ACCIDENT REPORT

Red Ensign Group

The Government of Anguilla

INVESTIGATED BY THE MAIB ON BEHALF OF THE GOVERNOR OF ANGUILLA

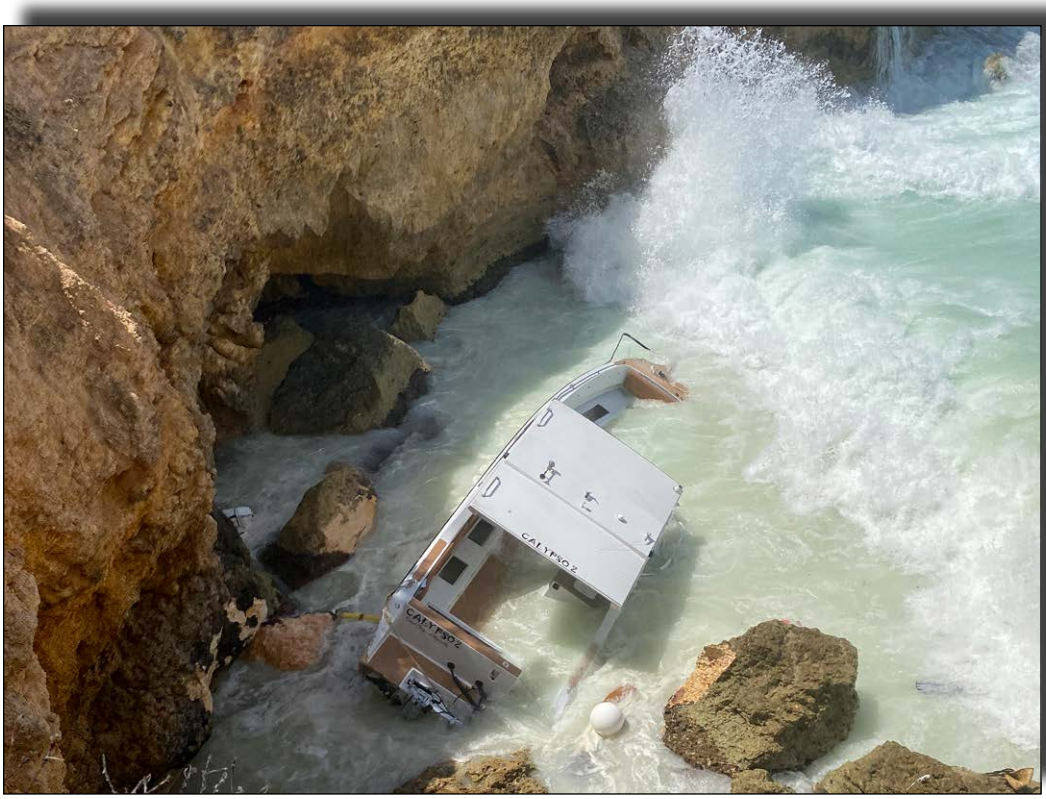
Report on the investigation of

the double fatality and subsequent loss of the small commercial vessel

# *Calypso 2*

near West End, Anguilla

on 11 March 2023



MAIB

MARINE ACCIDENT INVESTIGATION BRANCH

VERY SERIOUS MARINE CASUALTY REPORT NO 6/2025 APRIL 2025

**This investigation was carried out by the UK Marine Accident Investigation Branch (MAIB) on behalf of the Governor of Anguilla in accordance with the Memorandum of Understanding between the MAIB and the Red Ensign Group Category 2 registry, The Anguilla Maritime Administration.**

**Extract 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 an investigation to determine liability nor, except so far as is necessary to achieve its objective, to apportion blame."*

NOTE

This report 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.

The Marine Accident Investigation Branch was appointed to conduct the investigation reported here in accordance with section 28(2)(a) of the Anguilla Constitution, pursuant to Wrecks Inquiries Act, Revised Statutes of Anguilla, Chapter W35.

All MAIB publications can be found on our website: www.gov.uk/maib

Front cover image courtesy of Anguilla Fire and Rescue Service.

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# GLOSSARY OF ABBREVIATIONS AND ACRONYMS

| | | |
|---|---|---|
| AED | - | Automated External Defibrillator |
| AFRS | - | Anguilla Fire and Rescue Service |
| AIS | - | automatic identification system |
| AMASR | - | Anguilla Maritime Administration and Shipping Registry |
| CCL | - | Calypso Charters Ltd |
| cm | - | centimetre |
| CPR | - | cardiopulmonary resuscitation |
| DCCG | - | Dutch Caribbean Coast Guard |
| DSC | - | digital selective calling |
| EPIRB | - | Emergency Position Indicating Radio Beacon |
| ft | - | feet/foot |
| gt | - | gross tonnage |
| IMO | - | International Maritime Organization |
| ISM Code | - | International Safety Management Code for the Safe Operation of Ships and for Pollution Prevention |
| kts | - | knots |
| m | - | metres |
| M82-3 | - | Anguilla Small Commercial Vessels Regulations |
| MAIB | - | Marine Accident Investigation Branch |
| MCA | - | Maritime and Coastguard Agency |
| MRCC | - | Maritime Rescue Coordination Centre |
| MSN | - | Merchant Shipping Notice |
| PFD | - | personal flotation device |
| RAPF | - | Royal Anguilla Police Force |
| SAR | - | search and rescue |
| SCV Code | - | The Code of Safety for Small Commercial Vessels Operating in the Caribbean Trading Area, 2021 |
| SMS | - | safety management system |

| | | |
|---|---|---|
| SOLAS | - | International Convention for the Safety of Life at Sea, 1974, as amended |
| STCW | - | The International Convention on Standards of Training, Certification and Watchkeeping for Seafarers, 1978, as amended |
| UK | - | United Kingdom |
| US | - | the United States |
| UTC | - | universal time coordinated |
| VHF | - | very high frequency |
| W | - | watts |

**TIMES:** all times used in this report are UTC-4 unless otherwise stated.


*Calypso 2*

# SYNOPSIS

On 11 March 2023, the small commercial vessel *Calypso 2* entered a cove near West End on the north-west coast of Anguilla. The vessel was then overwhelmed by the force of large ground seas[1] that had developed near the coast, resulting in its four passengers and two crew being ejected into the water. Tragically, the mate and a female passenger lost their lives.

*Calypso 2* had been hired for an excursion around the island on 10 March 2023. The trip had been postponed due to adverse weather conditions and was rearranged for the following day. While the weather had improved overnight, high surf and swells remained in areas where there was a steep drop-off from the coast.

When *Calypso 2* entered the cove it adopted a beam on position to the breaking ground seas. The vessel was swamped and all the people on board were washed overboard. They were eventually recovered by combined land and sea rescue teams.

The investigation concluded that: the decision to enter the cove in the prevailing sea conditions was ill conceived and there was no specific plan or consideration of the danger in doing so; the vessel's operator, Calypso Charters Ltd did not have a safety management system that provided sufficient guidance and instruction to its skippers for the planning and safe execution of excursions; the maritime risks presented by the operation of small commercial vessels in Anguillan waters had been inadequately assessed; and there were omissions in the procedures and equipment available to the search and rescue responders.

A recommendation has been made to the Anguilla Maritime Administration and Shipping Registry to work with the Maritime and Coastguard Agency to develop and implement a marine safety management system to ensure that operational risks are adequately assessed and managed. Two further recommendations have been made to the Anguilla Maritime Administration and Shipping Registry to ensure that automatic identification system transponders have been installed as required on board Anguillan vessels, and that the safety management requirements for small commercial vessels are verified during routine inspections.

Calypso Charters Ltd has been recommended to develop and implement a safety management system for its domestically operating vessels. Recommendations have also been made to the Anguilla Fire and Rescue Service and the Royal Anguilla Police Force for the provision of additional equipment and the updating of triage procedures to improve the ability of the Anguillan authorities to respond to maritime emergencies.

[1] A West Indian name for a swell that occurs in calm weather and without obvious cause, breaking on the shore in heavy roaring waves.

# SECTION 1 – FACTUAL INFORMATION

## 1.1 PARTICULARS OF *CALYPSO 2* AND ACCIDENT

| **VESSEL PARTICULARS** | |
|---|---|
| Vessel's name | *Calypso 2* |
| Flag | Anguilla |
| Classification society | Not applicable |
| Official Number | 749978 |
| Type | Small commercial vessel |
| Registered owner | Calypso Charters Ltd |
| Manager(s) | Calypso Charters Ltd |
| Construction | Glass reinforced plastic |
| Year of build | 2011 |
| Length overall | 11.06m |
| Gross tonnage | 5.72 |
| Minimum safe manning | 2 |
| Authorised cargo | Not applicable |

| **VOYAGE PARTICULARS** | |
|---|---|
| Departure location | Rendezvous Bay, Anguilla |
| Arrival location | Rendezvous Bay, Anguilla (Intended) |
| Type of voyage | Coastal |
| Cargo information | Not applicable |
| Manning | 2 |

| **MARINE CASUALTY INFORMATION** | |
|---|---|
| Date and time | 11 March 2023 at 1015 (UTC -4) |
| Type of marine casualty or incident | Very Serious Marine Casualty |
| Location of incident | Anguilla |
| Place on board | Overside |
| Injuries/fatalities | 2 fatalities, 4 people injured |
| Damage/environmental impact | Vessel broke up on impact with the coast |
| Ship operation | In passage |
| Voyage segment | Mid-water |
| External & coastal environment | Fine and clear; south-easterly winds force 3 to 4; slight seas; ground seas near coast |
| Persons on board | 6 |

## 1.2 INVESTIGATION

This investigation into a very serious marine casualty was conducted by the Marine Accident Investigation Branch (MAIB) on behalf of the Governor of Anguilla in accordance with the memorandum of understanding between the MAIB and the Red Ensign Group[2] Category 2 registry, The Anguilla Maritime Administration.

### 1.2.1 Caveat

The events described in this investigation report are drawn from the evidence collected during the investigation. The recollections of the witnesses varied, and the narrative and facts presented in this report are therefore a best representation of the information gathered.

## 1.3 BACKGROUND

On 5 March 2023, a family of four US nationals comprising two parents and their adult son and daughter arrived at their resort hotel in Anguilla. The family had booked a 1-week stay and had pre-booked a 4-hour vessel excursion around the island on 10 March 2023. Late in the evening of 9 March 2023, the family was informed that the vessel's operating company, Calypso Charters Ltd (CCL), had cancelled the excursion due to the weather forecast for the following day. The excursion was subsequently rescheduled to 0930 on 11 March 2023, departing from the resort beach at Rendezvous Bay **(Figure 1)**.



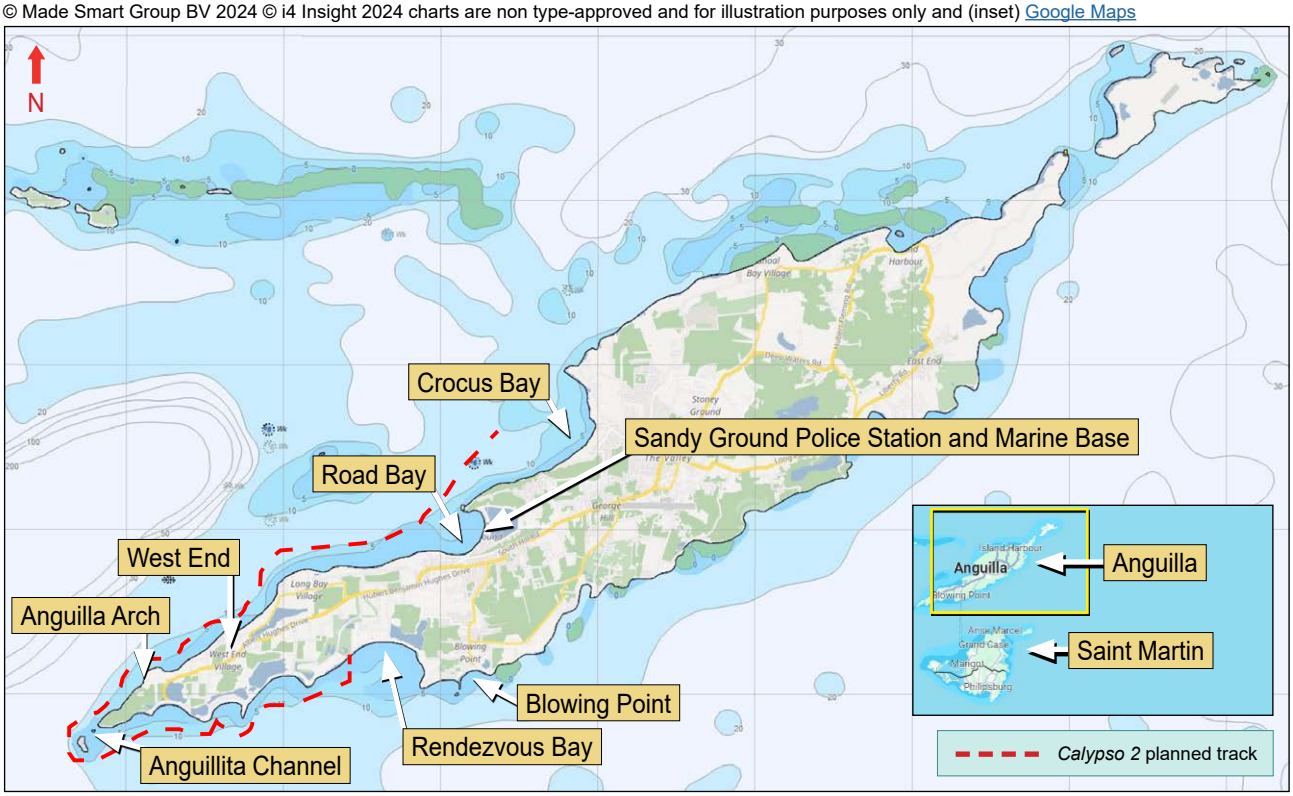


**Figure 1:** Anguilla and (inset) the Leeward Islands

[2] A group of British Shipping Registers formed of the UK, Crown Dependencies and UK Overseas Territories that operate shipping registers from their jurisdiction. A Category 2 register is able to register commercial ships and pleasure vessels of up to 150 gross tonnage (gt). This limit can be extended to 400gt by a memorandum of understanding with the UK.

## 1.4 NARRATIVE

### 1.4.1 The excursion

On 11 March 2023, the weather at Rendezvous Bay was fine and clear with rippled seas. By 0930, the small commercial vessel *Calypso 2* was anchored stern to the beach **(Figure 2)** ready for the scheduled excursion.

The family arrived at the beach shortly after 0935 and boarded *Calypso 2* one at a time, assisted by the vessel's skipper who boarded after the family members. The skipper showed the family where the lifejackets were stowed before going to the foredeck to raise the anchor and moving to the helming position. At about 0945, the skipper started the engines and manoeuvred *Calypso 2* out of Rendezvous Bay in a southerly direction.

The family settled in the seating area on the open foredeck, with the two parents sitting on the port side and their son and daughter on the starboard side **(Figure 3)**. The skipper manoeuvred the vessel in a south-westerly direction, intending to follow the coast around the southernmost point of the island then along Anguilla's northern coast to the popular tourist location of Crocus Bay **(**see **Figure 1)**.

*Calypso 2* proceeded south through increasingly choppy seas, during which the skipper left the helm on several occasions to brief the passengers on tourist sights. Sometimes, the mate took control of the vessel until the skipper returned; at other times, the skipper would helm the boat while speaking to the passengers from the doorway to the foredeck.

*Calypso 2*'s route passed through the Anguillita Channel on the island's western tip and then travelled to the north-west, following Anguilla's northern coast. There were no other vessels in the area.

Image courtesy of Rosenberg

**Figure 2:** *Calypso 2* at Rendezvous Bay on 11 March 2023

For illustrative purposes only: not to scale

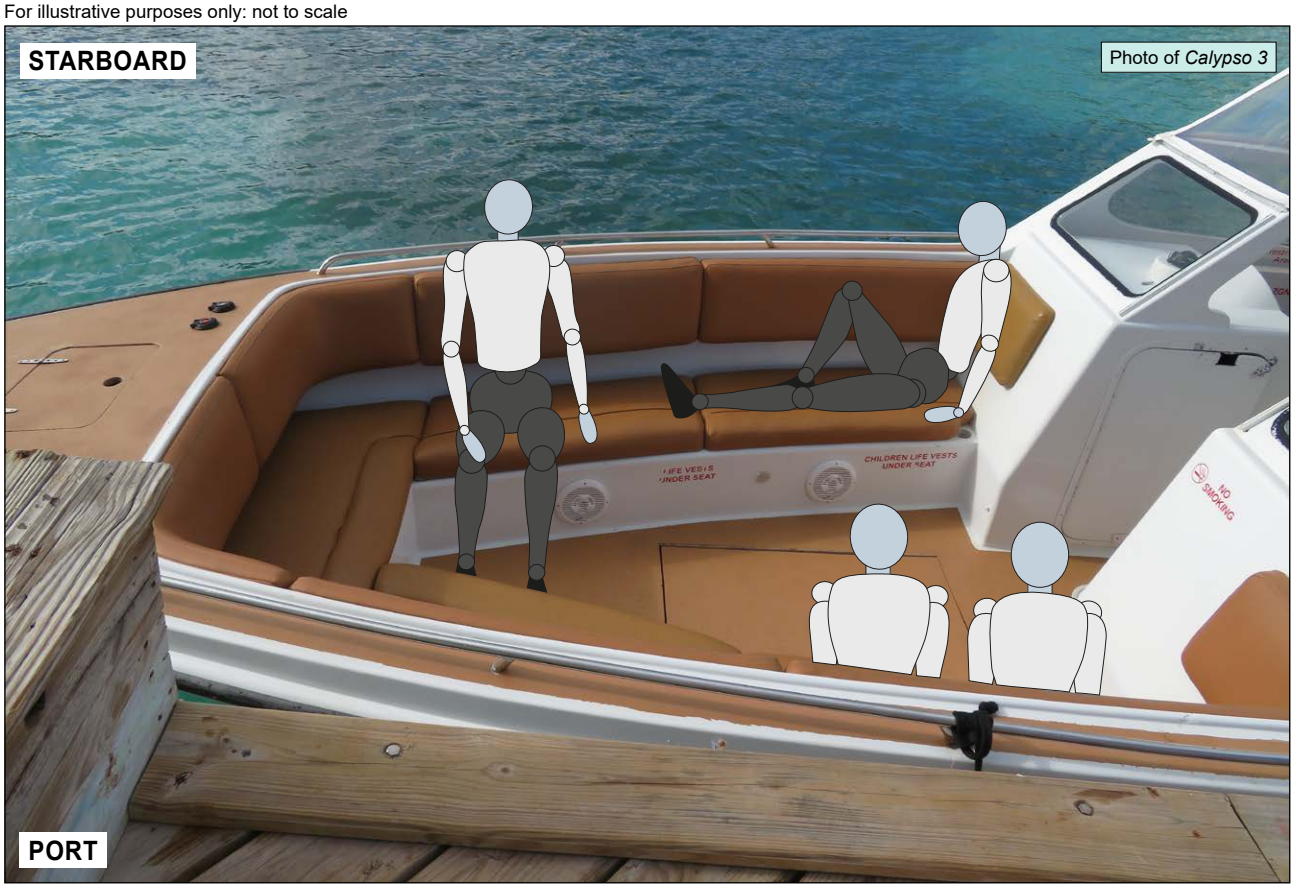


**Figure 3:** Passengers' seating positions on the foredeck

### 1.4.2 The accident

At about 1006, *Calypso 2* entered the cove adjacent to West End **(**see **Figure 1)** where the Anguilla Arch[3], a popular tourist attraction, is located. The skipper was standing in the doorway to the foredeck providing a narrative to the passengers, and the vessel's outboard engines were either in neutral or stopped.

*Calypso 2* was moving slowly on a southerly heading when its starboard side was struck by a large wave that swamped the vessel, washing the two parents overboard. The water swamping the vessel briefly submerged their son and daughter and the two crew, before a second wave overwhelmed the vessel and ejected everyone overboard and propelled the vessel into the cliffs. No one was wearing a personal flotation device (PFD).

### 1.4.3 Post-accident events

*Calypso 2*'s passengers and crew became separated once in the water **(Figure 4)**. The father, his son, and the skipper accessed the base of the cliff but the mother, her daughter, and the mate remained in the turbulent surf and ground seas. The daughter, who was a strong swimmer, managed to pull her motionless mother out past the breaking surf to calmer water. The mate was floating face down in the water. Those at the base of the cliff shouted for help.

[3] Known locally as The Arch.


**Figure 4:** Accident location, showing positions of the casualties

### 1.4.4 The rescue

At just after 1015, a tourist at The Arch heard the shouts for help coming from the cove to the north. The tourist saw the skipper and the son at the cliff base. Unable to obtain a mobile phone signal, the tourist left the area to find help.

About 10 minutes later, two other tourists staying at a nearby villa also heard the shouting and saw two people in the water. At 1032, the tourists made the first of several emergency calls to the Royal Anguilla Police Force (RAPF) reporting a drowning incident at "*West End by The Arch*". After collecting anything buoyant to throw to the people in the water the tourists drove the short distance towards the The Arch, where they met the other tourist.

At 1033, the Anguilla Fire and Rescue Service (AFRS) rescue vessel *SAR-1* was assigned to the incident and its five crew were paged and immediately responded. At 1045, *SAR-1* departed its berth at the Marine Base jetty, Sandy Ground **(**see **Figure 1)**. At the same time, the first RAPF responders arrived at the cliff top. They heard the shouts for help and met the three tourists, who informed them of the casualties at the cliff base and in the water. The first responders were not carrying any rescue equipment so relayed the actual nature of the emergency to their headquarters. The lead first responder then assisted the father to ascend the cliff.

At 1057, *SAR-1* arrived on scene. After initially assessing the conditions in the cove and spotting the two people in the water, two crew members jumped into the water to assist the mother and daughter. Both were recovered through the bulwark gate on *SAR-1*'s starboard quarter. The mother was unconscious and her daughter and *SAR-1*'s crew began administering cardiopulmonary resuscitation (CPR). Unable to render assistance to the son and the skipper trapped at the cliff base due to the conditions, *SAR-1* made its way at speed to the Marine Base jetty where, despite medical attention, the mother was declared deceased.

Meanwhile, a large crowd of local residents had been alerted to the cliff top through social media and word of mouth and began to effect a rescue with the first responders. After an unsuccessful attempt using an electrical cord, the rescuers used a rope attached to a boat fender to pull the son and the skipper up the cliff one at a time. Once at the top, *Calypso 2*'s skipper confirmed there had been six people on board and the rescuers began to search for the mate. The skipper and the father and son were transferred to hospital to be treated for minor injuries.

Shortly afterwards, an AFRS fire appliance arrived on scene and its crew descended the cliff. They found the mate at the cliff base and recovered her to the cliff top in a personnel basket **(Figure 5)** using a locally sourced mobile crane. The mate was subsequently declared deceased at the scene.

Image courtesy of Anguilla Fire and Rescue Service

**Figure 5:** Cliff rescue personnel basket

## 1.5 ENVIRONMENTAL CONDITIONS

### 1.5.1 Climate and topography

Anguilla is approximately 16 miles long and 3 miles wide at its widest point with predominantly flat terrain. The island's coastline is a combination of beaches and cliffs and there are many bays **(**see **Figure 1)**. Anguilla's northern coast has extensive reefs with flat sandbanks and seagrass beds.

The accident location comprised limestone and coral cliffs that had formed a cove with inlets. There were numerous large rocks and boulders at the cove, which had a sandy beach with a steep drop-off into deeper water.

A hydrographic survey of the area was undertaken in early 2017. The data from the survey was supplied to the UK Hydrographic Office and subsequently used to compile British Admiralty Chart 2047 – Approaches to Anguilla. The chart showed a depth of 0.7m to the south-west of the accident location. A rock symbol on the chart denoted the nature of the seabed.

### 1.5.2 Tidal streams and currents

The prevailing current around Anguilla sets from the west or north-west at a rate of about 1 knot, increasing to a maximum of 1.5 knots (kts) during the summer. The current could be influenced by west and south-westerly winds, though the island was generally sheltered from the south equatorial current by the banks surrounding it.

Anguilla's tidal range was about 0.3m with flood tidal streams setting to the west. The tidal height at West End was about 0.4m at the time of the accident.

### 1.5.3 Ground seas

Ground swells, known locally as ground seas, are generated by storms in the North Atlantic Ocean. Predominant from mid-October through to the end of March, ground seas were also known to occur in April.

Imray Chart A24[4] provided pilotage notes for the islands of Anguilla, Saint Martin, and Saint Barthélemy. The note on ground swells stated that:

> *…on any beach open to the northwest as far south as Antigua, there is the danger of ground swell, especially if the beach ashore is quite steep and the sand really soft.* [sic]
>
> *Ground swells are completely independent of the Caribbean weather systems; they are generated by storms in the North Atlantic.*

### 1.5.4 Weather warning

At 1630 on Wednesday 8 March 2023, Antigua and Barbuda Meteorological Services issued an urgent marine weather message that included warnings of:

- High surf from late Thursday (9 March) for Anguilla, Barbuda and Antigua, and the British Virgin Islands, with dangerous battering surfs of over 3m affecting some coasts.
- Moderate and long period swells that were expected to impact the northern coastline.
- A high risk to life, livelihood, property, and infrastructure.
- Swells that were expected to cause life-threatening surf and rip currents.
- Significant wave heights of 2m to 3m with swell periods of between 10 seconds and 15 seconds.

Precautionary actions urged all to *stay away from rocky and coastal structures along affected coastlines*. The warning was valid until Sunday, 12 March 2023.

### 1.5.5 Local environmental conditions at the time of the accident

It was a clear, sunny day with little cloud and slight seas. The winds were reported as south-easterly between 7kts and 14kts. There were ground seas on the northern coastline of Anguilla.

## 1.6 CREW AND PASSENGERS

### 1.6.1 Crew

The skipper was a dual Anguilla/US national who had joined CCL in 2015 as mate and was promoted to skipper in 2018. The skipper held an Anguilla Boatmaster Grade 1 License that was issued in October 2022, and had completed ship security

[4] Imray nautical charts were based on official hydrographic office data but edited and augmented with additional information aimed at the small vessel user. Chart A24 had an Imray stock code of ICA24-3.

officer, GMDSS[5] short range radio, sea survival and firefighting training. The skipper was confident in their ability to skipper small commercial vessels and had developed the practice of speaking to passengers from the doorway of the canopy while underway. At such times, the skipper would either hand the helm over to the mate or continue to steer from a position at the doorway. The skipper was able to swim.

The mate, Shanika Thomas, was a St. Vincent national who had joined CCL in 2021. She was employed as a hostess on board *Miss Ginger*, the largest vessel in the CCL fleet, but also acted as mate on the smaller vessels. In 2019, Shanika had completed all of the basic safety training required by STCW[6] in anticipation of a career on large internationally trading passenger ships. She did not hold a boat handling qualification or radio licence but had reportedly helmed *Calypso 2* before. It was reported that Shanika was able to swim.

### 1.6.2 Passengers

Robin Rosenberg, her husband, and adult son and daughter were described as good to strong swimmers who were in good physical health on the day of the accident.

### 1.6.3 Postmortem

Postmortem examinations of Robin Rosenberg and Shanika Thomas conducted in Anguilla recorded their cause of death as drowning.

## 1.7 CALYPSO CHARTERS LTD

### 1.7.1 Company

Founded in 2010, CCL was a family business based in Blowing Point, Anguilla. The office was managed by the owner, who was also the chief executive officer, asset manager and general manager.

### 1.7.2 Fleet

At the time of the accident, the CCL fleet comprised 14 passenger vessels that included 38ft charter vessels, a 40ft Sunseeker, a sports fishing vessel and a 65ft catamaran. The vessels were used for excursions around Anguilla and the neighbouring islands as well as to provide an international transfer service from St. Maarten.

### 1.7.3 Booking process

Excursions were booked either with CCL directly or through a third party such as a hotel concierge or travel agent. On receipt of a booking request detailing the number of guests and type of excursion required, CCL's asset manager would assign a vessel and crew before the booking was confirmed. The day before a booked excursion the assigned skipper was advised how many and what type of trips the vessel would be conducting, together with details of embarkation/disembarkation points, the number of guests, and any special requests.

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[5] Global Maritime Distress and Safety System.

[6] The International Convention on Standards of Training, Certification and Watchkeeping for Seafarers, 1978, as amended.

### 1.7.4 Safety management and procedures

CCL's safety management system (SMS) had been assessed in 2022 for the operation of its internationally trading vessels, but there was no evidence of an equivalent system covering its domestically trading vessels.

During the investigation, five generic procedural documents dated 13 March 2023 were submitted. There was no indication that these documents existed before the accident.

The procedures provided addressed pre-departure and departure protocols, conduct of private and shared excursions, disembarkation processes, and emergency preparedness. CCL did not define the maximum weather conditions in which its vessels could operate nor did it require any assessment of operational risks or passage planning.

### 1.7.5 Crew recruitment and assessment

New crew members were assessed by more experienced CCL crew. There was no formal induction procedure, and no records of the training completed by new joiners. After an introductory period, a new crew member would be allocated to a specific CCL vessel. It was common practice for the crew to circulate around the fleet, often with a change of roles. There was no formal procedure for assessing crew competence.

## 1.8 ANGUILLA MARITIME REGULATION

### 1.8.1 General

The Anguilla Maritime Administration and Shipping Registry (AMASR) was responsible for navigational management within Anguilla's coastal waters. The department consisted of the permanent secretary of infrastructure, communication, utilities, housing and information and technology, the superintendent of ports, and the registrar of ships.

The UK's Maritime and Coastguard Agency (MCA) provided support, funding, training and advice to AMASR through a series of audits and reviews. There were two AMASR authorised surveyors, both of whom had completed MCA surveyor training.

### 1.8.2 Anguilla Merchant Shipping Act 2010

The Anguilla Merchant Shipping Act 2010 enacted the Anguilla Small Commercial Vessels Regulations (M82-3). These regulations detailed the requirements for the inspection of small commercial vessels operating in Anguilla. Every vessel was required to be inspected, and a certificate of inspection issued that remained valid for a period not exceeding 3 years. Additionally, a vessel was required to undergo an annual inspection of the same scope as the initial one, but in less detail.

M82-3 required that vessels comply with the Code of Safety for Small Commercial Vessels Operating in the Caribbean Trading Area published by the International Maritime Organization (IMO) in September 2021 (SCV Code 2021).

AMASR produced an information sheet **(Annex A)** that set out its requirements for safety equipment and documentation required to be carried on small commercial vessels carrying less than 12 passengers. Included in the list of equipment was a Class B automatic identification system (AIS) transponder. Implementation of this requirement was reported to be slow.

M82-3 specified that a vessel must have someone in command who held an appropriate licence issued by AMASR and manned in line with the certificate of inspection held. The AMASR information sheet and vessel's certificate of inspection set out the qualification requirements for the crew.

### 1.8.3 Code of Safety for Small Commercial Vessels Operating in the Caribbean Trading Area

The SCV Code came into effect on 1 August 2021 and provided operating standards for safety, seafarer certification and wellbeing, and the protection of the marine environment for small vessels operating in the Caribbean Trading Area[7]. The SCV Code was initially based on the US Code of Federal Regulations Title 46 and the MCA code of practice titled Safety of Small Workboats and Pilot Boats.

The SCV Code stated that, before getting underway, the master should inform passengers of:

- emergency procedures;
- location of emergency exits;
- location of stowed lifejackets;
- proper manner for donning lifejackets;
- placard location for emergency equipment; and
- requirement for all passengers to wear lifejackets when possible hazardous conditions exist, as directed by the master.

The crews of small commercial vessels operating in coastal waters were required to undertake emergency drills and maintain a record of them. The SCV Code stated that, where a passenger vessel[8] was engaged on an international voyage, it needed to comply with the requirements of the International Safety Management Code for the Safe Operation of Ships and for Pollution Prevention (ISM Code).

The SCV Code required any vessel making a voyage in exposed or coastal waters to keep an accurate record of everyone embarking the vessel, including their name and gender and distinguishing between adults, children and infants.

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[7] Defined as the Gulf of Mexico and Caribbean Sea proper, including the bays and seas therein and that portion of the Atlantic Ocean within the boundary constituted by a curved line from a point on the east coast of the US in latitude 32° 00' north to the intersection 20° 00' north, 59° 00' west; from there, a curved line to the intersection of 7° 20' north, 50° west; from there, a curved line drawn south-westerly to the eastern boundary of French Guiana.

[8] A passenger vessel in the SCV Code is one that carries more than 12 passengers.

Vessels on coastal voyages around Anguilla were not required to comply with the requirements of the ISM Code, although the SCV Code stated that vessels must be operated safely *in such a manner as to afford adequate precaution against hazards, which might endanger the vessel, its passengers and cargo*. Chapter VIII section 4.10 further required that *a safety management system should be in place with related documentation commensurate with the vessel type, size and operation.* Annex 17 to the SCV Code provided an example of the suggested content of a safety management system.

### 1.8.4 Navigational risk assessment

In April 2021, AMASR completed a *Maritime Risk Assessment for the Coastal Waters up to the Economic Fishing Zone*. In August 2022, AMASR commissioned a marine consultancy to conduct a navigational risk assessment of Anguillan waters. The report of the assessment's findings, delivered in July 2023, highlighted that there had been six personal injuries, five missing persons and three fatalities recorded involving recreational and small commercial craft in the period between 2019 and 2023. The report stated that, *incidents involving crew and passengers onboard recreational vessels and small commercial vessels are considered a comparatively 'high risk'*. [sic]

The report's conclusions included that:

- a maritime safety management system was required to reduce risk;
- several reported incidents involving recreational and charter vessels had resulted in serious injuries and loss of life; and
- a risk register was required to identify hazards and risk controls.

The report noted the limited AIS data available from small commercial vessels operating in Anguillan waters.

## 1.9 *CALYPSO 2*

### 1.9.1 General

*Calypso 2* was built for CCL in Trinidad in 2011 by an unknown manufacturer. The vessel had a planing hull constructed from glass reinforced plastic and twin 350 horsepower outboard engines that had been fitted in December 2022. There were passenger seating areas around the foredeck and across the stern. Approximately one third of the vessel's length from the bow there was a partially enclosed cabin area that included the helm controls on the starboard side, the on board toilet, and a seating area on the port side **(Figure 6)**. The stern had a low transom to facilitate boarding from the water.

The helm was equipped with engine throttles; engine start-stop buttons; a global positioning system chart plotter; a compass; a bilge pump control; and a very high frequency (VHF) digital selective calling (DSC) radio with an alert button **(Figure 7)**. *Calypso 2* also carried a copy of the Imray A24 paper chart.

For illustrative purposes only: not to scale

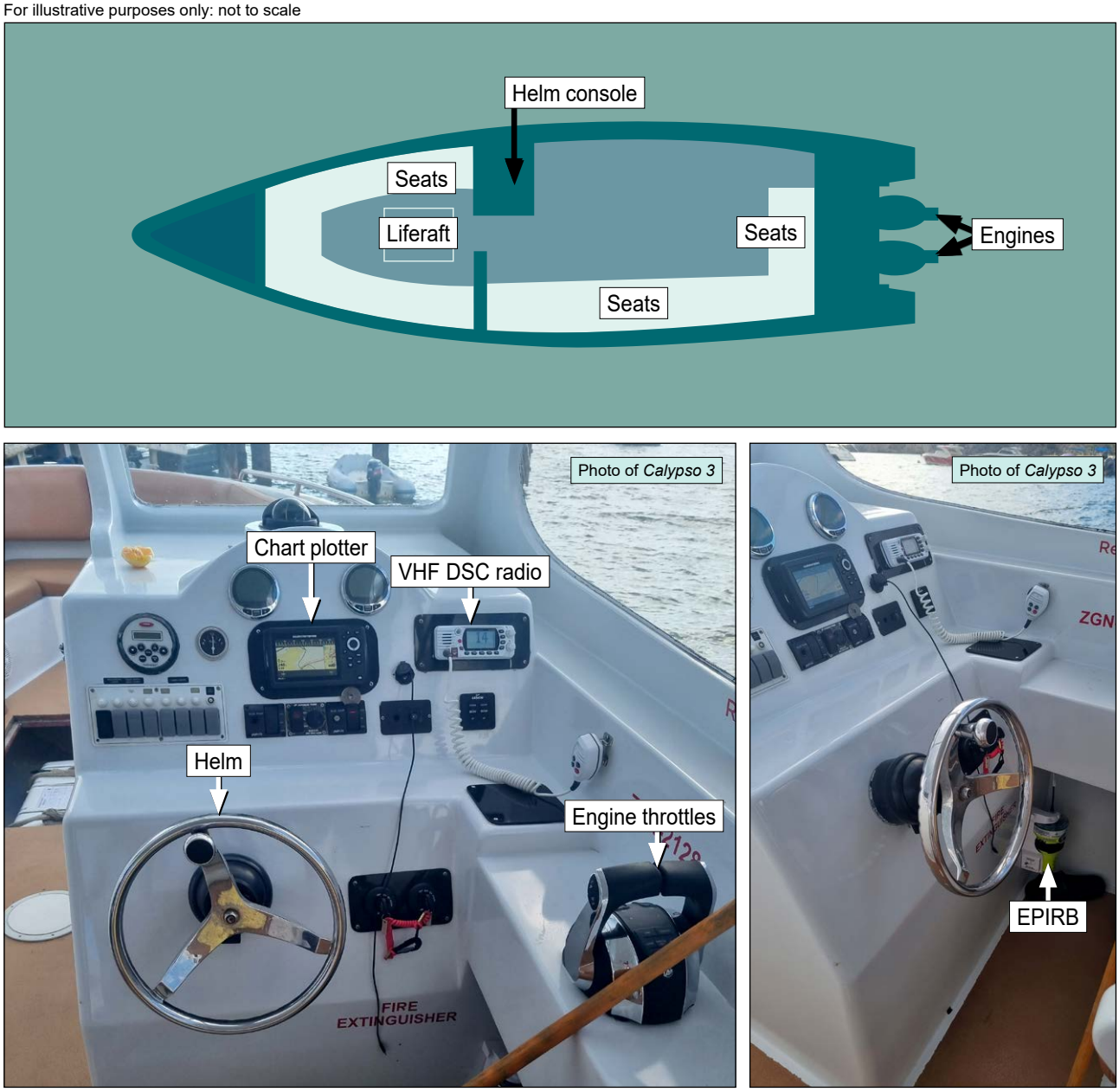


**Figure 6:** *Calypso 2* general arrangement and helm console


**Figure 7:** VHF DSC radio

### 1.9.2 Safety equipment

*Calypso 2* was equipped with 14 solid foam adult lifejackets suitable for persons weighing over 43kg and two child lifejackets. These were stowed under the seats in the bow. There was one 16-person liferaft in a hard case container stored under the foredeck seating area **(Figure 8)**. The vessel carried: a pack of pyrotechnic flares, comprising two orange smoke floats, six red parachute flares and six handheld flares; two lifebuoys, one with a light and one with a line; and two fire extinguishers.

An Emergency Position Indicating Radio Beacon (EPIRB) arranged for manual release and activation was stowed below the helm console **(**see **Figure 6)**. *Calypso 2* was not equipped with an AIS transponder.


**Figure 8:** Liferaft stowage in the foredeck seating area

### 1.9.3 *Calypso 2* inspection history

An inspection of *Calypso 2* out of the water was carried out on 19 July 2022, recorded on the report of inspection as being a survey. Five deficiencies were raised by the surveyor, which included loose fittings and minor hull damage.

A subsequent inspection of *Calypso 2* while afloat was completed by the same surveyor on 16 August 2022. Eight deficiencies were recorded, including that drills were neither frequent nor logged; the primary VHF radio was inoperative; and charts for the area of operation required updating. There was no observation or deficiency noting that *Calypso 2* was not equipped with a Class B AIS transponder.

No deficiencies related to safety management were raised in either assessment by the surveyor.

The deficiencies raised during the inspection were closed out as completed on 17 October 2022. A new certificate of inspection for a small passenger ship, in line with the requirements of M82-3, was issued on 25 October 2022. The expiry date for this certificate was 19 July 2023.

### 1.9.4 Post-accident examination

*Calypso 2* eventually broke up on the rocks in the cove **(Figure 9)**, visible from the cliff tops above the accident site. It was not possible to recover much of the wreckage due to its location, the nature of the seabed, and the predominant swell.

Despite the terrain, the RAPF recovered *Calypso 2*'s twin outboard engines. MAIB inspectors conducted a visual examination of the engines and noted that:

- Both engines showed damage from immersion in seawater.
- The port engine had lost its lower leg unit, including the gearbox and propeller.
- The starboard engine was almost complete and the propeller was still in place, though the blades were bent.

The engines were later sent to an engine specialist for technical examination, the findings of which concluded that:

- The port engine (left-hand rotation) had no useable electronic data that could be obtained from the unit **(Figure 10a)**.
- The starboard engine (right-hand rotation) showed evidence that the engine was in neutral or stopped when it came into contact with the ground.
- There was no brush damage on the propeller blades and no evidence of torque stress damage to the propeller drive splines. The drive pin was intact and the propeller hub was still theoretically useable **(Figure 10b)**.
- There was no evidence to indicate that either engine had hydraulically locked[9].

[9] Occurs when an engine is stopped by water entering the cylinder while running. The incompressibility of the water causes the engine to stop instantly.

Image courtesy of Anguilla Fire and Rescue Service


**Figure 9:** *Calypso 2* aground in the cove

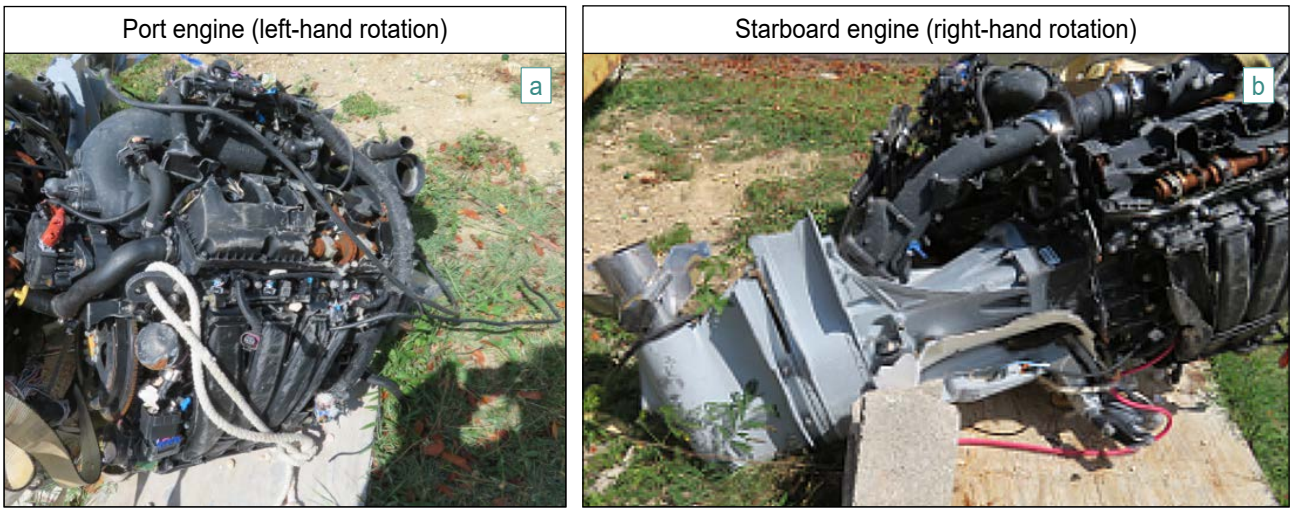


**Figure 10:** *Calypso 2*'s engines after the accident

## 1.10 ANGUILLA MARINE ACCIDENT RESPONSE

### 1.10.1 Royal Anguilla Police Force

The RAPF had around 95 officers and support staff and was responsible for emergency response on the island, including triaging emergency calls and escalating marine responses to the AFRS as necessary. There had previously been a RAPF marine branch that undertook sea patrols of Anguilla's coastal waters, but the patrol vessel had been badly damaged in a storm and was not replaced.

### 1.10.2 Anguilla Fire and Rescue Service

The AFRS was based at Anguilla's airport and managed the maritime search and rescue (SAR) unit and the marine response centre. Several of the firefighters were trained in cliff rescue and the required descent equipment was available on board the firefighting vehicles.

The marine response centre was manned by ARFS staff who coordinated the response to a notified marine incident. The centre was equipped with local charts, an incident control board showing vessel details and search areas, SAR manuals and a VHF DSC radio.

### 1.10.3 Search and rescue fast response vessel

A purpose-built SAR fast response vessel, *SAR-1*, was used by the AFRS to respond to maritime incidents. Located at Sandy Ground in Road Bay **(**see **Figure 1)**, the expected response time for *SAR-1* to mobilise to an incident was 15 minutes. *SAR-1* was equipped with a VHF DSC radio, AIS transponder, first aid kit, charts and lifejackets. The vessel usually carried an Automated External Defibrillator (AED), which was not on board on the day of the accident due to the awaited supply of replacement defibrillator pads.

On the starboard side of *SAR-1* there was a bulwark door with a lower edge that was 60cm above the waterline. The vessel was not equipped with the means of recovering an unconscious person or someone who was unable to assist in their own recovery from the water.

Nominated AFRS crew were tasked as crew and had completed STCW safety courses and the UK Royal Yachting Association Level 2 Powerboat Handling training, which was supplemented by MCA workshops. *SAR-1* was usually manned by two coxswains and three crew. The designated coxswains each held an Anguilla Boatmaster Grade 1 License. No formal training on the recovery of personnel in the water had been completed.

## 1.11 EMERGENCY RESPONSE

### 1.11.1 Dutch Caribbean Coast Guard

The Dutch Caribbean Coast Guard (DCCG) was the coastguard for the territorial waters of the Caribbean countries of the Kingdom of The Netherlands – Aruba, Curaçao and St. Maarten – and the adjacent Caribbean Sea. The DCCG had numerous air and sea assets at its disposal to respond to incidents. There was a memorandum of understanding between DCCG and AMASR for assistance when required.

### 1.11.2 Maritime Rescue Coordination Centre Fort-de-France

The nearest Maritime Rescue Coordination Centre (MRCC) to Anguilla was located in Fort-de-France on the island of Martinique. MRCC Fort-de-France was the regional centre responsible for the coordination of search and rescue incidents in the northern region of the Lesser Antilles, in which Anguilla is located.

Response to EPIRB notifications within Anguilla waters was coordinated by MRCC Fort-de-France.

### 1.11.3 Automatic identification system

The AIS is a short-range tracking system developed as an identification and positional information system for ships. The information it provides is used by both marine traffic and shore stations. Carriage of AIS is mandatory on all SOLAS vessels[10], but the system is only required on non-SOLAS vessels if stipulated by the local marine administration.

A SOLAS vessel is required to carry a Class A AIS transponder that transmits at 12.5 watts (W). Dynamic information, including position, course and speed, is transmitted every 2 to 10 seconds while a vessel is underway, or every 3 minutes when at anchor. Information including the vessel's name and cargo being carried is transmitted at 6-minute intervals.

In contrast, Class B AIS transponders transmit at 2W. Static data is also transmitted at 6-minute intervals, though dynamic data is transmitted every 30 to 180 seconds. Whereas Class A transponders can receive and transmit voyage and safety-related messages, Class B transponders can only receive such data.

There were a series of coastal radio stations on Anguilla, Saint Martin and Martinique that maintained a listening watch on VHF radio. The AFRS marine response centre had access to a web-based AIS monitoring resource during incidents.

## 1.12 TOURISM ON ANGUILLA

With 33 beaches and clear Caribbean waters, the popular tourist destination of Anguilla had attracted over 51,000 visitors during the period from January to March 2023.

In 2023, there were about 300 vessels registered in Anguilla, many of which were solely engaged in coastal day excursions inside Anguillan coastal waters. Additionally, there were several small charter vessels similar to *Calypso 2* that provided international shuttle or chartered services between Anguilla and Saint Martin.

[10] The International Convention for the Safety of Life at Sea (SOLAS), 1974, as amended, required the carriage of AIS on cargo vessels over 500 gross tonnage and all passenger vessels on international voyages.

## 1.13 SIMILAR ACCIDENTS

### 1.13.1 *Seadogz* – heavy contact with a navigation buoy

On 22 August 2020, a 15-year-old passenger on the 9.7m rigid inflatable boat *Seadogz* died when the craft struck a navigational buoy at high speed in Southampton Water, England (MAIB report 10/2023[11]). The investigation found that:

- There was no monitoring of small commercial craft operation.
- The SMS and risk assessments did not include all the hazards presented during the vessel's operation.

### 1.13.2 *Surprise* – grounding and evacuation

On 15 May 2016, the passenger vessel *Surprise* grounded on rocks during a sightseeing tour around the Isles of Scilly, England (MAIB report 14/2017[12]). All 48 passengers were safely transferred to other vessels, and the passenger vessel returned to harbour under its own power despite being damaged below the waterline. The investigation concluded that:

- A passage plan had not been prepared for the excursion.
- The vessel's SMS lacked guidance on the conduct of navigation and what actions to take in an emergency.
- Procedures for issuing local authority boatmen licences lacked rigour; there was no syllabus for candidates to follow; or assurance of training standards.

### 1.13.3 Unnamed Bayliner Capri – capsize of an open speedboat

On 10 March 2014, three men departed Great Yarmouth, England in a 5.7m Bayliner Capri 2000 speedboat to go fishing. About 3.5 hours later, the capsized hull was seen about 100m offshore. The three men lost their lives in the accident (MAIB report 28/2014[13]). The investigation established that:

- The men were insufficiently experienced and were probably not expecting the deteriorating weather conditions, despite the change having been forecast.
- The vessel had a low freeboard at its stern, making it vulnerable to swamping when its propeller became fouled.

[11] https://www.gov.uk/maib-reports/heavy-contact-between-the-high-speed-passenger-craft-seadogz-and-a-navigation-buoy-with-loss-of-1-life

[12] https://www.gov.uk/maib-reports/grounding-and-evacuation-of-domestic-passenger-vessel-surprise

[13] https://www.gov.uk/maib-reports/capsize-of-an-open-speedboat-being-used-to-recover-longline-fishing-gear-off-lowestoft-england-with-loss-of-3-lives

### 1.13.4 *Last Call* – sinking of a motor cruiser

On 27 November 2007, the skipper and two crew from the vessel *Last Call* were lost after heading out to sea from Whitby, England in inclement sea conditions. The vessel was swamped by the high surf shortly after clearing the harbour and all three people on board were ejected overboard (MAIB report 11/2008[14]). The investigation concluded that:

- The skipper and crew's lack of training and qualification in the use and operation of small craft contributed significantly to the accident.

- The vessel was overwhelmed by the force of the large seas that had developed.

### 1.13.5 *Swan* – capsize

On 14 October 2004, the passenger launch *Swan* flooded and capsized on the River Avon, England with a skipper and nine passengers on board. The skipper had manoeuvred the vessel too close to a weir to produce a 'unique thrill'. The vessel floundered, capsized, and tipped those on board into the water. About 20 minutes later, all were rescued and treated for minor injuries (MAIB report 11/2005[15]). The investigation found that no effective risk assessment had been carried out for the vessel's operation.

[14] https://www.gov.uk/maib-reports/sinking-of-motor-cruiser-last-call-in-heavy-weather-at-whitby-england-with-loss-of-3-lives

[15] https://www.gov.uk/maib-reports/flooding-and-capsize-of-passenger-launch-swan-under-pulteney-weir-on-river-avon-bath-england

# SECTION 2 – ANALYSIS

## 2.1 AIM

The purpose of the analysis is to determine the contributory causes and circumstances of the accident as a basis for making recommendations to prevent similar accidents occurring in the future.

## 2.2 OVERVIEW

The accident happened because *Calypso 2* was too close to shore, and was swamped and propelled into the rocks and cliffs by a large wave before it could be manoeuvred away. Robin Rosenberg and Shanika Thomas were not wearing PFDs and drowned after they were ejected into the water.

The circumstances of the accident and the reasons why two people lost their lives are analysed in this section of the report. The factors that contributed to this fatal accident will also be discussed, including the conduct of the excursion and the emergency preparedness.

## 2.3 THE ACCIDENT

### 2.3.1 Events leading up to the accident

*Calypso 2*'s skipper had been entertaining the family group by providing a narrative of the sights and notable buildings during the trip. Although it is unclear exactly why the skipper chose to enter the cove near West End and leave the helm when the vessel was near the cliffs, shallows, and rocks, it is possible that they had intended to show the family The Arch. It is highly likely that once inside the cove the skipper became distracted by their narrative to the family and did not realise how close *Calypso 2* was to the shore. In the prevailing circumstances and conditions, and against the weather warning's advice, to approach the cove at all was a serious misjudgement.

Once *Calypso 2* was in the cove it was at high risk of being carried inshore by the surf and ground seas. *Calypso 2* was swamped after entering the cove when it took up a beam on position to the ground seas rolling into the shore, and its skipper was unable to take avoiding action in sufficient time.

Similar to the prevailing conditions at the time of the accidents involving *Surprise*, the unnamed Bayliner Capri, and *Last Call*, those experienced by *Calypso 2* were to be avoided for the safety of craft, people and the environment. Without a formal assessment of the excursion, the opportunity to examine the hazards and risks of entering the cove was lost.

### 2.3.2 Manoeuvrability

It is unclear why *Calypso 2* was not manoeuvred out of the cove before the first wave struck. The vessel was equipped with relatively new engines that made it highly manoeuvrable and provided sufficient ability for it to leave the area; however, that there was no apparent attempt to do so possibly indicates that the helm was not manned at the time. The second wave followed in quick succession to the first

and it is unlikely there was time to react before everyone was ejected. There was nothing that could be done to resolve the situation once the occupants had been ejected overboard.

The post-accident examination of the engines indicated that they were not operated at high power just before they became damaged. This also suggests that the helm was either unmanned or, if someone was at the helm, they did not take effective action in sufficient time to avoid being swamped.

### 2.3.3 Personal flotation devices

None of the passengers or crew were wearing PFDs at the time of the accident. This was not unusual for recreational excursions in the Caribbean region, where PFDs were considered restrictive. Nevertheless, an adequate assessment of the prevailing sea conditions might have identified that the donning of PFDs was a prudent control measure in the circumstances. While lifejackets were available on board, they were of a heavy foam type intended to be donned in an emergency during a controlled abandonment of the vessel. These lifejackets might have been too cumbersome to wear for long periods of time on a vessel the size of *Calypso 2*.

Consequently, Robin's and Shanika's chances of survival were substantially reduced when they lost consciousness in the water without any additional buoyancy to support them and maintain their airways clear of the water.

### 2.3.4 Use of communication and alert systems

*Calypso 2* was equipped with an EPIRB that needed to be removed from its bracket under the helm and then manually activated, while the VHF DSC alert button was located on the helm console. Neither the EPIRB nor VHF DSC were activated in the emergency response phase to this accident.

Although the two waves struck in quick succession, the skipper or mate would have been afforded more protection than others on board due to the semi-enclosed nature of the helm area and the availability of handholds. Given that the two devices were within reach of the helm position, that the crew did not use either system possibly indicates that neither was near the helm position or they were insufficiently familiar with their use.

*Calypso 2*'s EPIRB has neither been recovered nor emitted an alert since the accident, calling into question the suitability and stowage position of such EPIRBs for a vessel operating in challenging seas.

### 2.3.5 Weather conditions

The weather in Anguilla follows a defined pattern and the weather experienced on the day of the accident was as forecast and had been widely promulgated via marine weather warnings.

The sharp incline to the water from the beach where the accident occurred was a common feature along Anguilla's northern coast. Imray Chart A24 and British Admiralty Chart 2047 provided sufficient information on ground seas for the danger to be adequately assessed by anyone with a basic understanding of the area. Additionally, a surf warning was in place that provided a fair indication that mariners could expect adverse conditions at such locations until Sunday, 12 March 2023.

There is no evidence that either CCL or *Calypso 2*'s skipper had considered the risk of ground seas in the prevailing conditions following the previous day's bad weather. Although such phenomena were common in the winter months, CCL did not provide guidance to its skippers on the precautions to be followed during inclement sea conditions. Consequently, the hazards involved with operating a vessel in such conditions were not identified or mitigated and skippers were instead left to make their own assessment.

## 2.4 SAFETY MANAGEMENT OF SMALL COMMERCIAL VESSELS

### 2.4.1 Safety management system

The SCV Code required passenger vessels operating internationally to operate under the requirements contained in the ISM Code. Though evidence was available to show that an SMS for the operation of the internationally trading vessels in the CCL fleet carrying more than 12 passengers had been audited in March 2022, there was no evidence that an equivalent system had been implemented on *Calypso 2*.

Given the requirement in the SCV Code for an SMS commensurate with the vessel's type, size and operation, it is almost certain that a critical assessment of the system in use at CCL carried out during inspections of the vessel would have deemed it to be noncompliant with the code requirements.

The absence of company guidance or procedures, coupled with a lack of regulatory oversight, meant that the skipper of *Calypso 2* had complete autonomy over how it was operated. Consequently, *Calypso 2*'s safety on the day of the accident relied on the skipper's decision-making and competence rather than a robust SMS meeting a defined standard.

### 2.4.2 Safety management on the day of the accident

The absence of CCL procedures or guidance left *Calypso 2* without a framework for its operation. Consequently, and contrary to the SCV Code, there was no company requirement for either a pre-excursion briefing between the skipper and the mate; a format for the passenger safety briefing; or for a copy of the passage plan to be retained ashore; this meant that the vessel's progress could not be checked or monitored.

There were no systems in place to support the skipper in making the initial decision to undertake the excursion or, should the excursion go ahead, a safe route to follow.

The decision to navigate *Calypso 2* into an area with charted shallows, known to experience ground seas and subject to a weather warning had similarities to the resultant safety issues from the investigation into the foundering of *Swan* and the accident involving *Seadogz*, where no effective assessment of the risk of a planned excursion were carried out.

*Calypso 2*'s skipper was experienced and qualified for their role. However, while M82-3 required that they were suitably qualified to helm the vessel, and to use the communication/distress systems on board, there was no requirement for the mate to be similarly capable. Without guidance to the contrary, the skipper likely felt at liberty to place the mate at the helm.

## 2.5 ANGUILLA NAVIGATIONAL RISK ASSESSMENT

The navigation risk assessment for the internal waters of Anguilla commissioned by AMASR noted the paucity of AIS data for small commercial vessels.

The assessment recommended implementing a maritime SMS that included a register of maritime risks. Ongoing monitoring of these risks in Anguilla would rely on periodic risk reviews. The identification of the comparatively high risks associated with small commercial vessels and the low adoption of AIS on these vessels pose challenges to identifying the population at risk and making an accurate assessment of risk in the sector.

There was no existing policy on how Anguillan authorities should use AIS data. The navigational risk assessment highlighted the poor AIS data from small commercial vessels, emphasising the need for better compliance by commercial vessels carrying fewer than 12 passengers. This would support the periodic reviews recommended in the assessment.

## 2.6 EMERGENCY PREPAREDNESS – ANGUILLA

The shore-based response to the accident was triggered by the emergency calls to the RAPF made by tourists reporting a drowning incident at The Arch. Despite several subsequent emergency calls being made, the lack of a complete understanding of the unfolding emergency made the organisation of an appropriate response difficult. That a vessel was involved only became apparent when the first RAPF responder arrived at the scene, though this did not delay the maritime response to the accident. Rapid and effective triage of an incident is vital to deliver an effective response to the casualties and to assess the risks to responders and the public during the rescue phase.

Although neither the DSC nor EPIRB systems were activated to indicate that *Calypso 2* was in distress, the agreements with DCCG and MRCC Fort-de-France provided Anguilla with experienced and well-equipped SAR services had they been required. The marine response centre at the airport was equipped with a VHF DSC system in order to receive distress messages but it is unlikely that the activation of the EPIRB or DSC on *Calypso 2* would have resulted in a quicker shore-based response to this accident due to the delay that a relay response inevitably introduces.

The mandate from AMASR was that small commercial vessels carrying fewer than 12 passengers must be equipped with a Class B AIS transponder. Although this was not a factor in the accident, the absence of AIS on *Calypso 2* meant that initial responders lacked a key indicator that a vessel might be involved and information on how many people were at risk. Even if *Calypso 2* had such equipment, the marine response centre not being equipped with an AIS unit limited the information available to the AFRS staff stationed there.

Despite the risks presented by using a rope connected to a boat fender to pull the son and skipper up the cliff, the rescue effected by the first responders and local residents was successful. The subsequent descent of the cliff by trained AFRS staff using appropriate equipment and the use of a mobile crane for the recovery of the mate allowed this phase of the response to be completed with minimal risk.

Despite the slightly protracted shore-based rescue phase, all those ejected from *Calypso 2* were recovered by the activities of the organisations involved in the response. On the causes of death it is likely that, once ejected overboard, the tragic loss of Robin and Shanika could only have been averted had they been wearing PFDs and had they received immediate medical attention on recovery.

## 2.7 EMERGENCY RESPONSE – *SAR-1*

### 2.7.1 Recovery of people from the water

The AFRS search and rescue craft *SAR-1* was purpose-built for emergency use around Anguilla's coastal waters. The vessel was sufficiently manned by qualified crew on the day of the accident. Despite *SAR-1* being specifically intended for deployment to waterborne incidents, no equipment was provided to facilitate the recovery of people from the water. The primary means for recovering a person from the water was to manually lift them through the bulwark door on the starboard side of the vessel.

*SAR-1* was alerted to a person drowning at "*West End by the Arch".* Responding to the reported drowning incident, the rescue craft mobilised in a timely manner. When *SAR-1* reached the scene of the accident, it was restricted in its ability to reach the casualties at the cliff base due to the turbulent seas and the proximity of shoals and rocks. The two casualties in the water were accessible to the boat, but Robin was unconscious and her daughter was extremely tired when the boat arrived. With no means of recovery fitted to the boat, the only way the crew could lift the casualties from the water was to enter the water themselves.

The crew of *SAR-1* would not have needed to enter the water had the rescue craft been fitted with equipment that facilitated the rescue of people who were unable to assist in their own recovery. This was a hazardous operation in the prevailing sea conditions and placed *SAR-1*'s crew at risk.

The shortcomings in the operational capabilities of *SAR-1* compared to the likely rescue scenarios to which the vessel was intended to respond had not been identified during its design or in its operation since entering service.

### 2.7.2 Automated External Defibrillator

*SAR-1* was initially equipped with an AED for use on casualties rescued from the water. Although on order, the replacements for the AED's expired pads had not been received and the defibrillator was not on board on the day of the accident. Though the CPR administered by the daughter and crew of *SAR-1* provided the best option for saving Robin in the circumstances, a functioning AED might have changed the outcome of this accident.

# SECTION 3 – CONCLUSIONS

## 3.1 SAFETY ISSUES DIRECTLY CONTRIBUTING TO THE ACCIDENT THAT HAVE BEEN ADDRESSED OR RESULTED IN RECOMMENDATIONS

1. *Calypso 2* was too close to the rocks in the onshore surf and ground seas. It was swamped and propelled into the rocks and cliffs by a large wave before it could be manoeuvred away. [2.3.1]

2. There was no assessment of the risk of entering the cove. The lack of appreciation of risk placed the people on board *Calypso 2* in danger when the decision was made to enter the cove. [2.3.1, 2.3.5, 2.4.2]

3. *Calypso 2* had sufficient available engine power to be manoeuvred out of the cove. That it was not indicates that either that there was no one at the helm or the person at the helm did not recognise the risk and so act to manoeuvre the vessel away from the cliffs. [2.3.2]

4. No one on board *Calypso 2* was wearing a PFD. This omission reduced each person's chances of survival once they entered the water. [2.3.3]

5. Calypso Charters Ltd lacked adequate systems for the management of operations and therefore the activities of the vessel were not managed in a way that ensured the safety of the people on board *Calypso 2*. [2.4]

## 3.2 SAFETY ISSUES NOT DIRECTLY CONTRIBUTING TO THE ACCIDENT THAT HAVE BEEN ADDRESSED OR RESULTED IN RECOMMENDATIONS

1. Neither the VHF DSC distress function nor the EPIRB were activated during the emergency response phase. The management of the initial response was unaware that a vessel was involved in the incident initially reported. [2.3.4, 2.6]

2. No effective oversight was exercised over compliance with the safety management requirements contained in the SCV Code during inspections leading to the certification of small commercial vessels. Vessels on domestic operations in Anguilla were not subject to scrutiny that assured their safe operation. [2.4.1]

3. The requirement for the installation of AIS on small commercial vessels was not effectively enforced. The opportunities for monitoring the operation of small commercial vessels in coastal waters both to inform emergency response and to facilitate the assessment of risks in the sector were missed. [2.5, 2.6]

4. *SAR-1* was not fitted with a suitable means of recovering an unconscious person from the water necessitating the crew entering the water to effect a rescue, which placed them at risk. [2.7.1]

5. *SAR-1* was awaiting replacement defibrillator pads for the AED carried on board. The lack of equipment reduced the ability of the crew of *SAR-1* to provide medical assistance to casualties recovered on board. [2.7.2]

# SECTION 4 – ACTION TAKEN

## 4.1 ACTIONS TAKEN BY OTHER ORGANISATIONS

The **Anguilla Fire and Rescue Service** has:

- Updated the inventory of equipment carried by shore-based assets when responding to coastal accidents.
- Updated the navigational and search equipment on board *SAR-1*.
- Replaced the AED on board *SAR-1*.
- Completed a multiagency tabletop response exercise with the Dutch Caribbean and French coastguards on Saint Martin.
- Engaged with organisations in the UK and Caribbean area for training in search and rescue operations.
- Reviewed and amended its firefighter training schedule.

## SECTION 5 – RECOMMENDATIONS

The **Anguilla Maritime Administration and Shipping Registry** is recommended to:

**2025/106** In collaboration with the **Maritime and Coastguard Agency**, develop and implement a marine safety management system that encompasses the recommendations made in the Navigation Risk Assessment for Internal Waters, Anguilla completed on 7 July 2023.

**2025/107** Ensure compliance with the Anguilla Maritime Administration and Shipping Registry requirement for the installation of automatic identification system transponders on board small commercial vessels carrying less than 12 passengers.

**2025/108** Ensure that the safety management requirements of Chapter VIII section 4.10 of the Code of Safety for Small Commercial Vessels Operating in the Caribbean Trading Area, 2021 form part of the assessment of small commercial vessels at inspections conducted for their certification.

The **Royal Anguilla Police Force** is recommended to:

**2025/109** Review and implement amendments to its operational procedures for the management and allocation of appropriate resources to marine incidents.

The **Anguilla Fire and Rescue Service** is recommended to:

**2025/110** Review and modify the arrangements of *SAR-1* to ensure that its operational capabilities include the ability to retrieve unconscious people from the water.

**Calypso Charters Ltd** is recommended to:

**2025/111** Develop and implement a safety management system for its domestically operating vessels in compliance with the requirements of Chapter VIII section 4.10 of the Code of Safety for Small Commercial Vessels Operating in the Caribbean Trading Area, 2021.

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

**Annex A**

Anguilla Maritime Administration Information Sheet

ANGUILLA MARITIME
ADMINISTRATION & SHIPPING REGISTRY

# Anguilla Maritime Administration Information Sheet

## Equipment & Documents for Certifying a Commercial Vessel (Under 12 Passengers Ship)

This information sheet presents a list of the safety equipment and documentation required as part of the commercial vessel (12 and under passengers) certification process.

## Safety Equipment

Type 1 Adult Life preservers for all persons on-board
Type 1 Children Life preservers (2% of the total number of life preservers on board the vessel)
SOLAS approved life rafts with capacity for all persons on-board
[2] Ring/Life Buoys which must have lights and line attached
[1] High Water Alarm
[1] First Aid Kit/Equipment
Flares

- [6] Hand Held Red Flare Signals
- [6] Rocket Parachute Flares
- [2] Buoyant Orange Smoke Signals

[1] 20lbs Anchor and 150ft of Rope
[1] VHF Radio equipped with DSC
[2] Handheld VHF radios
Navigational Chart for area of operation
[1] Compass
[1] GPS
[1] 406 MHz Emergency Position Indicating Radio Beacon (EPIRB)
[1] Electrical Horn
[1] Class B AIS Transceiver
[2] Blige Pumps one of which must be automatic
[3] Portable Fire Extinguishers

## Documents

1. Certificate of British Registry
2. Business Licence
3. Radio Licence
4. Insurance Certificate (must include coverage for the passengers)
5. Emergency Position-Indicating Radio Beacon (EPRIB) Registration Certificate **[This is only for new EPIRBs]**.
6. EPIRB Test Verification Report with replacement date battery
7. Portable Fire Extinguishers Certificate
8. Life Rafts (capacity for passengers and crew) Inspection Certificates **[Note that for a new life raft there must be an initial inspection certificate]**.
9. Minimum of (2) Crew Members of which one must be a certified Ship Security Officer (SSO).
10. Boatmaster's Licence of the correct Grade for the voyages to be undertaken by the vessel.
11. Standards of Training, Certification and Watch-keeping for Seafarers (STCW) Certificate for all Crew Members and Captains.
12. Seafarer Medical Report and Medical Fitness Certificate for all Crew Members and Captains.

**The original certificates must be maintained on the vessel. Eligible copies of the certificates must be submitted to the Anguilla Maritime Administration Office.**

Marine Accident Report

INVESTORS IN PEOPLE