-	-	-	1
Damage to ship or equipment	-	-	-	-	-	-	-	2	2
Fire/explosion	1	-	1	-	-	1	-	-	3
Flooding/foundering	-	-	-	1	-	-	-	2	3
Grounding	-	6	3	25	-	5	1	4	44
Loss of control	-	4	7	4	1	3	1	6	26
Total per vessel type	2	17	14	34	3	11	3	23	107
Deaths	-	-	2	-	-	-	-	-	2
Injuries	-	17	4	12	3	18	-	11	65

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UK FISHING VESSELS

There were 5 603 UK registered fishing vessels at the end of 2018. During 2018, 136 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 2018.

8 fishing vessels were reported lost (0.14% of the total fleet) and there were 6 fatalities to crew.

Table 15: Fishing vessel total losses

Date	Name of vessel	Age	Gross tonnage	Casualty event
Under 15n	n length overall (loa)			
14 Jan	Stella Maris	20	9.55	Fire
10 lan	Name Clair	27	10.55	Concining

14 Jan	Stella Maris	20	9.55	Fire
18 Jan	Nancy Glen	27	19.55	Capsizing
22 Feb	Boys Own	40	4.29	Flooding
24 Feb	Julie D	36	5.31	Grounding
16 Mar	Fiona Mary	46	9.17	Flooding
29 Mar	Consort	27	3.48	Capsizing
25 May	Denise II*	8	1.09	Capsizing
1 Aug	Zenith	36	1.36	Loss of control

15m length overall - under 24m registered length (reg)

None reported to the MAIB in 2018

Over 24m registered length (reg)

None reported to the MAIB in 2018

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^{*}Constructive total loss

UK fishing vessels

Table 16: Fishing vessel losses — 2009-2018 **⑤**

	Under 15m loa	15m loa to <24m reg	24m reg and over	Total lost	UK registered	% lost
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
2014	9	3	-	12	5 715	0.21
2015	8	5	-	13	5 746	0.23
2016	5	2	1	8	5 745	0.14
2017	5	1	-	6	5 700	0.11
2018	8	-	-	8	5 603	0.14

9 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	6	1.1
Collision	5	0.9
Damage to ship or equipment	2	0.4
Fire/explosion	6	1.1
Flooding/foundering	8	1.4
Grounding	19	3.4
Loss of control	90	16.1
Total	136	24.3

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Table 10. Eiching	vessels in casua	dtios by	natura of	cacualty
ianie To• Lizililis	VESSEIS III Casua	ILLIES — DV I	nature or	Casually

Under 15m length overall (loa) — vessels at risk: 5002

Capsizing/listing	6	1.2
Collision	3	0.6
Damage to ship or equipment	2	0.4
Fire/explosion	3	0.6
Flooding/foundering	8	1.6
Grounding	14	2.8
Loss of control	60	12.0
Total under 15m	96	19.2

15m loa - 24m registered length (reg) — vessels at risk: 468

Grounding Loss of control	25	53.4
Total 15m to 24m	31	66.2

24m reg and over — vessels at risk: 133

Loss of control 5	37.6
Grounding 2	15.0
Collision 2	15.0

*Rates may not add up due to rounding

Fleet total**	136	24.3

^{**}Total number of UK registered fishing vessels: 5 603

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UK fishing vessels

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

Main injury		Number of crew		
Drowning and asphyxiation	5			
	4			
Traun	1			
David for all was	Closed fractures			
Bone fractures	Open fractures	2		
Burns, scalds and frostbites	Burns and scalds (thermal)	1		
Consussions and intermelining	Concussion and intracranial injuries			
Concussions and internal injuries	Internal injuries	3		
Dislocations, sprains and strains	Dislocations, sprains and strains Dislocations and subluxations*			
Effects of temperature extremes, light and radiation	Effects of temperature extremes, light and radiation Effects of reduced temperature			
Deisonings and infections	Acute infections	1		
Poisonings and infections	Acute poisonings	1		
Manada and annadisial initiation	Open wounds	5		
Wounds and superficial injuries*	Superficial injuries*	2		
Other specified injur	1			
	1			
	38			

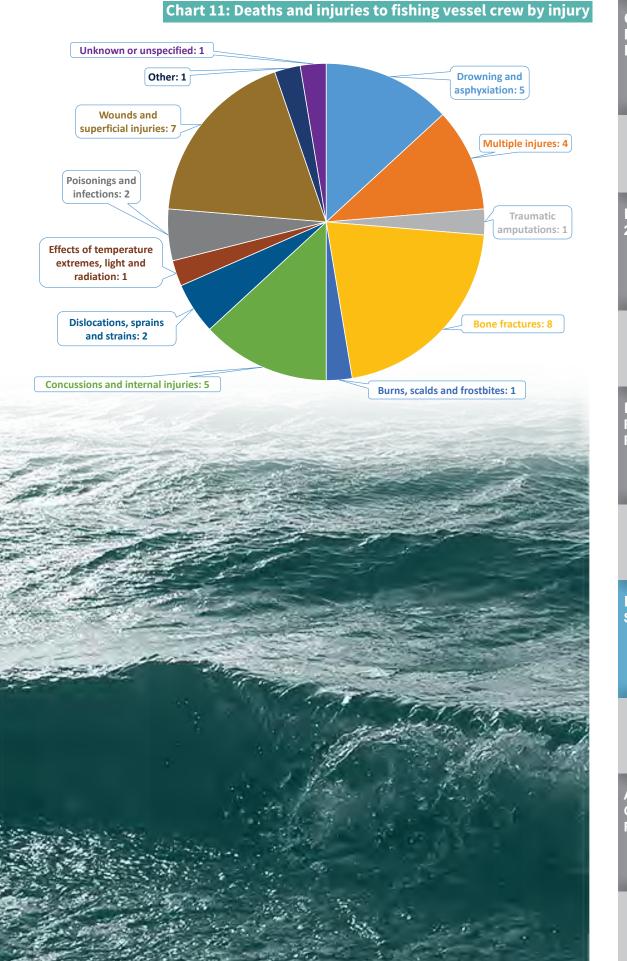
^{*}See "Terms" on page 99

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

Part of body injured		Number of crew
Whole body and multiple sites	Whole body (systemic effects)	6
	Multiple sites of the body affected	4
	Facial area	1
Head	Head, brain and cranial nerves and vessels	2
	Head, multiple sites affected	2
	Finger(s)	4
Upper limbs	Hand	4
	Wrist	2
	Arm, including elbow	1
	1	
	Chest area including organs	1
Torso and organs	Rib cage, ribs including joints and shoulder blade	4
	Torso, multiple sites affected	2
Lower limbs	Hip and hip joint	1
	Leg, including knee	2
	Lower extremities, multiple sites affected	1
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UK fishing vessels

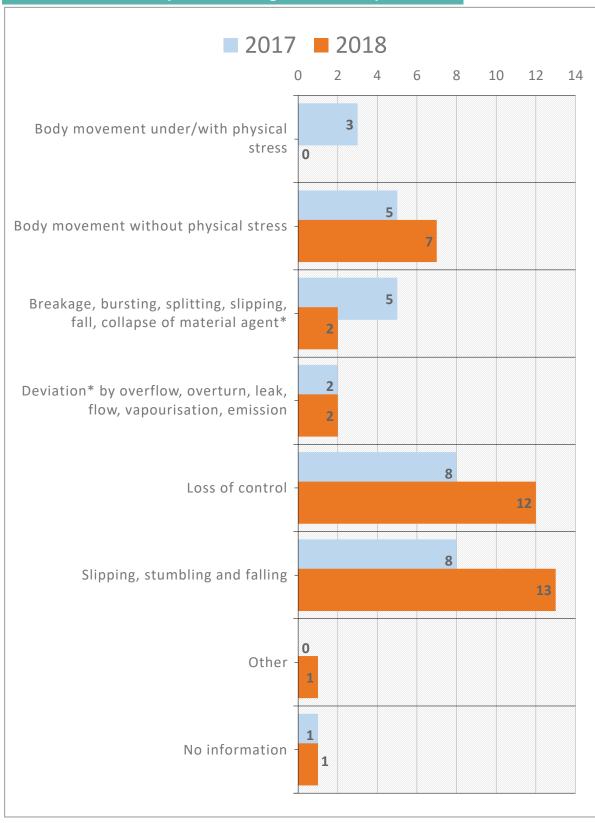
Table 21: Deaths and injuries of fishing vessel crew by deviation*

Deviation*		Number of crew
Body movement without any physical stress (generally leading to an external injury)	Being caught or carried away, by something or by momentum	6
	Other movements not mentioned above	1
Breakage, bursting, splitting,	Breakage, bursting - causing splinters (wood, glass, metal, stone, plastic, others)	1
slipping, fall, collapse of material agent*	Slip, fall, collapse of material agent* - from above (falling on the victim)	1
Deviation by overflow, overturn, leak, flow, vaporisation, emission	Gaseous state - vaporisation, aerosol formation, gas formation	2
	Of hand-held tool (motorised or not) or of the material being worked by the tool	2
	Of machine (including unwanted start-up) or of the material being worked by the machine	1
Loss of control (total or partial)	Of means of transport or handling equipment, (motorised or not)	7
	Of object (being carried, moved, handled, etc.)	2
	Fall of person - to a lower level	4
Slipping - stumbling and falling - fall of persons	Fall overboard of person	4
	Fall of person - on the same level	5
	1	
	1	
	38	

^{*}See "Terms" on page 99

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^{*}See "Terms" on page 99

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UK fishing vessels

Table 22: Deaths and injuries to fishing vessel crew by vessel length (of which, deaths shown in brackets) 2009-2018@

	Under 1	L5m loa	15m loa - under 24m reg		24m reg and over		Total	
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)
2014	22	(5)	14	(3)	10	-	46	(8)
2015	10	(4)	17	(1)	8	(2)	35	(7)
2016	16	(7)	19	(2)	5	-	40	(9)
2017	13	(3)	8	(2)	11	-	32	(5)
2018	14	(4)	18	(1)	6	(1)	38	(6)

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

Chart 13: Deaths and injuries to fishing vessel crew



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NON-UK COMMERCIAL VESSELS

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

There were no total losses of non-UK commercial vessels in UK waters reported to the MAIB in 2018.

Table 24: Non-UK commercial vessels in UK waters

	Cargo solid	Liquid cargo	Passenger	Service ship	Fishing vessel	Other/unknown	Total
Capsizing/listing	-	-	-	-	2	-	2
Collision	8	5	2	6	-	1	22
Contact	9	-	-	-	-	-	9
Damage to ship or equipment	3	-	-	1	-	-	4
Fire/explosion	4	-	-	-	-	-	4
Flooding/foundering	1	-	-	-	-	-	1
Grounding	24	2	1	3	1	1	32
Hull failure	-	-	1	-	-	-	1
Loss of control	8	4	1	2	4	-	19
Total per vessel type	57	11	5	12	7	2	94
Deaths	2	-	-	-	-	-	2
Injuries	14	5	14	6	1	1	41

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ANNEX A - STATISTICS COVERAGE

- 1. Data is presented by the year in which the incident was reported to the MAIB. Historic data tables contain information from the past 10 years.
- 2. Not all historical data can be found in this report. Further data is contained in previous MAIB Annual Reports.
- 3. United Kingdom ships are required by the Merchant Shipping (Accident Reporting and Investigation) Regulations 2012⁵ to report accidents to the MAIB.
- 4. Accidents are 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 (see Annex B on page 92) or MAIB's Regulations for more information.
- 5. Details of vessel types and groups used in this Annual Report can be found in Annex B supporting information on page 95.
- 6. 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.
- 7. The Maritime and Coastguard Agency, harbour authorities and inland waterway authorities have a duty to report accidents to the MAIB.
- 8. In addition to the above, the MAIB monitors news and other information sources for relevant accidents.

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 $^{^{5}\ \}underline{\text{https://www.gov.uk/government/organisations/marine-accident-investigation-branch/about\#regulations-and-guidance}}$

ANNEX B - SUPPORTING INFORMATION

Casualty definitions used by the UK MAIB - from 2012

Marine Casualty⁶

An event or sequence of events that has resulted in any of the following and has occurred directly by or in connection with the operation of a ship:

- the death of, or serious injury to, a person;
- the loss of a person from a ship;
- the loss, presumed loss or abandonment of a ship;
- material damage to a ship;
- the stranding or disabling of a ship, or the involvement of a ship in a collision;
- material damage to marine infrastructure external of a ship, that could seriously endanger the safety of the ship, another ship or any individual;
- pollution, or the potential for such pollution to the environment caused by damage to a ship or ships.

A Marine Casualty does not include a deliberate act or omission, with the intention to cause harm to the safety of a ship, an individual or the environment.

Each Marine Casualty is categorised as ONE of the following:

Very Serious Marine Casualty (VSMC)

Marine Casualty which involves total loss of the ship, loss of life, or severe pollution.

Serious Marine Casualty (SMC)

Marine Casualty where an event results in one of:

- immobilisation of main engines, extensive accommodation damage, severe structural damage, such as penetration of the hull underwater, etc., rendering the ship unfit to proceed;
- pollution;
- a breakdown necessitating towage or shore assistance.

Less Serious Marine Casualty (LSMC)

This term is used by MAIB to describe any Marine Casualty that does not qualify as a VSMC or a SMC.

Marine Incident (MI)

A Marine Incident is an event or sequence of events other than those listed above which has occurred directly in connection with the operation of a ship that endangered, or if not corrected would endanger the safety of a ship, its occupants or any other person or the environment (e.g. close quarters situations are Marine Incidents).

Note that under some IMO guidelines Less Serious Marine Casualties INCLUDE Marine Incidents. In UK data Less Serious Marine Casualties (and any other Marine Casualties) EXCLUDE Marine Incidents.

Accident

Under current Regulations⁶ Accident means any Marine Casualty or Marine Incident. In historic data, Accident had a specific meaning, broadly equivalent to (but not identical to) Marine Casualty.

Operation of a ship

To qualify as a Marine Casualty an event/injury etc must be in connection with the operation of the ship on which it occurs. MAIB's interpretation of this includes any "normal" activities which take place on board the vessel (e.g. a chef who cuts himself while preparing food is considered in connection with the operation of the ship).

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⁶ <u>http://www.legislation.gov.uk/uksi/2012/1743/regulation/3/made</u>

Changes to UK MAIB Casualty Event Definitions - with introduction of EU Directive 2009/18/EC1 (the Directive).

Collisions/Contacts – Until 2012 the UK defined a collision as a vessel making contact with another vessel that was subject to the collision regulations, after 2012 a collision is any contact between two vessels, i.e.

Until 2012

Collision - vessel hits another vessel that is underway, floating freely or is anchored.

Contact - vessel hits an object that is not subject to the collision regulations e.g. buoy, post, dock, floating logs, containers etc. Also another ship if it is tied up alongside. In order to qualify as the equivalent of a Marine Casualty the contact must have resulted in damage.

From 2013

Collision - a casualty caused by ships striking or being struck by another ship, regardless of whether the ships are underway, anchored or moored.

This type of casualty event does not include ships striking underwater wrecks. The collision can be with other ship or with multiple ships or ship not underway.

Contact - a casualty caused by ships striking or being struck by an external object. The objects can be: floating object (cargo, ice, other or unknown); fixed object, but not the sea bottom; or flying object.

Injury - The **EU** requires injuries to be reported if they are "3 day" injuries. This is described in more detail in section 4.2 of the European Statistics on Accidents at Work (ESAW) Summary methodology⁷ (Note that in this context the term "Accident" means an injury.)

"Accidents at work with more than three calendar days' absence from work. Only full calendar days of absence from work have to be considered, excluding the day of the accident. Consequently, 'more than three calendar days' means 'at least four calendar days', which implies that only if the victim resumes work on the fifth (or subsequent) working day after the date on which the accident occurred should the incident be included."

UK injury data also includes "serious" injuries. In addition to "3 day" injuries these are:

- any fracture, other than to a finger, thumb or toe;
- any loss of a limb or part of a limb;
- dislocation of the shoulder, hip, knee or spine;
- loss of sight, whether temporary or permanent;
- penetrating injury to the eye;
- any other injury -
 - leading to hypothermia or unconsciousness,
 - requires resuscitation, or
 - requiring admittance to a hospital or other medical facility as an inpatient for more than
 24 hours;

In the **IMO** Casualty Investigation Code⁸ (section 2.18) **Serious injury** means an injury which is sustained by a person in a casualty resulting in incapacitation for more than 72 hours commencing within seven days from the date of injury.

Due to the special working conditions of seafarers, injuries to seafarers while off-duty are considered to be occupational accidents in MAIB Annual Reports⁹.

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⁷ http://ec.europa.eu/eurostat/en/web/products-manuals-and-guidelines/-/KS-RA-12-102

http://www.imo.org/en/OurWork/MSAS/Casualties/Documents/Res.%20MSC.255(84)%20Casualty%20Iinvestigation%20Code. pdf

⁹ http://www.ilo.org/dyn/normlex/en/f?p=NORMLEXPUB:91:0::::P91_SECTION:MLC_A4 (Article II 1.(f) & Standard A4.3)

Machinery/Loss of control/Damage to Equipment

Until 2012

The UK used the generic term "Machinery" to describe most mechanical failures that caused problems to a vessel. In order to be considered the equivalent of a Marine Casualty the vessel needed to be not under command for a period of more than 12 hours, or the vessel needed assistance to reach port.

From 2013

While the IMO does not specify Machinery in its list of serious casualty events (MSC-MEPC.3/Circ.3¹⁰), it does define a Marine Casualty by the results and uses the term "etc" in the list of serious casualty events.

The European Union and the UK may interpret machinery failures as either:

- Loss of control a total or temporary loss of the ability to operate or manoeuvre the ship,
 failure of electric power, or to contain on board cargo or other substances:
 - Loss of electrical power is the loss of the electrical supply to the ship or facility;
 - Loss of propulsion power is the loss of propulsion because of machinery failure;
 - Loss of directional control is the loss of the ability to steer the ship;
 - Loss of containment is an accidental spill or damage or loss of cargo or other substances carried on board a ship.

or,

• Damage to equipment - damage to equipment, system or the ship not covered by any of the other casualty types.

Stranding/Grounding

Until 2012

Grounds means making involuntary contact with the ground, except for touching briefly so that no damage is caused.

From 2013

Grounding/stranding - a moving navigating ship, either under command, under power, or not under command, drifting, striking the sea bottom, shore or underwater wrecks.

Persons overboard

Until 2012

Any fall overboard from a ship or ship's boat was the equivalent of a Marine Casualty.

From 2013

Any fall overboard from a ship or ship's boat (that does not result in injury or fatality) is a Marine Incident.

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¹⁰ http://www.imo.org/en/OurWork/MSAS/Casualties/Documents/MSC-MEPC.3-Circ.3.pdf

Vessel Types included in MAIB Annual Report statistics from 2013 to date

- 1. MAIB use definitions in line with those used by EMSA and IMO. EXCEPT that the data presented in the MAIB Annual Reports includes certain vessel types that are outside the scope of EU Directive 2009/18/EC¹¹ (the Directive).
- 2. Vessel types outside the scope of the Directive that are INCLUDED in MAIB Annual Report statistics:
 - Fishing vessels of under 15 metres;
 - Government owned vessels used on government service (except Royal Navy vessels);
 - Inland waterway vessels operating in inland waters;
 - Ships not propelled by mechanical means;
 - · Wooden ships of primitive build;
 - Commercial recreational craft with fewer than 13 persons on board.
- 3. Vessel types outside the scope of the Directive that are EXCLUDED from MAIB Annual Reports:
 - Royal Navy vessels;
 - Fixed offshore drilling units.
- 4. Vessel Types (potentially) inside the scope of the Directive that are EXCLUDED from MAIB Annual Report statistics:
 - Recreational craft | Personal watercraft;
 - Recreational craft | Sailing surfboards;
 - Ships permanently moored which have no master or crew.
- 5. One "vessel" type, offshore drilling rigs, are inside the scope of the Directive, but usually outside the scope of MAIB. For UK-flagged installations, broadly, if an accident occurs while the installation is in transit MAIB investigate and record details, otherwise the Health and Safety Executive (HSE) is responsible for investigating and recording details. More information can be found on pages 40 to 41 of the Operational Working Agreement between MAIB, MCA & HSE¹².
- 6. Until 2012 the UK considered SAR craft to be non-commercial. From 2013 onwards they are considered commercial.

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 $^{^{11}\,\}underline{\text{http://emsa.europa.eu/emsa-documents/legislative-texts/72-legislative-texts/28-directive-200918ec.html}$

¹² Refer to pages 11 and 12 of the Operational Working Agreement between HSE, MCA and MAIB: http://www.hse.gov.uk/aboutus/howwework/framework/mou/owa-hse-mac-maib.pdf

Vessel categories used in MAIB Annual Report statistics from 2013 to date

Merchant vessels >=100gt

Trading and non-trading vessels of 100 gross tonnage (gt) or more (excluding fish processing and catching). Note that this category includes vessel types such as inland waterway vessels and vessels on government service that are specifically excluded from the scope of the Directive¹². It excludes Royal Navy vessels and platforms and rigs that are in place.

Merchant vessels <100gt

Vessels of under 100gt known, or believed to be, operated commercially (excluding fish processing and catching).

Commercial recreational

May be a subset of either of the above two entries. Those over 100gt may be, for instance, a tall ship or luxury yacht. Those under 100gt may be a chartered yacht or a rented dinghy.

UK fishing vessels

Commercial Fishing Vessels Registered with the UK Maritime and Coastguard Agency's Registry of Shipping and Seamen. Note that this category includes under 15 metre fishing vessels that are specifically excluded from the scope of the Directive.

Passenger

In addition to seagoing passenger vessels this category also includes inland waterway vessels operating on inland waters.

Service ship

Includes, but not limited to, dredgers, offshore industry related vessels, tugs and SAR craft.

Recreational craft

Recreational craft may be commercial or non-commercial. In the statistics section of each Annual Report only "Table 1: Loss of life..." includes non-commercial recreational craft.

Non-UK vessels in UK waters

Vessels that are not known, or believed to be, UK vessels, and the events took place in UK territorial waters (12 mile limit).

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GLOSSARY OF ABBREVIATIONS, ACRONYMS AND TERMS

► Abbreviations and Acronyms ◀

AIS - Automatic Identification System

ABP - Associated British Ports

BRM-P - Bridge Resource Management training for pilots

Circ. - Circular

CGOCs - Coastguard Operations Centres

Co - Company

CO - Carbon monoxide CO₂ - Carbon dioxide

DfT - Department for Transport

DVSA - Driver and Vehicle Standards Agency

EA - Environment Agency
EEA - European Economic Area

EMEA - Europe, the Middle East and AfricaEMSA - European Maritime Safety Agency

EPIRB - Emergency Position Indicating Radio Beacon
ESAW - European Statistics on Accidents at Work

EU - European Union fv - fishing vessel GM - Metacentric height

GNSS - Global Navigation Satellite System

GRP - Glass Reinforced Plastic

gt - gross tonnage

HMCG - Her Majesty's Coastguard
 HMPE - High Modulus Polyethylene
 HMSF - High Modulus Synthetic Fibre
 HSE - Health and Safety Executive

ICS - International Chamber of Shipping

IHMA - International Harbour Masters' Association

ILO - International Labour Organization
 IMO - International Maritime Organization
 IMPA - International Maritime Pilots' Association

IMSBC Code
 International Maritime Solid Bulk Cargoes Code
 ISAF
 International Sailing Federation (now World Sailing)
 ISGOTT
 International Safety Guide for Oil Tankers and Terminals

ISO - International Organization for Standardization

IT - Information Technology

kg - kilogram kN - kilonewton loa - length overall

LOLER - Lifting Operations and Lifting Equipment Reguations

LNG - Liquefied Natural Gas

LSMC - Less Serious Marine Casualty

Ltd - Limited (company)

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m - metre

MCA - Maritime and Coastguard Agency

MGN - Marine Guidance Note

(M+F) - Merchant and Fishing

(F) - Fishing

MI - Marine Incident

MMO - Marine Management Organisation

MSC - Maritime Safety Committee

MSN (M&F) - Merchant Shipping Notice (Merchant and Fishing)

N/a - Not applicable nav - navigation

NFFO - National Federation of Fishermen's Organisations

No - Number nm - nautical mile

NMOC - National Maritime Operations Centre
OCIMF - Oil Companies International Marine Forum

OSR - Offshore Special Regulations
PBA - Passenger Boat Association
PFDs - Personal Flotation Devices
PLB - Personal Locator Beacon
plc - Public limited company

PUWER - Provision and Use of Work Equipment Regulations (1998)

reg - registered

RCD - Recreational Craft Directive

RIB - Rigid Inflatable Boat
Ro-ro - Roll on, roll off vessel
RSW - Refrigerated salt water
RYA - Royal Yachting Association

SAR - Search and Rescue
SB - Safety Bulletin

SCV Code
 Seafish
 Sea Fish Industry Authority
 SFF
 Scottish Fishermen's Federation
 SIAS
 Ship Inspections and Surveys

SIGTTO - Society of International Gas Tanker and Terminal Operators

SMC - Serious Marine Casualty
 SOLAS - Safety of Life at Sea
 SPM - Single Point Mooring

TSGC - Tanker Safety Guide (Chemicals)

UAE - United Arab Emirates
UK - United Kingdom

UKHO - United Kingdom Hydrographic Offic

UR - Unified RequirementVHF - Very High Frequency

VSMC - Very Serious Marine Casualty

VTS - Vessel Traffic Services

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▶ Terms ◀

Cospas-Sarsat - COSPAS (Cosmicheskaya Sisteyama Poiska Avariynich Sudov)

is a Russian acronym for Space System for Search of Distress Vessels and SARSAT means Search and Rescue Satellite-Aided

Tracking.

D:d - Bending diameter: diameter of the rope

Deviation - The last event differing from the normal working process and

leading to an injury/fatality.

DUKW - A DUKW (commonly pronounced "duck") is an amphibious

landing vehicle that was designed to transport military personnel and supplies for the United States 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 frontwheel and rear-wheel drive capability (K and W, respectively).

E-log - Electronic log

Material agent - A tool, object or instrument.

MSL - Maximum Securing Load. MSL can be expressed in kN, kg or

t; e.g. a 100kN lashing is also referred to as a 10,000kg or 10t lashing. The variations in quantifier in the report reflects the variation in the source documentation. It is a term used to define the allowable load capacity for a device used to secure

cargo to a ship.

Subluxation - Incomplete, or partial dislocation.

Superficial injuries - Bruises, abrasions, blisters etc.

the Directive - EU Directive 2009/18/E

FURTHER INFORMATION

Marine Accident Investigation Branch

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105 Commercial Road

Southampton

SO15 1GH

Email

maib@dft.gov.uk

General Enquiries

+44 (0)23 8039 5500

24 hour accident reporting line

+44 (0)23 8023 2527

Press enquiries

+44 (0)1932 440015

Press enquiries (out of office hours)

+44 (0)20 7944 4292

Online resources

www.gov.uk/maib

https://twitter.com/maibgovuk

www.facebook.com/maib.gov

www.youtube.com/user/maibgovuk

www.linkedin.com/company/marineaccident-investigation-branch CHIEF INSPECTOR'S REPORT

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