

SAFETY BULLETIN

SB4/2024 OCTOBER 2024

Extracts from The United Kingdom **Merchant Shipping** (Accident Reporting and Investigation) Regulations 2012 Regulation 5:

"The sole objective of a safety investigation into an accident under these Regulations shall be the prevention of future accidents through the ascertainment of its causes and circumstances. It shall not be the purpose of such an investigation to determine liability nor, except so far as is necessary to achieve its objective, to apportion blame."

Regulation 16(1):

"The Chief Inspector may at any time make recommendations as to how future accidents may be prevented."

Press Enquiries: +44 (0)1932 440015

Out of hours: +44 (0)20 7944 4292

Public Enquiries: +44 (0)300 330 3000

NOTE

This bulletin is not written with litigation in mind and, pursuant to Regulation 14(14) of the Merchant Shipping (Accident Reporting and Investigation) Regulations 2012, shall be inadmissible in any judicial proceedings whose purpose, or one of whose purposes is to attribute or apportion liability or blame.

© Crown copyright, 2024

See http://www. nationalarchives.gov.uk/doc/ open-government-licence for details.

All bulletins can be found on our website: https://www.gov.uk/maib

For all enquiries: Email: maib@dft.gov.uk Tel: +44 (0)23 8039 5500

Foundering of the fishing vessel

Argos Georgia

approximately 190 nautical miles east of Port Stanley,

Falkland Islands

with the loss of 13 lives

on 22 July 2024

Image courtesy of Royal Air Force



Argos Georgia foundering

Safety bulletin produced in association with St Helena Government.

MAIB SAFETY BULLETIN 4/2024

This document, containing safety lessons, has been produced for marine safety purposes only, on the basis of information available to date.

The Merchant Shipping (Accident Reporting and Investigation) Regulations 2012 provide for the Chief Inspector of Marine Accidents to make recommendations at any time during the course of an investigation if, in his opinion, it is necessary or desirable to do so.

The Marine Accident Investigation Branch is carrying out an investigation on behalf of St Helena Government into the foundering of the fishing vessel *Argos Georgia* on 22 July 2024, with the loss of 13 lives.

The MAIB will publish a full report on completion of the investigation.

Captain Andrew Moll OBE

Chief Inspector of Marine Accidents

Rida E Mell

NOTE

This bulletin is not written with litigation in mind and, pursuant to Regulation 14(14) of the Merchant Shipping (Accident Reporting and Investigation) Regulations 2012, shall not be admissible in any judicial proceedings whose purpose, or one of whose purposes, is to apportion liability or blame.

BACKGROUND

On 22 July 2024, the St Helena registered longline fishing vessel *Argos Georgia* capsized and sank while on passage from Port Stanley, Falkland Islands to fishing grounds near the island of South Georgia. Of the 27 people on board, 13 perished and 14 were recovered during the search and rescue (SAR) operation. At the time, wave heights were reported to reach up to 7m accompanied by winds of up to 50 knots.

At about 1230¹, in a position approximately 190 nautical miles east of Port Stanley, *Argos Georgia* suffered an uncontrolled ingress of water through the shell door into the hauling compartment on its starboard side. Water then entered other areas aft of the hauling compartment (see **Figure**) and the vessel took on a starboard list. *Argos Georgia* was turned into the weather and the master raised the alarm via a colleague on a fishing vessel operating in the same region. This alarm was relayed to the authorities in the Falkland Islands and a SAR operation initiated using air and sea assets, supported by other fishing vessels.

Figure: Plan of Argos Georgia main deck, showing the extent of the initial flooding

As the list of the vessel steadily increased, the crew mustered and donned their immersion suits. At about 1445, *Argos Georgia* lost propulsion and the vessel drifted in the heavy seas. At about 1600, with the list continuing to increase and the aft deck becoming immersed, and with darkness approaching, the crew started abandoning ship into two liferafts. By approximately 1130 on 23 July 2024, two of the responding vessels had recovered 14 survivors and 9 deceased crew members. Four crew members remain missing, presumed dead.

INITIAL FINDINGS

The ongoing investigation has found that, before the accident, the shell door in the starboard side of *Argos Georgia* was raised in the closed position. At the time of the accident the door was observed on closed-circuit television to descend slowly into the fully open position. This allowed significant quantities of water to enter the vessel. The crew were unable to close the shell door once it had opened.

¹ The times in this safety bulletin are local time: universal time coordinated (UTC) -4 hours.

Internal doors leading from the hauling compartment were open. This allowed water to flow unhindered into other areas of the vessel, causing a significant list that progressively increased as more water entered. The crew were unable to control the passage of water into other spaces in the vessel, which increased the list still further until the vessel foundered.

SAFETY ISSUES

The initial stages of the investigation have identified that:

- the means of maintaining the shell door in the closed position did not ensure it remained shut at the time of the accident.
- the crew were unable to close the shell door once it had opened.
- some doors in the boundary of the hauling compartment were in the open position, allowing consequential flooding of adjacent spaces.
- the crew were unable to close the boundary doors to the hauling compartment.

RECOMMENDATIONS

All **owners**, **operators** and **skippers** of **fishing vessels** that are fitted with side shell doors are recommended to:

S2024/137M

Urgently ensure that a suitable and sufficient assessment of the risk of water entering the vessel through a side shell door has been undertaken and documented, noting the safety issues identified in this safety bulletin, and that:

- mitigations identified are immediately implemented to reduce the risks associated with a failure of a shell door;
- where a risk of consequential flooding between compartments exists, appropriate measures including maintaining internal doors in the closed position are taken; and
- the crew are informed of the findings of the risk assessment and the measures taken for their protection.

Safety recommendations shall in no case create a presumption of blame or liability

Issued October 2024