ANNUAL REPORT

MAIB

MARINE ACCIDENT INVESTIGATION BRANCH

2024

Marine Accident Recommendations and Statistics

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

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MARINE ACCIDENT INVESTIGATION BRANCH

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.

INVESTIGATION PROCESS

The MAIB records just over 1,400[1] reports of accidents (casualties and incidents[2]) each year. The number of reports received exceeds this figure, as not all reports received are recorded in the National Database.

The simplified schematic on this page shows the sequence of events involved in investigating an accident.

When the decision to conduct an investigation is made, a team of inspectors will be deployed to gather further evidence and conduct interviews to gain a full understanding of the circumstances and causes of the accident or incident. After initial analysis, the findings are presented to the Chief Inspector of Marine Accidents for a decision about the scope of the investigation and to establish the need for any urgent safety recommendations. Further investigation and analysis will then be undertaken and reviewed before any recommendations are formulated and the report is written.

Draft investigation reports are subject to a statutory 30-day consultation process, and all comments received are reviewed and the report amended if appropriate before it is finally published.

Details of all accidents and incidents received are recorded on the branch's case management system (COMPASS) and National Marine Accident Database. An anonymised subset of data is publicly available via the MAIB Data Portal. In addition, the findings and reports of all published investigations are uploaded to the International Maritime Organization's Global Integrated Shipping Information System (GISIS) database.

[1] The 5-year average is 1,437

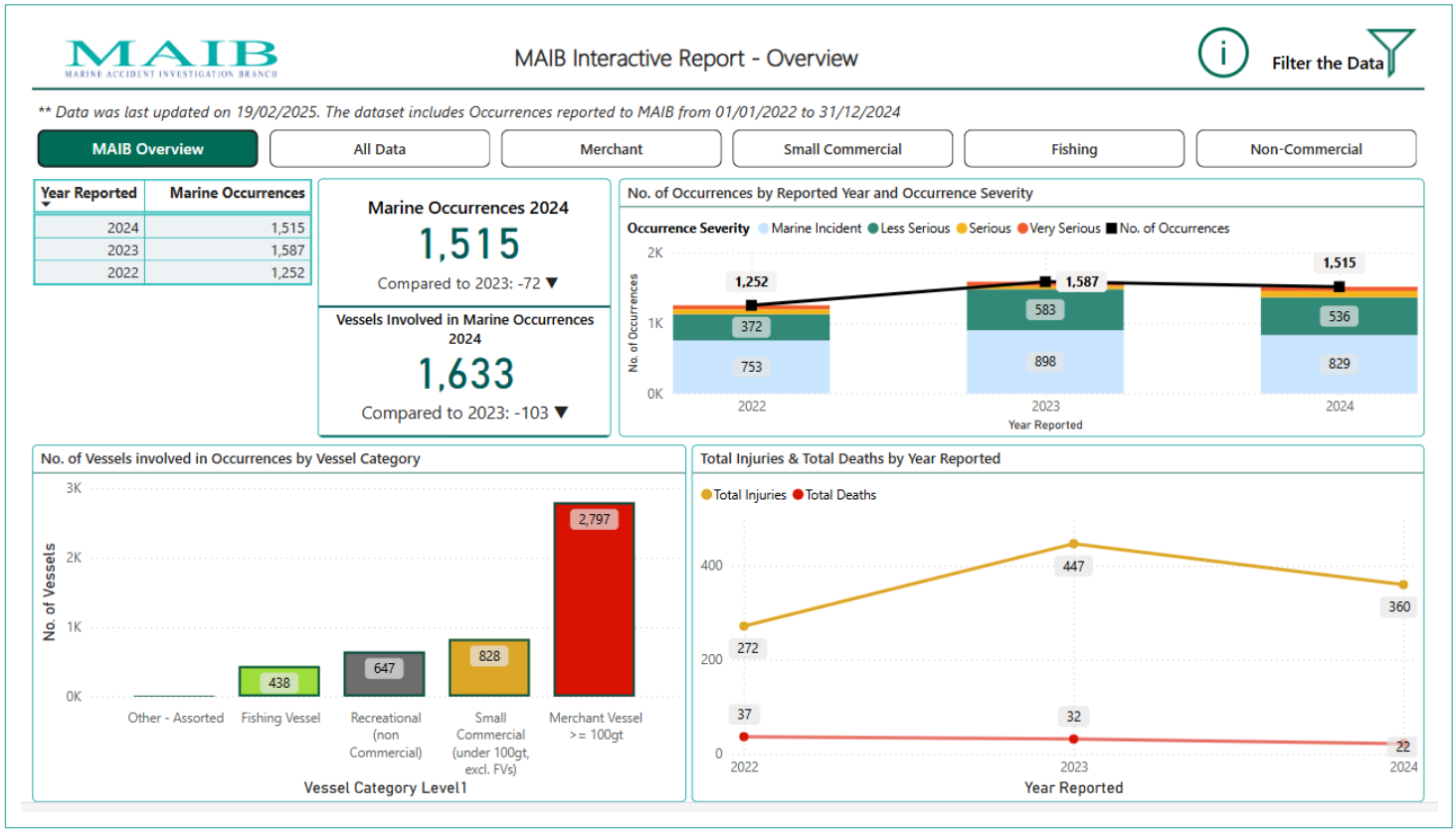
[2] As defined in Annex B.

MAIB DATA PORTAL

The MAIB Data Portal is designed to provide public access to an anonymised subset of maritime accident data. In development since August 2022, the data portal gives the public and industry open access to download and analyse MAIB's data. Data for occurrences reported to MAIB in 2021, 2022, 2023 and 2024 is available and earlier years will be added as the data quality is assured.

- Filter data using MAIB's published dashboard
- Download the most recent data sets
- Download a pre-configured data model (.pbix data set)

An example of the interactive dashboard



Occurrences table

This table includes data on each reported occurrence such as main event, severity, location, description and number of vessels involved.

Vessels table

This table includes data on each vessel involved in an occurrence such as details of the vessel category, damage, pollution and a summary of fatalities and injuries.

Affected persons table

This table includes data on fatalities and injuries such as details of each affected person, type of injury, gender and age of the individual.

Download a pre-configured Power BI data set

Users experienced with reporting data analysis tools can download the MAIB dashboard as a .pbix file. This contains a pre-built Power BI data set with the three tables already added to enable the creation of ad hoc analysis.

Users will need Microsoft Power BI Desktop installed on their workstation to open and edit the respective file. The free version of Power BI Desktop can be downloaded directly from Microsoft's website.

To access the service visit: **https://maps.dft.gov.uk/maib-data-portal/web-pages/index.html**

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INTRODUCTION

I am pleased to introduce the MAIB Annual Report for 2024. As usual I will comment on statistics and safety matters before moving on to the work of the branch.

Year	Marine Casualties and Marine Incidents[1]	Investigations started	Investigations started involving loss of life
2024	**1,515**	**15**	**7**
2023	1,587	19	12
2022	1,252	16	8
2021	1,531	22	14
2020	1,223	19	10
2019	1,075	22	12
Average[2] [3]	**1,364**	**18.8**	**10.5**

At the start of 2024, the MAIB had 41 ongoing investigations; an unrealistically high legacy workload that was impacting on the pace at which investigations could be completed. Since then, we have been more discerning about the discretionary investigations we take on and, in particular, have encouraged the administrations of foreign-flagged vessels that suffer accidents in UK waters to lead investigations where appropriate. This slight reduction in investigations started, combined with an increase in reports published (20 in 2024 compared with 10 in 2023), has reduced the backlog. As I write, the branch is on track to publish a further 20 investigation reports in 2025, and the time taken to complete investigations is reducing.

[1] Including those reported to the MAIB under the Red Ensign Group memorandum of understanding (MOU).

[2] Rounded to the first decimal place.

[3] MAIB regularly reviews its accident data. On occasion, data from previous years can and will change based on these reviews.

The 85% acceptance of 2024's recommendations, although lower than 2023, remains in tolerance. However, as I highlighted last year, that some recipients cannot commit to implementation timescales remains a concern.

SAFETY ISSUES

Merchant ships

Significant collisions between and groundings of merchant vessels show no sign of reducing. The fatal collision between *Scot Carrier* and *Karin Høj* (MAIB report 5/2023) resulted from poor watchkeeping practices. However, the collision between *Scot Explorer* and *Happy Falcon* (MAIB completed preliminary assessment 3/2024), the fatal collision between *Verity* and *Polesie* (under investigation) and the dramatic and tragic collision of the *Solong* into the anchored *Stena Immaculate* earlier this year (also under investigation), indicate a need to radically rethink the role of human watchkeepers in the digital age. Humans do not make good monitors and if under-stimulated they will find other things to occupy themselves. But, as the DMAIB[4]/MAIB application and usability of ECDIS safety study[5] indicated, humans can also be reluctant to utilise system functions that will alert them to impending problems. The MAIB will seek to explore this phenomenon in more depth during future investigations.

Commercial fishing vessels

Three investigations[6] and one preliminary assessment[7] were started into UK fishing vessels flooding/foundering during 2024. Fortunately, none resulted in the loss of life, but the losses to flooding last year indicates how vulnerable many fishing vessels are to water ingress. Most of the UK fishing fleet have little, if any, watertight subdivision so any appreciable inflow of water can swiftly overwhelm the on board pumps. In such circumstances, raising the alarm early and being well-practised in abandonment routines can and does save lives.

As worrying as flooding is the number of deaths and serious injuries resulting from occupational accidents. Two fishing vessel crew died as a result of marine accidents in 2024, the same number as in 2020, with both years being the equal lowest recorded level of fatalities in the last decade. Less positive is that both deaths occurred on well-crewed vessels as a result of unsafe systems of work. Future MAIB investigation reports will likely develop the theme of moving beyond 'having a risk assessment' to the proactive management of risk.

BRANCH ACTIVITY AND DEVELOPMENT

The MAIB's data portal went live in 2023 and anonymised data from 2021 to 2024 is now available. Data for 2020 should be added before the end of 2025 to complete a 5-year dataset, and additional data will be added each following year once it has been quality assured. While there are currently no plans to add more early years' data to the portal, we are continuing to invest in developing our database and case management system (COMPASS) to streamline workflows and improve efficiency where possible.

Recent reductions in the Civil Service headcount have also impacted the MAIB, reducing the branch circa 15%. Some leavers have taken advantage of the recent voluntary exit scheme, which has helped reduce our headcount to its new, lower level. Increased efficiencies will mitigate against some of this reduction, but a smaller branch will mean fewer investigations can be taken on and it will be some months before the branch has all the right skills in the right places.

[4] Danish Maritime Accident Investigation Board.

[5] Read **Application and usability of ECDIS safety study**

[6] *Freedom II* (CN 111), *Opportune* (LK 209) and *Odyssey* (FR 70).

[7] *Crig-A-Tana* (SC 25).

Finally, a review of the air, marine and rail accident investigation branches that reported in April 2025 made recommendations about the future functioning of the branches and the need to build future resilience. Work is ongoing within DfT to determine which of the review's recommendations to take forward, and to what timescale. While that deliberation is ongoing the MAIB will continue to do what it does best, which is to impartially investigate marine accidents and make recommendations to help prevent reoccurrence in the future.

FINANCE

The annual report deals principally with the calendar year 2024. However, for ease of reference, the figures below are for the financial year 2024/25, which ended on 31 March 2025. The MAIB's funding from the DfT is provided on this basis, and this complies with the government's business planning programme.

Costs (£)	Budget (£)	Outturn (£)
Pay	3,019,100	3,210,017
Non Pay	1,396,000	1,278,704
Total	**4,415,100**	**4,488,721**

Captain Andrew Moll OBE
Chief Inspector of Marine Accidents

PART 1: CASUALTY REPORTS TO MAIB IN 2024

The MAIB recorded 1,631 reports of accidents to UK vessels worldwide or any vessels within UK coastal waters during 2024. A total of 1,753 vessels were involved.

1,510 recorded notifications were within the scope of the *Merchant Shipping (Accident Reporting and Investigation) Regulations 2012* and five fell within the scope of the Red Ensign Group MOU. 116 were not in scope of the Regulations or the MOU and are not included in any of the statistics contained in this annual report.

This statistical overview represents 950 accidents, involving 1,017 commercial vessels that experienced an actual or potential casualty to a vessel. Accidents to people are not included in this section.

Chart 1: Accidents involving UK commercial vessels or non-UK commercial vessels in UK waters

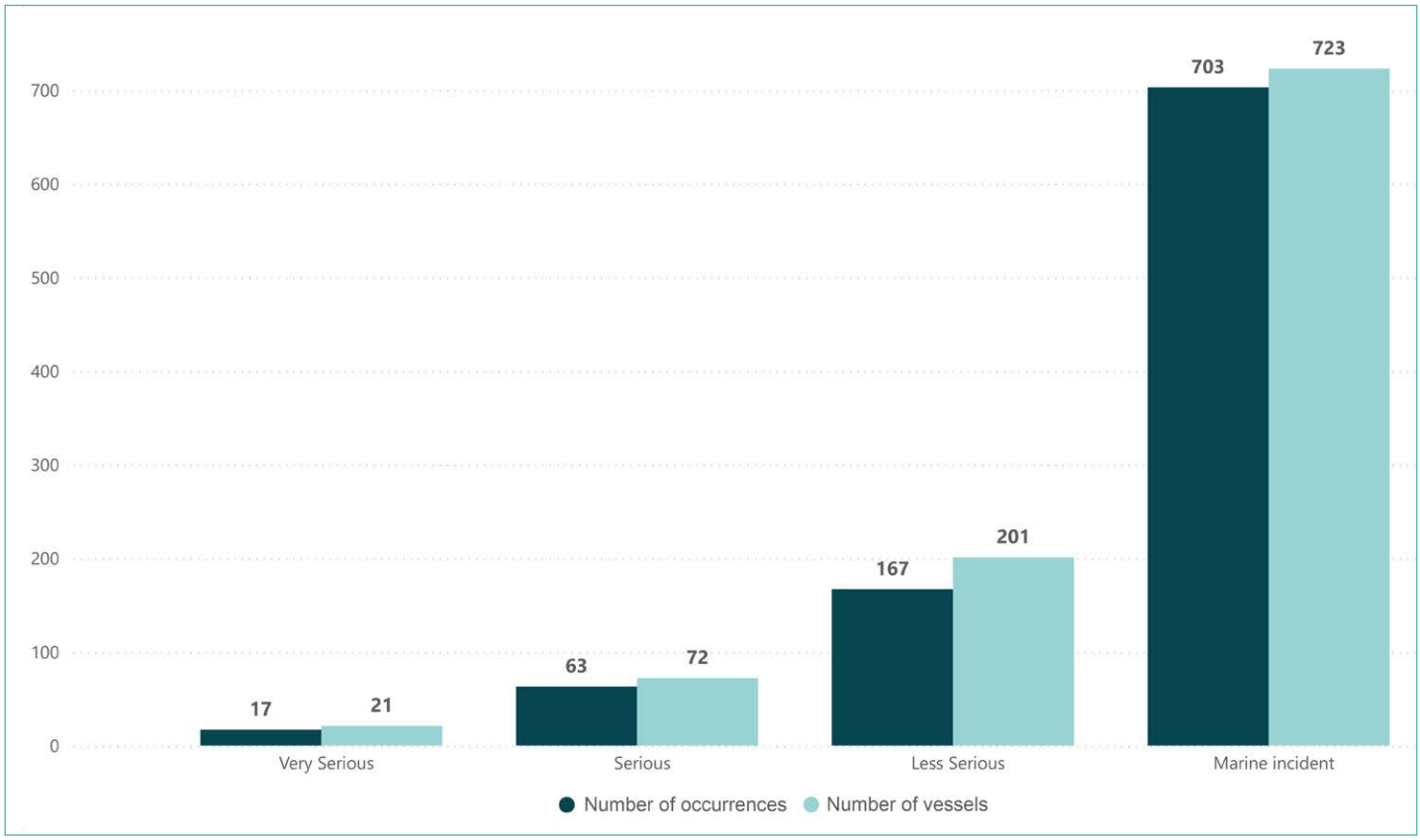


Chart 2: UK merchant vessels of 100gt or more

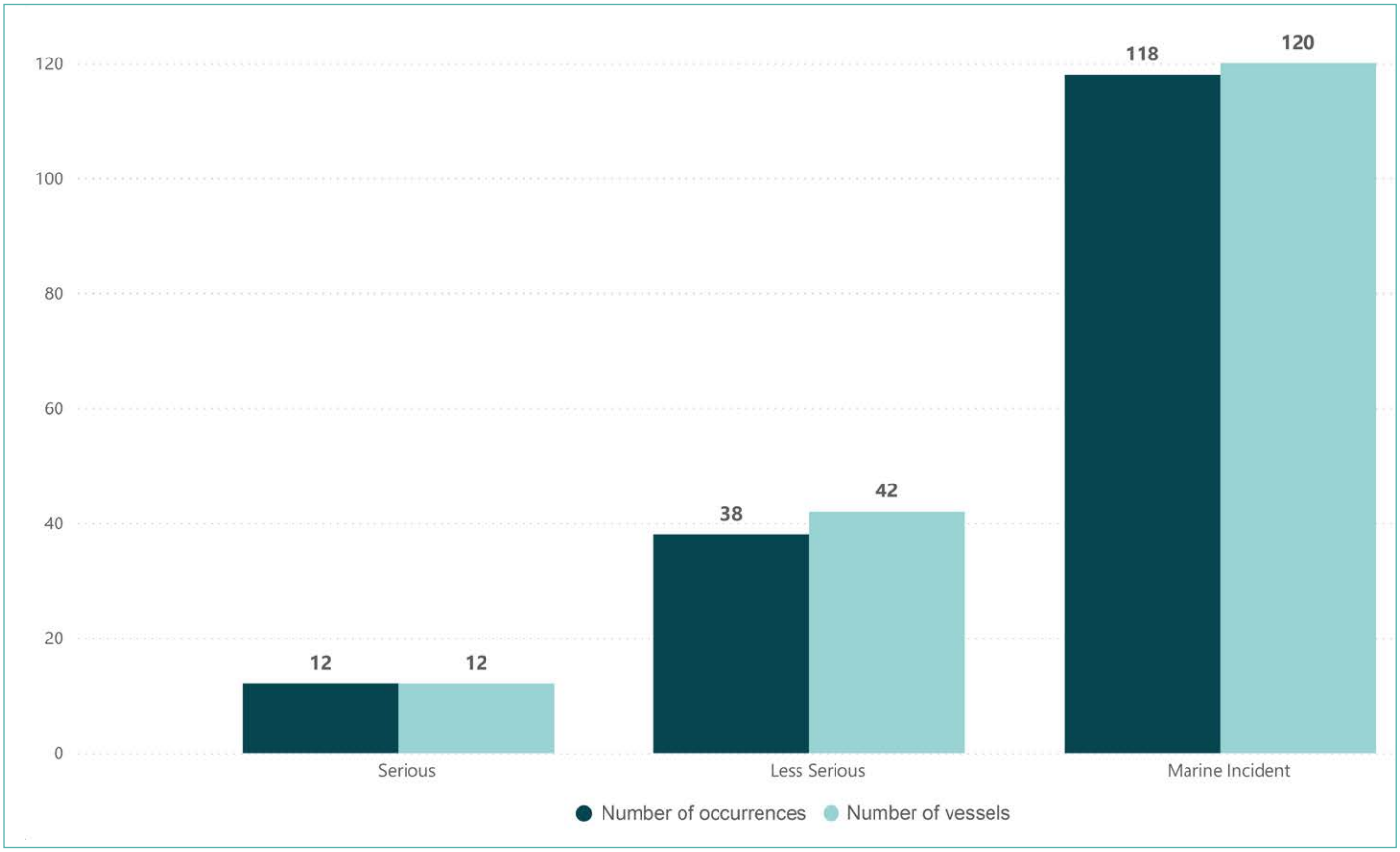


Chart 3: UK merchant vessels of under 100gt

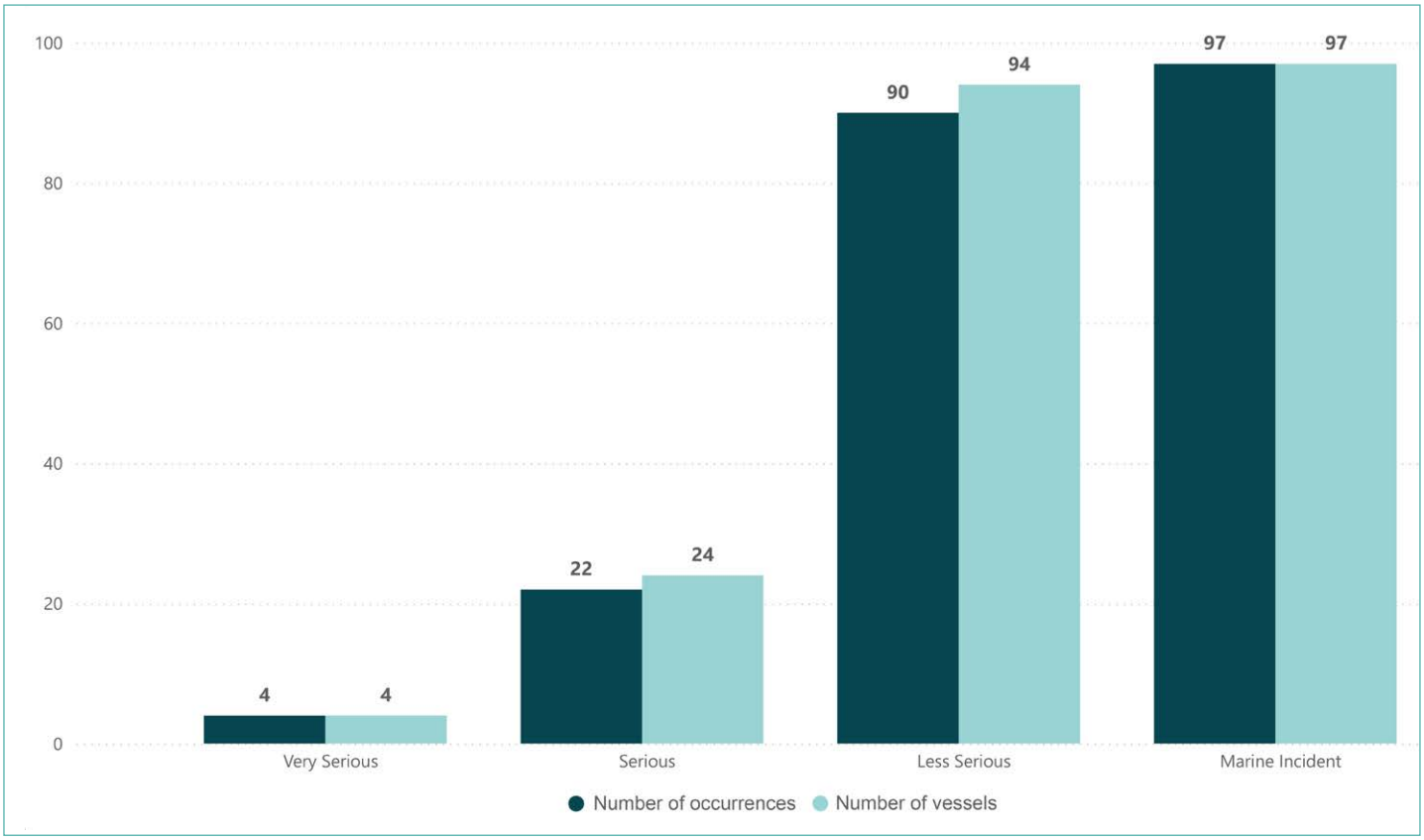


Chart 4: UK fishing vessels

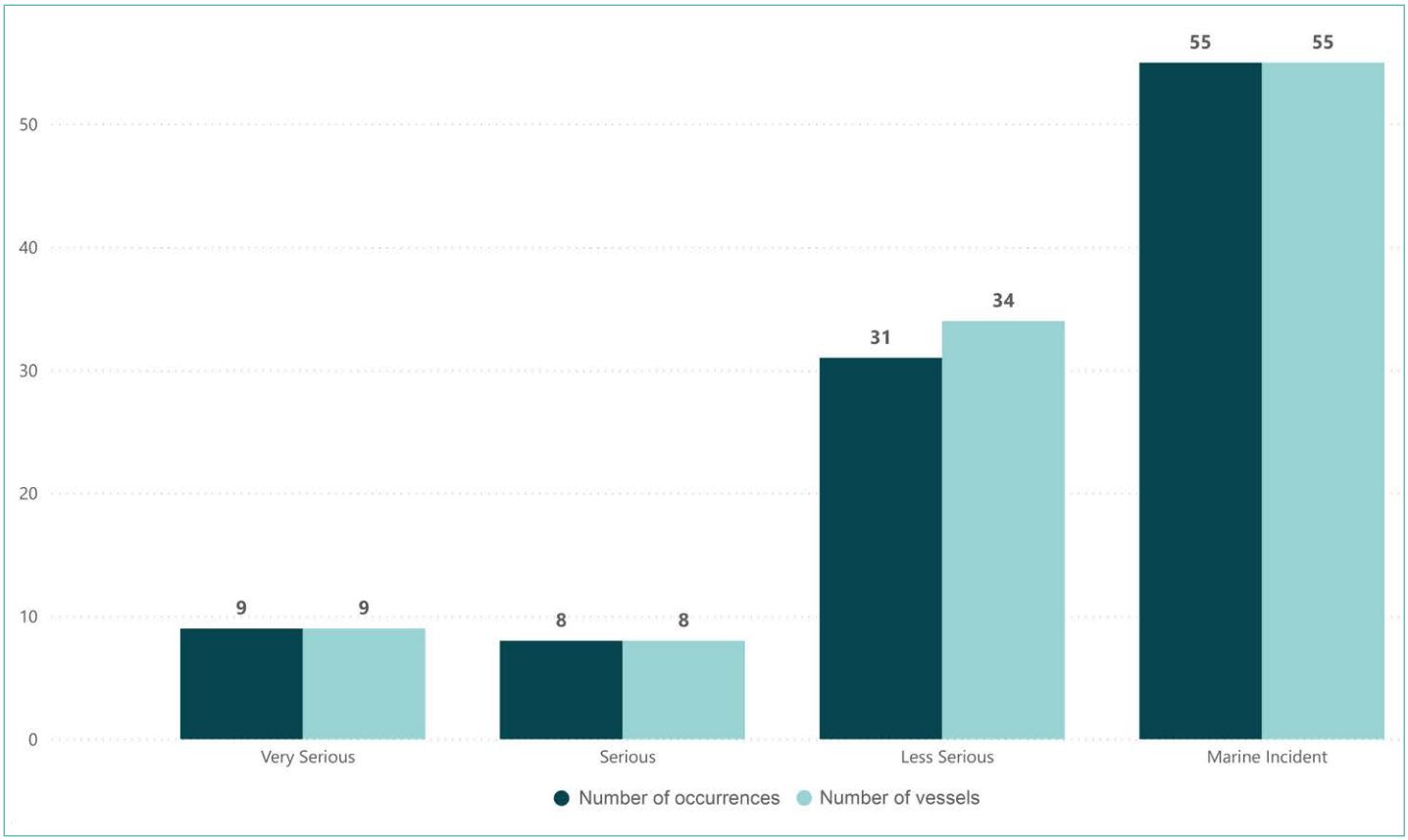
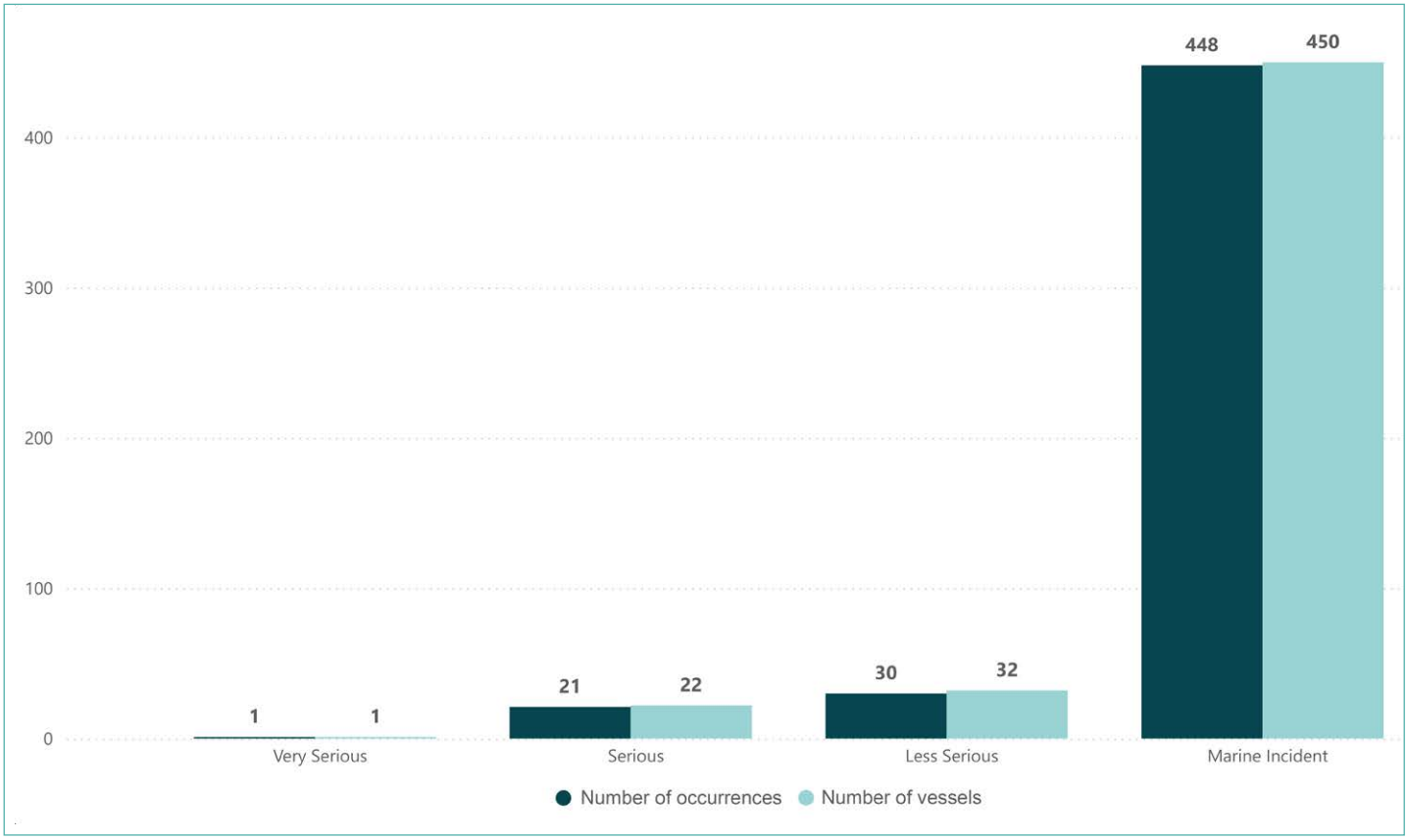


Chart 5: Non-UK merchant vessels in UK 12-mile waters



INVESTIGATIONS STARTED IN 2024

Date	Occurrence details
19 Jan	Fall of a crew member in their cabin on board UK registered emergency response and rescue vessel ***Vos Voyage***r (9411276) during heavy weather in the North Sea, resulting in serious injury.
21 Feb	Flooding and sinking of UK registered fishing vessel ***Freedom II*** (CN111) while under tow approximately 11.5nm south-west of Oban, Scotland. The crew were rescued with no major injuries.[8]
23 Feb	Fatality of the chief engineer on board Isle of Man registered yacht ***Baton Rouge*** (1010935) while alongside at Falmouth Harbour, Antigua.[9]
24 Mar	Foundering of UK registered stern trawler ***Opportune*** (LK209) in the North Sea, approximately 36 miles east of Lerwick in Shetland. The uninjured crew were rescued from the vessel's liferaft.
25 Apr	Collision between Greece registered oil tanker ***Apache*** (9749489) and UK registered fishing vessel ***Serinah*** (GH116) approximately 6nm south-west of Ardrossan, Firth of Clyde, Scotland, resulting in the sinking and loss of ***Serinah***.[10]
22 May	Fatal person overboard from UK registered 11.16m fishing vessel ***Weston Bay*** (GY123) approximately 11nm east of Spurn Head, Humber Estuary, England.
25 Jun	Grounding of St Kitts and Nevis registered general cargo vessel ***Baltic Arrow*** across the River Nene, West Walton, Norfolk.[11]
12 Jul	Fatal person overboard from UK registered 18.35m fishing vessel ***Kingfisher*** (DH110) approximately 30nm east-north-east of Wick, Scotland.[12]
13 Jul	Fatal injury to a crew member on board Malta registered roll-on/roll-off cargo vessel ***Laureline*** (9823352) while loading freight vehicles in Purfleet, England.
22 Jul	Grounding of UK registered dive support vessel ***Jean Elaine*** in Deer Sound, Orkney.
22 Jul	Foundering in heavy seas of St Helena registered[13] fishing vessel ***Argos Georgia*** (9812690) approximately 190nm east of Port Stanley, Falkland Islands, resulting in loss of 13 lives.[14]
27 Jul	Collision between the tender to Gibraltar registered[15] ***Isabell Princess of the Sea*** and Turkish RIB ***Vega*** in the port of Göcek, Turkey.
19 Aug	Foundering of UK registered sailing vessel ***Bayesian*** (9503392) 0.5nm south-east of the entrance to Porticello harbour, Sicily. Of the 22 people on board, 15 were able to escape from the vessel and were recovered ashore.[16]

[8] An **interim report** was issued in February 2025.

[9] The **accident investigation report** was subsequently published on 23 January 2025.

[10] An **interim report** was published in April 2025.

[11] The completed **preliminary assessment** was subsequently published on 24 September 2024.

[12] A **safety bulletin** was issued on 5 September 2025.

[13] Under investigation on behalf of the St Helena Government.

[14] A **safety bulletin** was issued on 10 October 2024.

[15] Under investigation on behalf of the Government of Gibraltar.

[16] An **interim report** was published in May 2025.

Date	Occurrence details
29 Oct	Foundering of UK registered 23.1m fishing vessel ***Odyssey*** (FR70) approximately 130nm east of Fife Ness, Scotland. The uninjured crew were rescued from the vessel's liferaft.
23 Nov	Crew fatality on board UK registered patrol vessel **HMC *Vigilant*** (9276353) while alongside at Cowes, Isle of Wight, England.[17]

Image courtesy of Steve Hubbard (BBC)

Baltic Arrow

Image courtesy of Bristow Group HM Coastguard helicopter rescue service

Freedom II

[17] This investigation was concluded as a **preliminary assessment**

PART 2: REPORTS AND RECOMMENDATIONS

Status as of 3 March 2025

INTRODUCTION

The following pages list the accident investigation reports and safety bulletins published by the MAIB during 2024. 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 86.

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 or by letter from the Chief Inspector of Marine Accidents to the organisations involved, which can be published or issued 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 can 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.

The *Merchant Shipping (Accident Reporting and Investigation) Regulations 2012* require that the person or organisation to whom a recommendation is addressed considers the recommendation and replies to the Chief Inspector of Marine Accidents within 30 days of its receipt. The reply shall include details of the plans to implement the recommendation or, if it is not going to be implemented, an explanation as to why not. Under the Regulations, the Chief Inspector of Marine Accidents must annually *inform the Secretary of State of those matters* and make them publicly available. This Annual Report to the Secretary of State for Transport fulfils this requirement.

RECOMMENDATION RESPONSE STATISTICS 2024

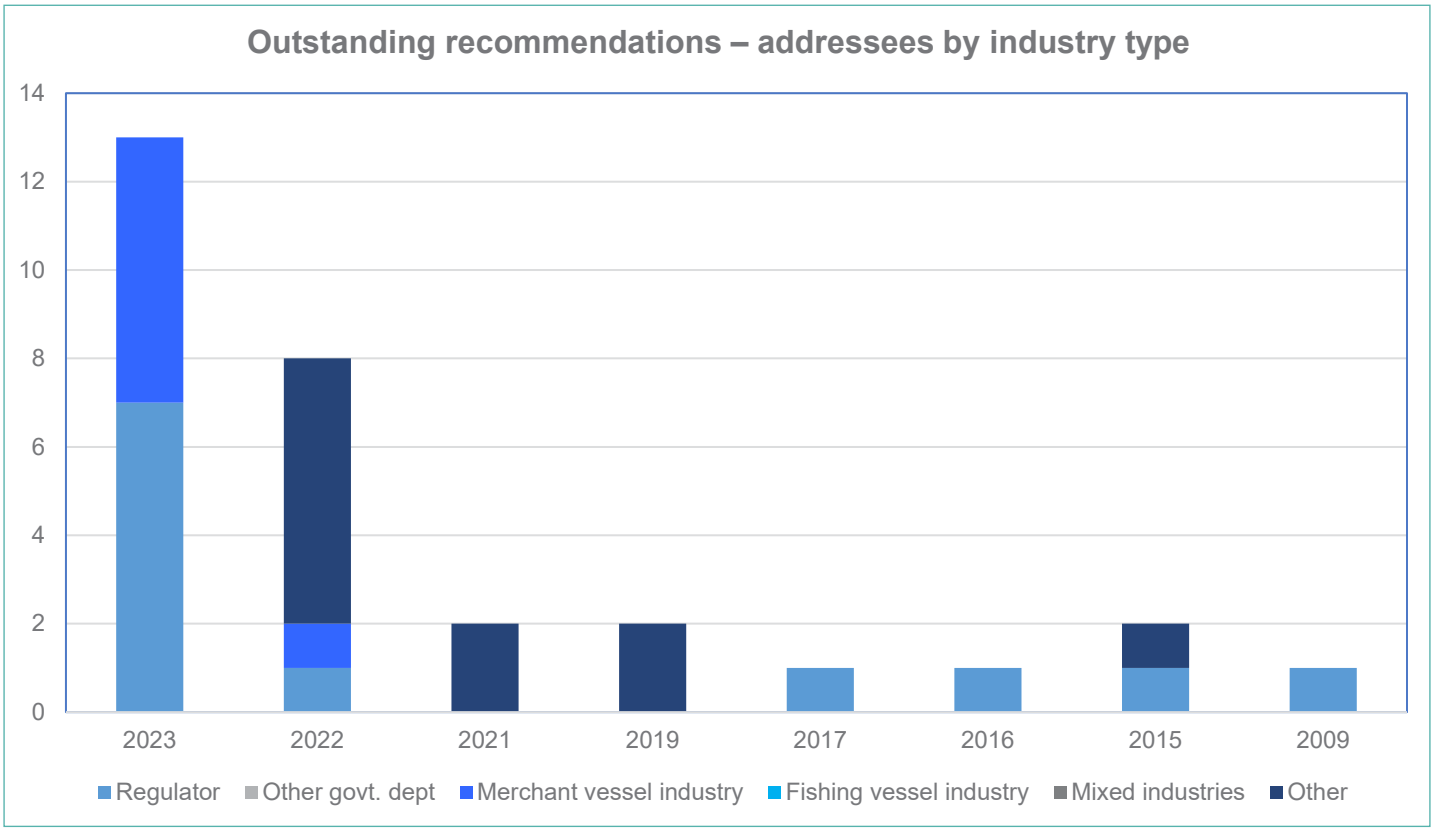
74 recommendations were issued to 36 distinct addressees[18] in 2024. The percentage of all recommendations that are either **accepted and implemented** or **accepted, yet to be implemented** is **85%**.

Year	Total*	Accepted action		Partially accepted	Withdrawn	Rejected	No response received
		Implemented	Yet to be implemented				
2024	74	32	31	2	0	3	6

* Total number of recommendations issued

RECOMMENDATION RESPONSE STATISTICS FROM PREVIOUS YEARS

The chart below shows the number of recommendations issued under the closed-loop system that remain open at the time of this publication. There are no outstanding recommendations from 2004 to 2008, 2010 to 2014, 2018 and 2020.



[18] For the purpose of these statistics, recommendation S2024/102M to all owners, operators and skippers of UK scallop dredgers and beam trawlers that use chain as part of the derrick head quick-release mechanism on board their vessels, and recommendation S2024/137M to all owners, operators and skippers of fishing vessels that are fitted with side shell doors have been classed as one distinct addressee.

PUBLICATIONS AND RECOMMENDATIONS ISSUED IN 2024

Vessel name(s)	Category*	Publication	Publication date	Recommendations	Page
Honeybourne III	Very Serious Marine Casualty	SB 1/2024	7 Feb	Yes	14
Eder Sands	Very Serious Marine Casualty	1/2024	8 Feb	Yes	15
Awesome	Very Serious Marine Casualty	2/2024	25 Apr	No	16
Alfred	Serious Marine Casualty	3/2024	22 May	Yes	16
Kirkella/Shovette	Serious Marine Casualty	4/2024	13 Jun	Yes	17
Piedras	Very Serious Marine Casualty	5/2024	20 Jun	No	18
Karin	Very Serious Marine Casualty	SB 2/2024	27 Jun	Yes	18
Ali Ka	Serious Marine Casualty	6/2024	18 Jul	Yes	19
Channel Queen	Very Serious Marine Casualty	7/2024	25 Jul	Yes	20
Angelena	Very Serious Marine Casualty	8/2024	1 Aug	Yes	21
Inflatable migrant boat	Very Serious Marine Casualty	9/2024	15 Aug	No	22
Kingfisher	Very Serious Marine Casualty	SB 3/2024	5 Sep	Yes	22
Pelican of London	Very Serious Marine Casualty	10/2024	12 Sep	Yes	23
Kommandor Orca	Serious Marine Casualty	11/2024	19 Sep	No	24
Equinox Seas	Very Serious Marine Casualty	12/2024	27 Sep	Yes	24
Guiding Light/Guiding Star	Very Serious Marine Casualty	13/2024	3 Oct	Yes	25
Argos Georgia	Very Serious Marine Casualty	SB 4/2024	10 Oct	Yes	26
Wheelyboat 123	Very Serious Marine Casualty	14/2024	17 Oct	Yes	26
Ocean Maid	Very Serious Marine Casualty	15/2024	24 Oct	Yes	28
Clipper Pennant	Very Serious Marine Casualty	16/2024	7 Nov	Yes	29
Biter/Hebridean Princess	Very Serious Marine Casualty	17/2024	13 Nov	Yes	31
Mona Manx	Very Serious Marine Casualty	18/2024	21 Nov	Yes	33
Pioneer	Very Serious Marine Casualty	19/2024	4 Dec	Yes	34
Stena Europe	Serious Marine Casualty	20/2024	12 Dec	Yes	34

* As defined in Annex B

Preliminary Assessment summaries published on the MAIB's website in 2024

Vessel name(s)	Category*	Publication	Publication date	Description
Crig-A-Tana	Very Serious Marine Casualty	1/2024	6 Feb	Capsize and sinking of fishing vessel approximately 6nm south-east of Lizard Point, Cornwall, England on 12 November 2022.
Thames Kestrel	Less Serious Marine Casualty	2/2024	6 Feb	Contact with brow of pier by passenger ferry at Gravesend Town Pier, England on 19 July 2023.
Scot Explorer/ Happy Falcon	Serious Marine Casualty	3/2024	5 Mar	Collision between general cargo vessel and gas carrier about 12nm north-west of Thyborøn, Denmark on 5 March 2024.
Indian Partnership	Serious Marine Casualty	4/2024	23 Aug	Grounding of bulk carrier off the coast of Misool Island, Indonesian archipelago on 23 August 2024.
Baltic Arrow	Serious Marine Casualty	5/2024	24 Sep	Grounding of general cargo vessel on the River Nene, Wisbech, England on 24 September 2024.
Oceandiva London	Serious Marine Casualty	6/2024	21 Oct	Loss of propulsion control and contact with moored barges by passenger vessel at Halfway Reach, River Thames, England on 21 October 2024.

Oceandiva London

* As defined in Annex B

Channel Queen

Argos Georgia

Biter

2024 RECOMMENDATIONS – PROGRESS REPORT Status as of 3 March 2025

Honeybourne III

Safety bulletin number: SB1/2024

Fishing vessel (PD905) Accident date: 6/10/2023

Fatal injury to a deckhand following a chain failure on the scallop dredger *Honeybourne III* (PD905) approximately 16 nautical miles south of Newhaven, England

Safety Issues

- Inappropriate quick-release gear design which involved a chain being bent over a fixed pin
- Lack of effective inspection of lifting equipment
- Lack of effective risk mitigation of working under suspended equipment

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

S2024/101 Conduct a focused inspection campaign on board UK scallop dredgers and beam trawlers fitted with derrick head quick-release mechanisms that incorporate chain to:

- raise awareness among skippers and crews of the significant hazards associated with the use of chain links passing over a static pin as part of the derrick head quick-release mechanism;
- confirm that the risk of a failure of the derrick head quick-release mechanism has been assessed, mitigated and documented by the owner, operator and/or skipper of the vessel; and
- verify that the crew has been informed of the findings of the risk assessment and the measures taken for their protection in the event of a failure of the derrick head quick-release mechanism.

Appropriate action implemented

No. **Recommendation(s) to:** **All owners, operators and skippers of UK scallop dredgers and beam trawlers that use chain as part of the derrick head quick-release mechanism on board their vessels** to:

S2024/102M Urgently ensure that a suitable and sufficient assessment of the risk of a failure of the derrick quick-release mechanism chain has been undertaken and documented, noting the safety issues identified in this safety bulletin, and that:

- mitigations are identified and immediately implemented to reduce the risk to the crew associated with a failure of the derrick quick-release mechanism to a level that is as low as reasonably practicable; and
- the crew are informed of the findings of the risk assessment and the measures taken for their protection.

Appropriate action implemented

Eder Sands

Report number: 1/2024

Fishing vessel (UL 257)

Accident date: 7/10/2022

Fatal fall overboard from the fishing vessel *Eder Sands* (UL 257) approximately 150 nautical miles west of Ireland

Safety Issues

- No safe procedure in place for shooting the nets
- Incomplete risk assessment
- PFD incorrectly worn
- PFD not appropriate for the vessel's operation

No.	Recommendation(s) to: **Maritime and Coastguard Agency** to:
2024/103	Review and revise MGN 588 (F) to: • advise fishing vessel owners of the requirement in MSN 1870 (M+F) to review the suitability of personal flotation devices to ensure they are appropriate for the risks to which the seafarer is exposed; and • ensure that it reflects fishing industry advice on the selection of personal flotation devices with safety features appropriate to the vessel's operation, including lights, crotch straps, spray hoods and personal locator beacons. **Appropriate action implemented**

No.	Recommendation(s) to: **Ondar Fishing Company Limited** to:
2024/104	Amend its safety management system in accordance with MGN 596 (F) and make it available to the crew in the working languages of the vessel and ensure that it includes: • formal written operational procedures for shooting and hauling nets; • accurate vessel-specific risk assessments for shooting and hauling the nets and working at height, including the implementation of appropriate control measures to ensure the safety of the crew at all times; • a requirement to record the inspection and maintenance of each personal flotation device carried on board. **Appropriate action implemented**
2024/105	In light of the risk assessments conducted in accordance with recommendation 2024/104, review the suitability of the personal flotation devices on board *Eder Sands* to ensure this equipment supports the survival and swift location and recovery of any crew that have fallen overboard; this process should consider the provision of a light, spray hood and personal locator beacon. **Appropriate action implemented**
2024/106	Take action to ensure that its crew follow the guidance in MGN 588 (F) and wear their working personal flotation devices in accordance with the manufacturer's instructions. **Appropriate action implemented**

Awesome

Report number: 2/2024

Powerboat

Accident date: 2/10/2022

Loss of control of the powerboat *Awesome* near Little Thatch Island, British Virgin Islands, resulting in two fatalities

Safety Issues

- Lack of maintenance led to catastrophic mechanical failure
- PFDs were carried on board but none were worn
- Inappropriate number of people on board: 5 seats for 11 people
- Engine cut off device was not used

No. **Recommendation(s) to:** Not applicable

No recommendations have been made in this report.

Alfred

Report number: 3/2024

Roll-on/roll-off passenger ferry

Accident date: 5/7/2022

Grounding of the roll-on/roll-of passenger ferry *Alfred* at Swona Island, Pentland Firth, Scotland

Safety Issues

- Fatigue leading to loss of awareness
- Inadequate passage plan and ineffective use of ECDIS
- Lack of oversight by vessel traffic services
- Increased risks from navigating too close to land
- Inadequate audit and inspection processes

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

2024/107 Direct its surveyors to ensure that vessel passage plans have been loaded into ECDIS or drawn on to paper charts (as appropriate) in accordance with the vessel's safety management system.

Appropriate action implemented

2024/108 In a similar manner to the Cruise Lines International Association, issue guidance to the UK domestic passenger fleet on the need to secure heavy objects on board their vessels.

Inappropriate action implemented or planned

2024/109 Review the general exemption issued to UK domestic passenger vessels that removes the requirement for them to carry voyage data recorders.

Appropriate action implemented

No.	Recommendation(s) to: **Pentland Ferries** to:
2024/110	Review its emergency response team procedures to ensure that it captures passenger details and injuries post-accident.

Appropriate action implemented

Kirkella/Shovette

Report number: 4/2024

Fishing vessel (H7)/harbour tug

Accident date: 24/6/2022

Collision between the fishing vessel *Kirkella* (H7) and harbour tug *Shovette* resulting in pollution at King George Dock, Hull, England

Safety Issues

- Loss of propulsion control at transfer from bridge to engine room due to lack of interlocks
- No procedure for changing propulsion control between stations
- Approval standards for propulsion control system transfers unclear

No.	Recommendation(s) to: **Det Norske Veritas** to:
2024/111	Propose to the International Association of Classification Societies that Unified Requirement M43.12 is reviewed to clarify its intent.

Appropriate action planned: no date

2024/112	Inform its customers that the Rolls-Royce Helicon-X3 system might allow remote control station changeover with mismatched levers and suggest that the manufacturer be contacted for advice.

Appropriate action planned: no date

No.	Recommendation(s) to: **Kongsberg Maritime** to:
2024/113	Issue a service letter to its customers advising that the Rolls-Royce Helicon-X3 system remote control changeover process can allow mismatching of levers resulting in the propelling thrust altering significantly, and advise them of methods of operation and/or rectification should these be requested.

Appropriate action planned: no date

Piedras

Report Number: 5/2024

Fishing vessel (FD528)

Accident date: 1/6/2022

Foundering of the fishing vessel *Piedras* (FD528) 78 nautical miles south-west of Mizen Head, Ireland

Safety Issues

- No flood action plan
- Lack of watertight integrity
- Noncompliant liferaft servicing
- Inadequate watchkeeping standards
- Inaccessible safety documentation

No. **Recommendation(s) to:** Not applicable

Recommendations were previously made to Survitec Group Limited, which are now closed.

Karin

Safety bulletin number: SB2/2024

Recreational dive support boat

Accident date: 28/9/2023

Fatal injury to a recreational diver after contact with the recreational diving support boat *Karin* in Scapa Flow, Orkney Islands, Scotland

Safety Issues

- Ineffective watchkeeping
- Inadequate communication between vessels
- Ineffective risk mitigation
- Attaching dive support marker buoy to person

No. **Recommendation(s) to:** The **British Diving Safety Group** to:

S2024/114 Disseminate this safety bulletin to all organisations and agencies within its membership drawing attention to the safety issues raised, in particular:

- that owners, operators and skippers of diving support boats should ensure compliance with COLREGs Rule 5 concerning provision of a lookout, especially when operating in proximity to divers in the water.
- to raise awareness among its members of the hazards to divers of attaching a DSMB to their person while submerged, and that the recognised good practice is for the reel to be held in their hand.

Appropriate action implemented

Chemical tanker Accident date: 25/10/2022

Contact of the chemical tanker *Ali Ka* with Oikos Jetty 2 on the River Thames at Canvey Island, England

Safety Issues

- Likely fatigue affected pilot's decision-making
- Ineffective master/pilot exchange
- Failure to learn from previous accidents
- Ineffective control of risks

No.	Recommendation(s) to: **Port of London Authority** to:	
2024/115	Conduct a thorough review of the risk assessments for all COMAH and high-risk berths in collaboration with their operators for the conduct of all berthing and unberthing manoeuvres in the Statutory Harbour Area, and implement any resulting mitigations. Specific consideration should be given to tug use in a range of environmental conditions.	**Appropriate action implemented**
2024/116	Highlight to all PLA marine pilots the best practice contained in the ICS Bridge Procedures Guide, particularly Chapter 6 – Pilotage; reference this guide in the SMS; and, provide guidance to pilots on recognising and responding to challenges from the bridge teams being assisted.	**Appropriate action implemented**
2024/117	Develop and implement a stop procedure to include detailed guidance on the roles and responsibilities associated with the recognition, escalation and safe resolution of challenges.	**Appropriate action implemented**
2024/118	Review the risks to safe pilotage from pilot fatigue, informed by an independent, specialist review of current working practices and, as necessary, implement a comprehensive fatigue risk management system that encapsulates the requirements and responsibilities outlined in regulatory and maritime industry guidance.	**Appropriate action planned: 31 July 2025**

No.	Recommendation(s) to: **Trans Ka Tankers** to:	
2024/119	Review and revise its Bridge Resource Management training to include agreeing and assigning roles and responsibilities in support of embarked pilots, diligent exercise of the MPX, and challenge and response procedures specific to working with an embarked pilot.	**Appropriate action implemented**

2024/120 Review and revise the policy for the accurate setting of safety contours in ECDIS to best support pilotage and the appreciation of risk during manoeuvring to and from the berth.

Appropriate action implemented

No. **Recommendation(s) to:** **Oikos Storage Ltd** to:

2024/121 Conduct risk assessments of its berths in collaboration with the Port of London Authority for the conduct of all berthing and unberthing manoeuvres, and implement any resulting mitigations. Specific consideration should be given to assurance mechanisms where Oikos is dependent on mitigations delivered by external organisations, and particularly pilotage and tug use in a range of environmental conditions.

Appropriate action implemented

No. **Recommendation(s) to:** **International Chamber of Shipping** to:

2024/122 Include specific roles and responsibilities to be agreed during the master/ pilot exchange in checklists C1.1 and C1.2 in the next iteration of the Bridge Procedures Guide.

Appropriate action implemented

Channel Queen

Report number: 7/2024

Commercial swim event support vessel

Accident date: 20/7/2023

Grounding and loss of the motor vessel *Channel Queen* near the Needles, Isle of Wight, England

Safety Issues

- Ineffective passage planning
- No qualified crew on board at time of accident
- Ineffective navigational watchkeeping practices

No. **Recommendation(s) to:** **Swimon Proprietary Limited** to:

2024/123 Implement a process to ensure that any vessel operated by Swimon, or engaged from a third party to support its events, is crewed by sufficient numbers of personnel suitably qualified for the intended area of operation and that they remain on board at all times when underway.

Rejected

2023/124 Review the method of navigation passage planning used on board any vessel it operates to ensure that recommended practice is followed, including making appropriate use of charts and charting systems.

Rejected

MAIB comment: **Swimon Proprietary Ltd has elected to reject the two recommendations made. It is disappointing that the company has chosen not to embrace the spirit of the accident investigation report to improve the safe operation of its vessel.**

Angelena

Report number: 8/2024

Fishing vessel (BM271)

Accident date: 18/6/2021

Capsize and foundering of the fishing vessel *Angelena* (BM271) south-east of Exmouth, England

Safety Issues

- Vessel stability was compromised
- Loss of control while lifting heavy loads
- Liferaft unable to automatically float free, inflate and break free

No.	Recommendation(s) to: **Maritime and Coastguard Agency** to:	
2024/125	In its implementation of the new Fishing Training Regulations, require fishing skippers to have completed advanced stability training before any certificate of competency is issued under acquired rights; and to engage with the fishing industry to explore, and then implement, pathways to enhance and improve fishers' practical knowledge of stability, advising fishing vessel skippers to complete small fishing vessel advanced stability training during the intervening period.	**Appropriate action planned: 28 February 2026**
2024/126	In collaboration with the fishing industry, develop and then implement a process to ensure that owners and operators of fishing vessels undertake risk assessments to define the safe crewing required for the conduct of fishing operations, and for that definition of safe crewing to be documented in an appropriate manner.	**Appropriate action planned: 31 July 2025**
2024/127	Align its definitions on float-free arrangements for liferafts in its marine safety, guidance and information notices, and instructions to surveyors, to ensure a consistent requirement to use hydrostatic release units so that liferafts float free, inflate and break free automatically.	**Appropriate action implemented**

No.	Recommendation(s) to: The **owner and skipper of *Angelena*** to:	
2024/128	Complete the Seafish Advanced Stability Awareness training course to gain a thorough knowledge of stability principles and what factors might impact the stability of any fishing vessel they operate in the future.	**Appropriate action implemented**

Inflatable migrant boat

Report number: 9/2024

Inflatable boat

Accident date: 14/12/2022

Flooding and partial sinking of an inflatable migrant boat, resulting in the loss of at least 8 lives in the Dover Strait.

Safety Issues

- Unsuitability of small boats attempting to cross the Dover Strait
- Lack of contingency plan to provide aerial surveillance in the Dover Strait
- Informal methods used to raise the alarm when in distress

No. **Recommendation(s) to:** Not applicable

In view of the recommendations made, and subsequently implemented by the MCA and Border Force, in MAIB report 7/2023 and the actions already taken, no further recommendations have been made.

Kingfisher

Safety bulletin number: SB3/2024

Fishing vessel (DH110)

Accident date: 12/7/2024

Fatal man overboard from the fishing vessel *Kingfisher* (DH110) approximately 30 nautical miles east-north-east of Wick, Scotland

Safety Issues

- Damaged PFD, making it unsuitable for use
- Poor preparation and updates to risk assessments
- Inadequate communication of snagging hazard

No. **Recommendation(s) to:** The **Home and Dry Safety Forum** to:

S2024/129M Immediately communicate through its members the need for owners and crew of creel fishing boats to review their deck working risk assessments to ensure that:

- the hazards associated with shooting and recovering creels, such as the risk of entrapment in a running backrope, are fully mitigated;
- when working deck PFDs are provided, they are of the required standard and are appropriate for the work being undertaken by the deck crew; and
- when new hazards are identified, such as the risk of entanglement from loose lifting strops on PFDs, they share the information among the crew and source alternative PPE as soon as possible.

Appropriate action implemented

Pelican of London

Report number: 10/2024

Sail training vessel

Accident date: 2/10/2023

Fatal man overboard from the sail training vessel *Pelican of London* at Sharpness, England

Safety Issues

- Unsafe gangway
- Excessive alcohol consumption
- Ineffective risk assessment
- Ineffective procedures

No.	Recommendation(s) to: **Seas Your Future** management to:
2024/130	Review and amend fleet policy, procedures and training for rigging and approving the gangway arrangement to include guard ropes to prevent falls and gangway nets to arrest the fall of a person. **Appropriate action implemented**
2024/131	Review and amend the onboard risk assessment procedure, as guided by the COSWP Annex 1.4, such that: • operational risks can be mitigated to a level that is as low as reasonably practicable • local work instructions are produced that control the hazards **Appropriate action implemented**
2024/132	Review and amend the fleet policy and procedure on drugs and alcohol to include specific consideration of: • individual responsibilities • alcohol testing • returning on board from recreational time ashore. **Appropriate action implemented**

Kommandor Orca

Report number: 11/2024

Survey and supply vessel

Accident date: 16/8/2022

Serious injury to a crew member on board the survey and supply vessel *Kommandor Orca* at Portland, England

Safety Issues

- No onboard procedures
- Crew training flawed
- Crane not operated correctly

No. **Recommendation(s) to:** Not applicable

In view of the actions already taken, no recommendations have been made.

Equinox Seas

Report number: 12/2024

Bulk carrier

Accident date: 17/4/2023

Fall from height on the bulk carrier *Equinox Seas* resulting in one fatality at ONEX Syros Shipyard, Ermoupoli, Syros, Greece

Safety Issues

- Poor barrier controls
- No risk assessment
- Poor safety management
- Ineffective coordination and communication
- Limited access to safety guidance

No. **Recommendation(s) to:** **ONEX Syros Shipyards S.A.** to:

2024/133 Update its safety management and communication procedures to ensure that risks created by the work carried out in its shipyards are effectively managed and coordinated with the relevant ship's crew and that the delineation of responsibility for safety on board is clearly understood between all parties.

No response, closed

Guiding Light/Guiding Star

Report number: 13/2024

Fishing vessel (H 90)/Fishing vessel (H 360)

Accident date: 6/10/2022

Collision between the pair trawlers *Guiding Light* (H 90) and *Guiding Star* (H 360) resulting in the flooding and sinking of Guiding Star 33 nautical miles south-east of Fair Isle, Scotland

Safety Issues

- Poor supervision of fishing operations
- Fish transfers not risk assessed
- No flood action plan
- Inaccessible survival equipment
- Ineffective communications

No.	Recommendation(s) to: **Maritime and Coastguard Agency** to:
2024/134	On the next review of MGN 165 (F), ensure that the consequences of flooding on fishing vessels are highlighted appropriately and update the guidance to surveyors to ensure that crew preparedness for a flooding emergency is checked and that the crew are aware of the actions to take.

Appropriate action planned: 30 June 2025

No.	Recommendation(s) to: **Peter & J. Johnstone Limited** to:
2024/135	Ensure the best practice guidance in MGN 313 (F) is followed, in particular that the wheelhouse is not left unattended and the impact of fishing operations on the navigational watch is evaluated.

Appropriate action planned: no date

2024/136	Ensure skippers are familiar with their vessel's survivability and understand and practise the actions to take in the event of flooding during regular flooding drills. This should include reviewing the survival equipment's location to ensure it is readily accessible in case of an emergency.

Appropriate action planned: no date

Argos Georgia

Safety bulletin number: SB4/2024

Fishing vessel

Accident date: 22/7/2024

Foundering of the fishing vessel *Argos Georgia* approximately 190 nautical miles east of Port Stanley, Falkland Islands with the loss of 13 lives

Safety Issues

- Shell door not adequately secured
- Vessel flooding prevented closing of shell door and internal weathertight doors
- Internal watertight separation ineffectively managed

No.	Recommendation(s) to:	All **owners, operators and skippers of fishing vessels** that are fitted with side shell doors 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.

Appropriate action implemented

Wheelyboat 123

Report number: 14/2024

Recreational craft

Accident date: 8/6/2022

Capsize of the recreational craft *Wheelyboat 123* with the loss of two lives on Roadford Lake, Devon, England

Safety Issues

- Inadequate maintenance
- Inadequate guidance or procedures for the safe conduct of operating the vessel with disabled people on board
- Inadequate risk assessment
- The operation and maintenance of the vessel was not monitored

No.	Recommendation(s) to:	The **Local Government Association** to:
2024/138		Bring the report and safety issues to the attention of local authorities and to consider the role of local government in overseeing waterborne charitable activities.

Partially accepted

MAIB comment: **Unfortunately, The Local Government Association is unable to complete the first part of the recommendation as it does not have the jurisdiction to bring safety issues to the attention of the local authority. However, it has brought the report to the attention of its members.**

No.	Recommendation(s) to: **South West Lakes Trust** to:
2024/139	Update the planned maintenance system used by its activity centres to include the specific maintenance tasks required by the manufacturers of the watercraft they operate, including boats used by people with disabilities. **Appropriate action planned: 31 July 2025**
2024/140	Employ a permanent member of staff dedicated to the maintenance and condition monitoring of all activity centre craft. **Appropriate action implemented**
2024/141	Ensure instructors and support staff attend and complete recognised disability awareness training. **Appropriate action implemented**
2024/142	Ensure instructors at its activity centres are educated in how to evaluate the weight and load distribution for users of craft designed for wheelchair users to ensure compliance with the design loading and manufacturer's instruction. **Appropriate action planned: 31 July 2025**
2024/143	Revise driver assessment requirements for craft designed for wheelchair users to ensure drivers are equipped to recognise developing dangerous situations and take emergency action. **Appropriate action planned: 31 July 2025**

No.	Recommendation(s) to: **Burdon Grange** to:
2024/144	Revise its risk assessments for activities provided by organisations outside of the care home environment to identify any hazards faced by the residents taking part in that activity and take steps to assure itself that appropriate risk mitigation measures are in place. **Appropriate action implemented**

No.	Recommendation(s) to: **The Wheelyboat Trust** to:
2024/145	Review the wheelyboat owner's manual to ensure that guidance around wheelchair securing and the carriage of heavy, motorised wheelchairs is appropriate. **Appropriate action planned: 31 December 2025**

2024/146 Remind operators of wheelyboats supplied under a placement agreement of the need to submit annual condition notes and take action to ensure wheelyboats are being maintained in line with the owner's manual and The Wheelyboat Trust's requirements.

Appropriate action implemented

Ocean Maid

Report number: 15/2024

Fishing vessel (BA 55)

Accident date: 24/10/2022

Grounding and subsequent loss of the fishing vessel *Ocean Maid* (BA 55) on Cairnbulg Point, Aberdeenshire, Scotland

Safety Issues

- No passage plan
- Unqualified watchkeeper
- Impaired night vision
- Ineffective sleep management to prevent fatigue

No. **Recommendation(s) to:** **Ocean Maid Limited** to:

2024/147 Enhance the safety of any vessel it may own in the future by applying the best practice guidance promoted in MGN 313 (F), in particular:

- the planning and checking of the intended passage before departure;
- the effective monitoring of the vessel's position;
- that watchkeepers maintain an effective visual lookout;
- the removal of domestic media devices from the wheelhouse; and
- ensuring that watchkeepers are sufficiently rested to take a watch, as required by MSN 1884 (F).

No response received, closed

Clipper Pennant

Report number: 16/2024

Roll-on/roll-off cargo vessel

Accident date: 20/7/2021

Fatal crush accident to a bosun during cargo operations on board the roll-on/roll-off cargo vessel *Clipper Pennant* at Gladstone Dock, Liverpool, England

Safety Issues

- Routine and widespread divergence from safe working practices
- No safe system for loading high-risk stowage spaces
- Ineffective supervision of vehicle deck operations
- Insufficient organisational learning and improvement

No.	Recommendation(s) to: **UK Chamber of Shipping** and **Port Skills and Safety Limited** to:

2024/148 Develop a jointly agreed and consolidated industry Code of Practice for vehicle deck safety on roll-on/roll-off vessels by consulting with the Maritime and Coastguard Agency, Health and Safety Executive, Interferry, and ro-ro ferry operators, considering existing best practice guidance and the lessons learned from this accident and other previous similar accidents. The guidelines should cover, inter alia:

- The role, responsibilities and positioning of banksman while marshalling on vehicle decks in or near the path of a moving vehicle;
- The dynamic nature of vehicle deck loading operation that reflects the moving danger zone around a semi-trailer;
- Identification and risk mitigation of vehicle stowage spaces with limited or obstructed areas for escape;
- Suitable control measures to reduce the risk to people working in close proximity to moving vehicles, including the development of cargo handling procedures and safe systems of work;
- Safe access arrangements for crew during and after cargo operations;
- An agreed industry standard for signalling and communication on vehicle decks; and
- The use of technology to improve safety on deck.

Appropriate action planned: 31 October 2025

2024/149 Ensure that the consolidated industry Code of Practice for vehicle deck safety on roll-on/roll-off vessels developed in accordance with recommendation 2024/148 is effectively promulgated to the industry.

Appropriate action planned: 31 December 2025

No.	Recommendation(s) to: **Port Skills and Safety Limited**, in consultation with the **Health and Safety Executive** to:

2024/150 Develop a national occupational driving standard for tractor unit drivers.

Appropriate action implemented

No.	Recommendation(s) to: **Maritime and Coastguard Agency** to:
2024/151	Consider the consolidated industry Code of Practice for vehicle deck safety on roll-on/roll-off vessels developed in accordance with recommendation 2024/148 and ensure that its related guidance documents are reviewed and, as appropriate, updated and aligned to reflect this industry best practice.

Appropriate action planned: 31 March 2026

No.	Recommendation(s) to: The **Health and Safety Executive** to:
2024/152	Consider the consolidated industry Code of Practice for vehicle deck safety on roll-on/roll-off vessels developed in accordance with recommendation 2024/148 and ensure that its related guidance documents are reviewed and, as appropriate, updated and aligned to reflect this industry best practice.

Appropriate action planned: 30 April 2026

No.	Recommendation(s) to: **CLdN RoRo Limited** to:
2024/153	Review the findings of its previous safety climate surveys and, with support from external sources, take further action to develop and implement a plan to encourage a positive organisational culture that supports learning from incidents and accidents and encourages reporting.

Appropriate action planned: no date

2024/154	Ensure the effective on board supervision of vehicle deck cargo loading operations on its vessels by considering the roles, responsibilities and allocation of resources and the use of technology to oversee and assure the safety of personnel working on deck at all times.

Appropriate action planned: no date

No.	Recommendation(s) to: **P&O Ferries Limited** to:
2024/155	Introduce a program to verify that its ports consistently follow its vehicle deck safety procedures, specifically to ensure that tractor unit drivers understand and implement the company's safe systems of work.

Appropriate action planned: 31 July 2025

2024/156	Implement a procedure for the effective engagement and liaison with the operators of vessels that it charters to ensure that: • the safety management systems are aligned; and • there is an agreed safe system of work for chartered vessels with appropriate training in place.

Appropriate action planned: 31 July 2025

Biter/Hebridean Princess

Report number: 17/2024

Tug/passenger vessel

Accident date: 24/2/2023

Capsize and sinking of the tug *Biter*, with the loss of two lives, while assisting the passenger vessel Hebridean Princess off Greenock, Scotland

Safety Issues

- Towage plan not understood and agreed by all parties
- Tug's gob rope was unable to withstand force exerted on it
- Passenger vessel's speed exceeded port's guidance
- Open watertight doors prevented tug remaining afloat
- Inadequate training and experience

No. **Recommendation(s) to:** **Clyde Marine Services Limited** to:

2024/157 Review the company's safety management system to provide clear guidance on the safe speed for conducting the peel off/drop back manoeuvre and the rigging of tug gob ropes.

Partially accepted

2024/158 Adopt an appropriate training and qualification scheme for its tug masters that is demonstrably equivalent to those specified in MGN 468 (M) and MGN 495 (M+F).

Rejected

MAIB response: **Clyde Marine Services Limited report that it will assess the experience of new masters and consider the level of training that would be appropriate for them. However, the company believe that it is for the MCA to determine if mandatory training is required by tug masters.**

No. **Recommendation(s) to:** **Clydeport Operations Limited** to:

2024/159 Commission an independent review of its tug training for pilots within the port.

Appropriate action planned: no date

2024/160 Formalise the conduct of pilot/tug information exchanges and ensure that they are routinely carried out within its port.

Appropriate action planned: 31 July 2025

2024/161 Conduct a risk-based review of the Pilot Grade Limits and the Tug Matrix within its waters.

Appropriate action planned: 11 April 2025

2024/162 Consider requiring all tugs and workboats, that routinely operate within its statutory harbour area, to be fitted with and operate AIS transponders.

Appropriate action planned: no date

No.	Recommendation(s) to:	The **UK Maritime Pilots' Association**, in conjunction with the British Ports Association, UK Harbour Masters' Association, British Tugowners Association and The Workboat Association, to:
2024/163		Develop guidance for inclusion in the Port Marine Safety Code's Guide to Good Practice and other appropriate publications that emphasises the importance of conducting a pilot/tug exchange, in addition to the master/pilot exchange, to ensure that the pilot, bridge team and tug crew have a common understanding of the intended arrival/departure manoeuvre, the potential hazards and their respective roles in managing them.

Appropriate action planned: 4 March 2025

No.	Recommendation(s) to:	The **UK Harbour Masters' Association**, in conjunction with the UK Maritime Pilots' Association, British Tugowners Association and The Workboat Association, to:
2024/164		Develop for inclusion in the Port Marine Safety Code's Guide to Good Practice, best practice guidance on matching the capability of the tug to the intended task to ensure that the most appropriate tugs are assigned.

No response received

2024/165		Develop for inclusion in the Port Marine Safety Code's Guide to Good Practice, guidance that harbourmasters require tugs and workboats that routinely operate within their statutory harbour area to be fitted with and operate Auto Identification System transponders.

No response received

No.	Recommendation(s) to:	The **British Tugowners Association** and **The Workboat Association** to:
2024/166		Develop guidance on the testing of gob ropes and towlines used during harbour towage.

Appropriate action planned: 31 March 2025

Mona Manx

Report number: 18/2024

Bulk carrier

Accident date: 26/8/2021

Fatal accident during mooring operations on board the bulk carrier *Mona Manx* at Puerto Ventanas, Chile

Safety Issues

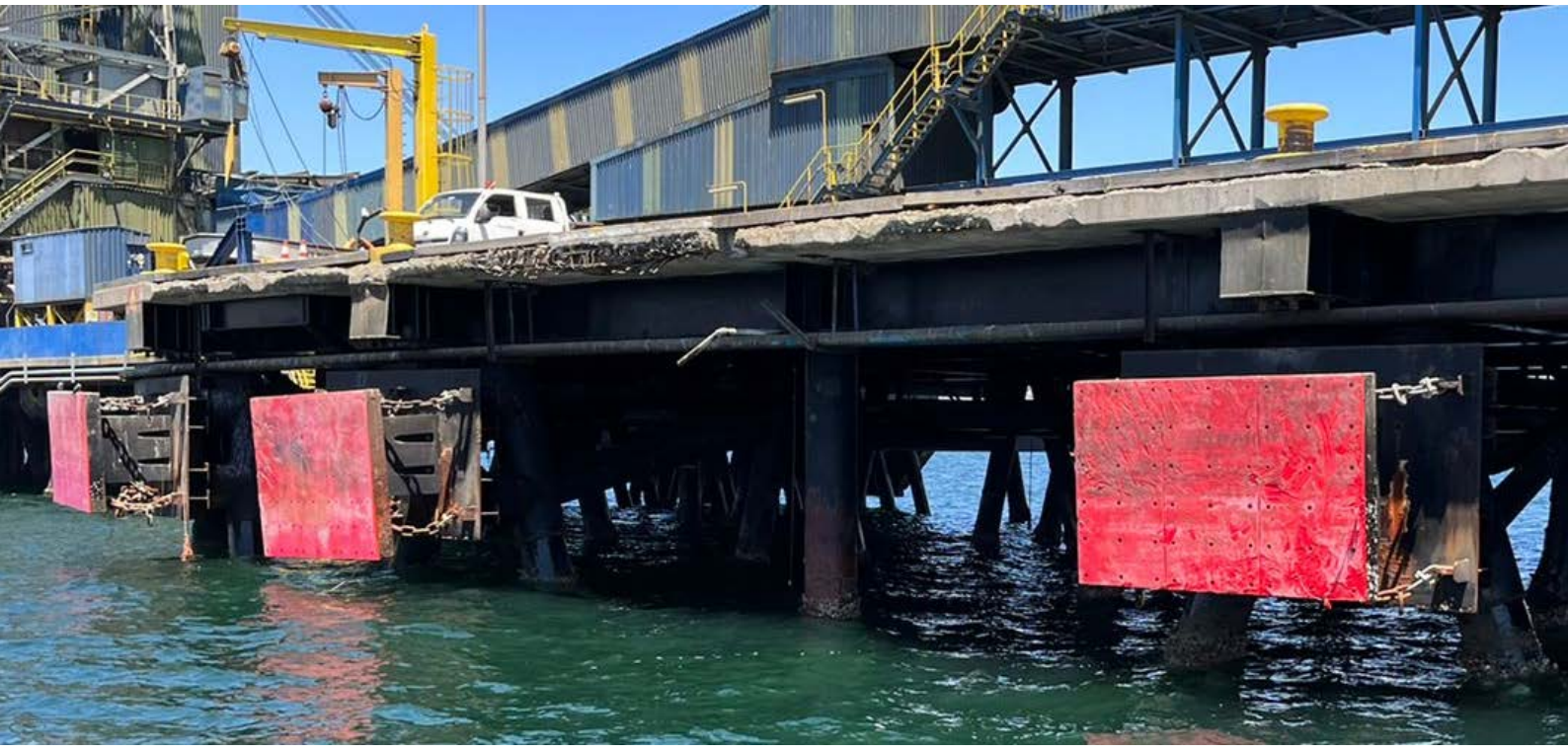
- Guidance did not include the risk of vertical recoil of mooring lines
- Risks of manoeuvring with mooring lines attached were not identified
- Poor communication between ship and shore

No.	Recommendation(s) to: **Puerto Ventanas S.A** to:
2024/167	Review and update the information made available to masters and pilots before a port call, including: • instructions that engines are not to be used to conduct manoeuvres while moored alongside; and • guidance on the risks associated with line entrapment on shore fixtures and fittings, such as fenders.

No response received, closed

No.	Recommendation(s) to: **Quintero Port Authority** to:
2024/168	Ensure that the master/pilot exchanges conducted by its pilots consider the risks associated with mooring line entrapment and recoil and vessels manoeuvring alongside using their engines.

No response received, closed



Pioneer

Report number: 19/2024

Fishing vessel (NN200)

Accident date: 29/7/2021

Fatal man overboard from the potting vessel *Pioneer* (NN200) south of Hastings, England

Safety Issues

- Not wearing a PFD
- Poor safety management
- No effective means to recover an unconscious person
- Inspection guidance and close-out of deficiencies unclear

No.	Recommendation(s) to: **Maritime and Coastguard Agency** to:
2024/169	Revise its instructions for the guidance of surveyors to provide clarity on the conduct and recording of fishing vessel surveys and inspections, and review its guidance on the closing out of deficiencies.

Appropriate action planned: 30 June 2025

Stena Europe

Report number: 20/2024

Roll-on/roll-off passenger ferry

Accident date: 11/2/2023

Engine room fire on board the roll-on/roll-off passenger ferry *Stena Europe* while approaching Fishguard, Wales

Safety Issues

- Inadequate detection of exposed hot surfaces
- Long-standing defects in fuel system
- Lack of defect reporting

No.	Recommendation(s) to: **Maritime and Coastguard Agency** to:
2024/170	Submit a paper to the International Maritime Organization proposing an amendment to Maritime Safety Committee.1/Circular.1321 to introduce a requirement for the use of thermographic equipment to identify exposed surfaces with temperatures above 220°C, which could be impinged in the event of a pressurised oil system failure.

Appropriate action planned: 31 May 2026

No.	Recommendation(s) to: **Stena Line Ltd** to:
2024/171	Review the use of the existing defect reporting functions within the planned maintenance system on vessels within its fleet to ensure that defect reports and remedial actions can be tracked readily.

Appropriate action implemented

2024/172 Review and provide training to improve how its chief engineers conduct class-related equipment inspections that are credited to class surveys to ensure that inspections are conducted thoroughly and reported accurately.

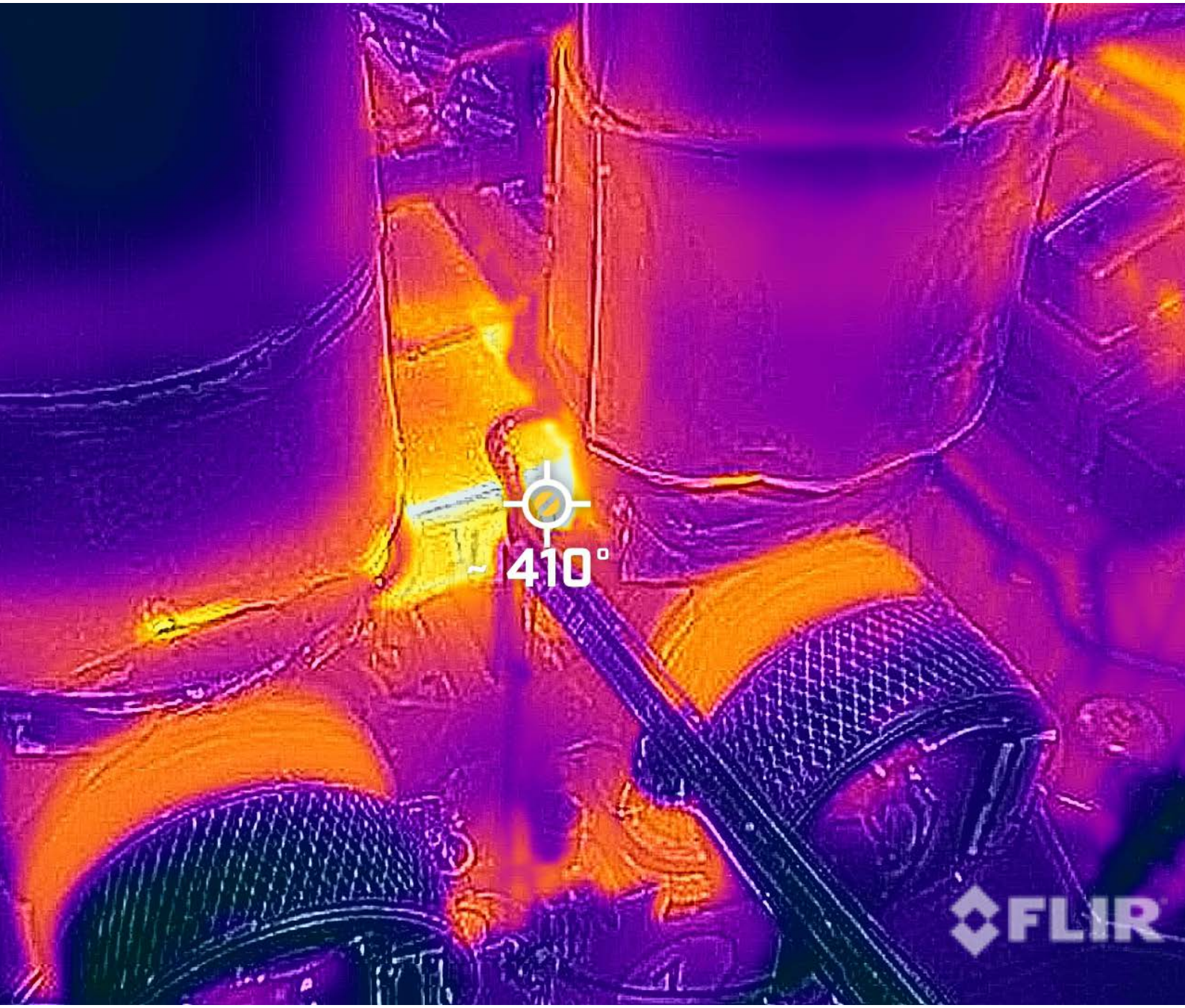
Appropriate action planned: 31 July 2025

2024/173 Promulgate details of this accident to all ships within its fleet to emphasise the importance of training and highlight the hazards of entering a fire-damaged space without the correct personal protective equipment.

Appropriate action implemented

2024/174 Introduce the use of thermal imaging cameras to all Stena vessels with appropriate functionality for the detection of exposed hot surfaces of over 220°C within machinery spaces.

Appropriate action implemented



ONGOING RECOMMENDATIONS FROM PREVIOUS YEARS

2023 RECOMMENDATIONS – PROGRESS REPORT

Status as of 3 March 2025

Harriet J

Report number: 2/2023

Fishing vessel (AH180)

Accident date: 28/8/2021

Fatal man overboard from the lone-operated creel fishing vessel *Harriet J* (AH180) west of Fast Castle Head, south-east Scotland

Safety Issues

- There was no effective way for the skipper to enter the working deck without the risk of being entrapped in the fishing gear
- The chance of survival was reduced because a PFD was not being worn nor a personal locator beacon carried
- The risks of becoming entrapped and pulled into the water had not been fully assessed or mitigated
- Once in the water, there was no means for the skipper to remotely stop the engine
- Promulgation of safety information related to safety in this sector of industry continues to be problematic

No.	Recommendation(s) to: **Fishing Industry Safety Group** to:
2023/101	Expedite the delivery of the outcomes of its working group on lone-operated fishing vessels, taking into account the work commissioned by the MCA and Seafish.

Appropriate action planned: 30 September 2025

Copious

Report number: 3/2023

Fishing vessel (LK 985)

Accident date: 18/2/2021

Man overboard from the stern trawler *Copious* (LK 985) resulting in one fatality approximately 30 nautical miles south-east of the Shetland Isles, Scotland

Safety Issues

- Ineffective risk assessment
- PFD worn incorrectly
- Ineffective manoverboard drills
- No toolbox talk
- Ineffective man overboard recovery equipment for unconscious casualties

No.	Recommendation(s) to: **Maritime and Coastguard Agency** to:
2023/102	Amend commercial fishing vessel regulations to ensure that there is an explicit requirement, in line with that in The Workboat Code Edition 2, for fishing vessels to have an efficient means to recover an unconscious person from the water that is demonstrable during surveys and inspections.

Appropriate action planned: 31 March 2027

Scot Carrier/Karin Høj

Report number: 5/2023

General cargo vessel/split hopper barge

Accident date: 13/12/2021

Collision between the general cargo vessel *Scot Carrier* and the split hopper barge *Karin Høj*, resulting in the capsize of the barge with two fatalities in the Bornholmsgat traffic separation scheme, Sweden

Safety Issues

- No lookout in darkness
- Distraction of watchkeeper
- Alcohol impairment
- Management of ships' crews

No.	Recommendation(s) to: **Intrada Ships Management Ltd** to:
2023/105	Review the results of its programme of navigational audits and determine what additional training and instruction is needed for its masters and crews. Any additional development needs identified from this process should be completed within 12 months.

Appropriate action implemented

BBC Marmara

Report number: 8/2023

General cargo vessel

Accident date: 25/7/2021

Grounding of the general cargo vessel *BBC Marmara* in the Little Minch, off the west coast of Scotland

Safety Issues

- Disregard of company alcohol policy
- Absence of lookout in hours of darkness
- Disablement of Bridge Navigational Watch Alarm System
- Poor passage planning management

No.	**Recommendation(s) to: Maritime and Coastguard Agency** to:
2023/112	Ensure that the hazards of distraction to vigilance-based roles such as VTM and the management of vigilance related hazards are captured in appropriate training packages, practices, and the Coastguard Information Portal pages.

Appropriate action implemented

2023/113	Carry out a study into the cognitive performance needed by the coastguard teams to successfully maintain the VTM function throughout the national network and implement the findings of the study when considering the future management of the network.

Appropriate action planned: 30 October 2025

Resurgam

Report number: 9/2023

Fishing vessel (PZ1001)

Accident date: 15/11/2019

Accidental discharge of a FirePro condensed aerosol fire-extinguishing system during its installation on board the fishing vessel *Resurgam* (PZ1001) resulting in one fatality in Newlyn Harbour, Cornwall, England

Safety Issues

- Ineffective oversight at the system design stage for the vessel and lack of oversight for the installation on board by either Ocean Engineering[19] or the MCA
- The hazards to human health associated with the activation of the condensed aerosol generators were not identified in FirePro's safety-related documentation
- The owner/operator of the fishing vessel did not have a robust system for the control and safe management of contractors work on its fishing vessels
- There was no nationally developed standard for the training of designers and installers of fire-extinguishing systems on UK registered vessels

No.	Recommendation(s) to: **FirePro** to:
2023/117	Undertake a specific risk assessment for the installation and operation of each of its fire-extinguishing systems to identify and mitigate all of the associated hazards, including those identified as part of this investigation, to a level that is considered as low as reasonably practicable. **Appropriate action implemented**
2023/118	Review its safety-related documentation for its fire-extinguishing systems (including, but not limited to, the installation and operational guidance and material safety data sheet) to: • Incorporate the hazards identified as part of this investigation, specifically those associated with carbon monoxide generation and risk of inhalation injury, and the required control measures. **Appropriate action implemented**

[19] Ocean Engineering went into liquidation in 2022. As a result of the liquidation no MAIB recommendations were made.

Seadogz

Report number: 10/2023

High-speed passenger craft

Accident date: 22/8/2020

Contact between the high-speed passenger craft *Seadogz* and a navigation buoy, resulting in one fatality in Southampton Water, England

Safety Issues

- Limitations in regulatory requirements for craft design and operation
- Loss of positional awareness due to high mental workload
- No safety management system in place
- Craft provided little protection for occupants in crash

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

2023/120 Conduct an anthropometric assessment of the design and operational requirements for small high-speed passenger craft safety to develop a framework for assuring the protection of passengers and crew provided by the craft with respect to whole-body vibration and sudden decelerations in the event of a horizontal impact. The assessment should consider, among other things, the:

- full anthropometric range of passengers and crew;
- operational profile of the craft, including the range of speeds;
- crash protection and general protection of the seating arrangements, including the design and use of handholds and restraints.

Appropriate action planned: 30 June 2027

2023/121 Ensure that the relevant outputs of the anthropometric assessment of the design and operational requirements for small high-speed passenger craft safety conducted in accordance with the MAIB recommendation 2023/120 are, where appropriate:

- promulgated in appropriate guidance for the operators and designers of small high-speed passenger craft at the earliest possible opportunity; and
- incorporated into a future revision of The Sport & Pleasure Vessel Code as requirements for the crash protection and general protection of passengers and crew.

Appropriate action planned: 31 December 2029

2023/122 Further to the previous MAIB recommendations 2009/126, 2015/120 and 2017/115 made in relation to revisions of The Small Commercial Vessel and Pilot Boat (SCV) Code, expedite the introduction of The Sport & Pleasure Vessel Code and its enabling legislation at the earliest possible opportunity to ensure that additional requirements are introduced for small commercial high-speed passenger craft for:

- the operators of such craft to implement a safety management system that includes, but is not limited to:
    - operational procedures for the craft's full range of intended operations, including navigational and emergency response procedures.
    - accident reporting and investigation procedures;
- appropriate deck manning levels for the craft's intended operations;

- forward visibility from the helm position aligned with the requirements in BS EN ISO 11591;
- the installation and use of automatic identification systems;
- the recording of information relating to the permitted crewing level and function of the craft on the certificate issued to show the craft's compliance with The Sport & Pleasure Vessel Code.

Appropriate action planned: 31 July 2026

No.	Recommendation(s) to:	**British Standards Institution** to:

2023/123 Propose to the International Organization for Standardization that the ISO 11591 standard is revised to incorporate a requirement for the effect of the full loading of persons to be included in the evaluation of the operator's field of vision with the craft at its maximum running trim angle value to ensure that the actual operational forward visibility is adequate and compliant with the standard.

Appropriate action planned: 30 May 2027

No.	Recommendation(s) to:	The **British Ports Association**, the **UK Harbour Masters' Association**, and the **UK Major Ports Group** to:

2023/124 Contribute to the development of guidance for their members clarifying the requirements and best practices for the oversight of small commercial craft operating in their areas of responsibility.

Appropriate action planned: no date

No.	Recommendation(s) to:	**Red Bay Boats Ltd** to:

2023/127 Conduct a risk-based review of the design of the small commercial high-speed craft that it manufactures and undertake any required modifications to its processes and craft designs to ensure that the:

- documentation provided for its craft is accurate, consistent and includes all required information; and
- design of the seats, handholds and restraints meets the latest relevant industry guidance, including MGN 436 (M+F), the *Passenger Safety on Small Commercial High Speed Craft & Experience Rides – A Voluntary Code of Practice* and, when introduced, The Sport & Pleasure Vessel Code.

Appropriate action planned: 30 May 2025

2022 RECOMMENDATIONS – PROGRESS REPORT Status as of 3 March 2025

Rib Tickler

Report number: 3/2022

Rigid inflatable boat/ Personal watercraft

Accident date: 8/8/2020

Collision resulting in one fatality in the Menai Strait, Wales

Safety Issues

- Uncoordinated high-speed manoeuvres in close proximity
- Inappropriate leisure craft training, knowledge and skills
- Inadequate compliance with the Port Marine Safety Code
- Inconsistent approach to national governance

No.	Recommendation(s) to: **Isle of Anglesey County Council** to:
2022/102	Reviewing the current legislation governing the waters at Menai Bridge and, if appropriate, seeking to amend and improve its powers via a Harbour Revision Order.

Appropriate action planned: no date

Diamond Emblem 1

Report Number: 5/2022

Motor cruiser

Accident date: 19/8/2020

Fatal person overboard at Great Yarmouth Yacht Station, River Bure, England

Safety Issues

- Fall into the water near a moving propeller
- Inadequate guardrail around the motorboat's stern
- Loss of control caused heavy impact
- Insufficient knowledge of dual helm controls
- Unclear visual positive indication of the active helm at either helm position
- Incomplete boat handover and documentation provided to the group

No.	Recommendation(s) to: **Association of Inland Navigation Authorities**, in consultation with its members to:
2022/113	Provide its members with comprehensive best practice guidance on processes for the administration and oversight of compliance with The Code for the Design, Construction and Operation of Hire Boats, commonly referred to as the Hire Boat Code, in order to support their adoption of the code as mandatory in 2022.

Appropriate action planned: no date

MAIB comment: The Association of Inland Navigation Authorities in consultation with its members is yet to implement this recommendation. The MAIB is awaiting an update.

No.	Recommendation(s) to: **Boat Safety Scheme** to:
2022/123	Conduct a review of the Boat Safety Scheme requirements for hire boats with multiple helm control positions or systems with the intention of: • Aligning the requirements with the technical standards outlined in ISO 25197:2020 to require positive visual indication of the active helm control position and that the transfer of command between helm control positions can only be completed at the intended active helm control position; and • Including a requirement to incorporate system interlocks in order to prevent inadvertent engine operation from an inactive helm control position. **Appropriate action planned: no date**

Nicola Faith

Report number: 8/2022

Whelk potter (BS 58)

Accident date: 27/1/2021

Foundering in Colwyn Bay, North Wales with the loss of three lives

Safety Issues

- Eroded margins of stability due to extensive vessel modification
- Unsafe operation due to overloading of the vessel to the point of instability
- Noncompliance in respect to the provision of mandatory safety equipment and wearing of a PFD
- Insufficient guidance on modifications provided for MCA surveyors

No.	Recommendation(s) to: **Maritime and Coastguard Agency** to:
2022/125	Revise the wording in MSN 1871 Amendment No. 2 (F) *The Code of Practice for the Safety of Small Fishing Vessels of Less than 15m Length Overall* to refer to a load limit rather than a catch limit. **Appropriate action planned: 30 June 2028**

Paddleboards

Report number: 13/2022

Stand up paddleboards

Accident date: 30/10/2021

Four fatalities during a commercial river tour at Haverfordwest Town Weir, Wales

Safety Issues

- Inadequate planning and preparation for the tour overlooked the treacherous conditions at the weir
- Inadequately qualified tour leaders
- Lack of weir risk assessment to establish the hazard it posed to public safety
- Inadequate signage to alert river users to the extreme hazard posed by the weir
- Participants were not wearing quick release waist leashes
- Inconsistent UK stand up paddleboard safety messaging and no means for participants to judge the competence of the business providing the tour

No.	Recommendation(s) to: **UK National Sports Councils** to:
2022/134	Complete their review of the governance of stand up paddleboarding in the UK and urgently ensure that the recognised national governing body(ies) have the resource, support and expertise to issue advice and guidance, including appropriate training standards to control risk to those who take part in this fast-growing sport.

Appropriate action planned: no date

2022/135	Review and develop as necessary its criteria for conferring recognition as a national governing body, to include the management of safety and adherence to good practice by the governing body and any organisation or companies it accredits.

Appropriate action planned: no date

2022/136	Develop and publish a national governing body Guide to Good Practice.

Appropriate action planned: no date

MAIB comment: **The UK national Sports Councils are yet to implement these recommendations or provide a completion date. The MAIB is awaiting an update.**

Svitzer Mercurius

Report number: 15/2022

Tug

Accident date: 22/12/2019

Failure of a towline pennant resulting in injury to the crew in Southampton, England

Safety Issues

- Insufficient induction for temporary crew due to commercial pressure
- Ineffective vessel condition assessment
- Ineffective tow winch maintenance led to its contamination and subsequent slippage
- Failure to identify the condition of the pennant as unfit for purpose
- Inability of the wheelhouse windows to withstand towline snapback impact

No.	Recommendation(s) to: **Svitzer Marine Limited** to:
2022/138	Undertake a fleetwide risk assessment to determine the level of risk associated with towline failure and snapback and the potential for impact by a line recoiling into wheelhouse windows, and, where appropriate, employ appropriate laminated glass or other defences to mitigate against the risk of flying glass injuring its tug crews.

Appropriate action planned

MAIB comment: **Svitzer Marine Limited is yet to implement this recommendation. The MAIB is awaiting an update.**

2021 RECOMMENDATIONS – PROGRESS REPORT Status as of 3 March 2025

Stolt Groenland

Report number: 9/2021

Chemical tanker

Accident date: 28/9/2019

Cargo tank explosion and fire at Ulsan, Republic of Korea

No.	Recommendation(s) to: **Cayman Islands Shipping Registry, through the UK as the Member Government for the Red Ensign Group to the International Maritime Organization** to:
2021/117	Propose to the IMO a revision to Section 15.13 of the IBC Code to: • Include in the certificate of protection the actions to be taken in the event of a cargo falling outside of the manufacturer's specified oxygen and temperature limits, and that • Any actions should be realistic, taking account of the limitations on board ships regarding the monitoring, adding, and mixing of inhibitor during the voyage. **Appropriate action planned: no date**

No.	Recommendation(s) to: **Chemical Distribution Institute** to:
2021/120	Amend its publication '*Chemical Tanker Operations for the STCW Advanced Training Course – A Practical Guide to Chemical Tanker Operations*' to make it clear that: • The stowage of heated and inhibited cargoes can result in a dynamic situation in which the degree of heat transfer may be complex and difficult to predict. • One tank separation between heated and heat sensitive cargoes might not be sufficient. • Promulgate this report to its members. **Appropriate action planned: 1 September 2026**

2020 RECOMMENDATIONS – PROGRESS REPORT

There are no outstanding recommendations for 2020.

2019 RECOMMENDATIONS – PROGRESS REPORT

Status as of 3 March 2025

Unnamed Rowing Boat

Report number: 2/2019

Rowing boat

Accident date: 24/3/2018

Failure of a throw bag rescue line during a capsize drill at a rowing club in Widnes, England

No.	Recommendation(s) to: **British Standards Institution** to:
2019/105	Develop an appropriate standard for public rescue equipment ensuring that the topic of throw bags and their rescue lines is addressed as a priority.

Appropriate action planned: 31 December 2026

CV30

Report number: 7/2019

Commercial racing yacht

Accident date: 18/11/2017

Fatal man overboard approximately 1500nm west of Fremantle, Australia

No.	Recommendation(s) to: **British Standards Institute Committee** to:
2019/110	Review and amend ISO 12401 and ISO 15085 at the earliest opportunity in light of lessons learned from this accident to: • Ensure the danger of snagging of tether hooks is highlighted and suitable precautions are taken for terminating jackstays. • Clarify that the ISO 12401 standard test assumes that the tether is loaded longitudinally and that the hook must be free to rotate to align with the load, and lateral loading of the hook must be avoided. • Clarify what force should be applied during an accidental hook opening test. • Consider including a requirement for a tether overload indicator.

Appropriate action planned: 31 December 2025

2018 RECOMMENDATIONS – PROGRESS REPORT

There are no outstanding recommendations for 2018.

2017 RECOMMENDATIONS – PROGRESS REPORT

Status as of 3 March 2025

Osprey/Osprey II

Report number: 10/2017

RIBs

Accident date: 19/7/2016

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

No.	Recommendation(s) to: **Maritime and Coastguard Agency** to:
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. • 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: 31 December 2025**

2016 RECOMMENDATIONS – PROGRESS REPORT

Status as of 3 March 2025

JMT

Report number: 15/2016

Fishing vessel (M99)

Accident date: 9/7/2015

Capsize and foundering of a small fishing vessel 3.8nm off Rame Head, English Channel with loss of two lives

No.	Recommendation(s) to: **Maritime and Coastguard Agency** to:
2016/131	Require skippers of under 16.5m fishing vessels to complete stability awareness training. **Appropriate action planned: 1 February 2028**

2015 RECOMMENDATIONS – PROGRESS REPORT

Status as of 3 March 2025

Cheeki Rafiki

Report number: 8/2015

Sailing yacht

Accident date: 16/5/2014

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 Federation**[20] to:
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: no date

MAIB comment: **British Marine is yet to implement this recommendation. The MAIB is awaiting an update.**

No.	Recommendation(s) to: **Maritime and Coastguard Agency** to:
2015/120	Include in the SCV Code a requirement that vessels operating commercially under ISAF[21] OSR should undergo a full inspection to the extent otherwise required for vessels complying with the SCV Code.

Appropriate action planned: 31 December 2025

2014 TO 2010 RECOMMENDATIONS – PROGRESS REPORT

There are no outstanding recommendations for 2014, 2013, 2012, 2011 and 2010.

[20] British Marine Federation is now known as British Marine.

[21] International Sailing Federation (ISAF) is now known as World Sailing.

2009 RECOMMENDATIONS – PROGRESS REPORT Status as of 3 March 2025

Celtic Pioneer

Report number: 11/2009

Rigid inflatable boat

Accident date: 26/8/2008

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

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

Appropriate action planned: 31 December 2025

PART 3: STATISTICS[22]

For details of reporting requirements and terms used in this section please see Annex A: Statistics Coverage on page 83 and glossary on page 86.

Table 1: Loss of life reported to the MAIB in 2024

Date	Name of vessel	Type of vessel	Location	Accident description
Merchant vessels 100gt and over				
28 Aug	*Arvia*	Cruise	Off the coast of Almería, Spain	Passenger loss of footing while descending the atrium stairs, resulting in hip and ankle fractures and subsequent death.
Merchant vessels under 100gt (including commercial recreational)				
27 Jun	*Eve*	Recreational craft	Kennet and Avon Canal, Wiltshire, England	Passenger fall into the water while stepping across a gap to reboard an inland waterways vessel that was alongside a lock landing. The vessel moved and fatally trapped/crushed the passenger.
Fishing vessels				
22 May	*Weston Bay*	Potter	11nm south-east of Spurn Head, England	Fall overboard of two crew members from a fishing vessel, resulting in one fatality.
12 Jul	*Kingfisher*	Potter	North Sea, north-east of Wick, Scotland	Fishing vessel crew member became entangled in the back rope and was dragged overboard. He was recovered back on board the vessel but later declared deceased.
Pleasure craft (excluding commercial recreational)				
1 Apr	*Konsorted*	Sailboat (aux. motor)	Off the coast of St Margaret's at Cliffe, England	Fall overboard of a crew member from a recreational craft. Their lifejacket failed to inflate on entering the water and they did not survive.
19 Aug	*Bayesian*	Sailboat (aux. motor)	Porticello, Italy	Capsize and subsequent foundering of a sailing vessel, resulting in the loss of seven lives.
9 Sep	*Final Fling*	Motorboat	Oyster Creek, Canvey Island, England	Grounding of a motor cruiser on a mudbank. One crew member was recovered unconscious and later died in hospital.
11 Oct	Rowing Four	Rowing boat	River Thames, Weybridge, England	Capsized rowing craft, resulting in all the craft's four occupants and one person from a support craft entering the water. Four of the five people were recovered but one person was unaccounted for. They were later found and confirmed deceased.

[22] MAIB regularly reviews its accident data. On occasion, data from previous years can and will change based on these reviews.

Date	Name of vessel	Type of vessel	Location	Accident description
13 Oct	T/T yacht *Nipper*	Rowing boat	River Medway, England	Capsized tender, resulting in the lone accupant entering the water. The person remains missing, presumed deceased.
13 Oct	Tender to recreational craft *Sea Den*	Rowing boat	River Thames, Southend-on-Sea, England	Capsized tender with two people entering the water, resulting in one fatality.
17 Dec	*High Cirrus*	Sailboat (aux. motor)	Dartmouth, England	Crew member reported missing from a sailing vessel. They were recovered and confirmed deceased a month later.

Weston Bay


Bayesian

Table 2: UK merchant vessels >= 100gt total losses in 2024

Date	Name of vessel	Type of vessel	Age	gt	loa	Casualty event
None						

Table 3: UK merchant vessels >= 100gt total losses 2015 to 2024

Year	Number lost	UK fleet size	Gross tonnage lost
2015	0	1,385	0
2016	0	1,365	0
2017	0	1,356	0
2018	0	1,332	0
2019	0	929	0
2020	0	1,242	0
2021	0	1,199	0
2022[23]	2	611	298
2023	0	1,226	0
2024	**0**	**1,054**	**0**

[23] In 2022 there was an under-reporting of non-trading vessels. This was rectified in 2023 after liaising with Sea by Maritech.

Table 4: UK merchant vessels >= 100gt by nature of casualty and vessel category in 2024[24]

Casualty event	Liquid cargo	Livestock carrier	Solid cargo	Inland waterway vessel	Passenger ship	Commercial Recreational	Service ship	Submersible	Unknown	Wing-in-the-ground craft	Total
Capsizing/listing	0	0	0	0	0	0	0	0	0	0	**0**
Collision	1	0	5	3	5	0	12	0	0	0	**26**
Contact	0	0	1	0	2	0	1	0	0	0	**4**
Damage/loss of equipment	0	0	0	0	0	0	0	0	0	0	**0**
Explosion	0	0	0	0	0	0	0	0	0	0	**0**
Fire	0	0	0	0	2	0	0	0	0	0	**2**
Flooding	0	0	0	0	0	0	0	0	0	0	**0**
Foundering	0	0	0	0	0	0	0	0	0	0	**0**
Grounding/stranding	0	0	2	2	2	2	8	0	0	0	**16**
Hull failure	0	0	0	0	0	0	0	0	0	0	**0**
Loss of control	0	0	0	2	2	1	1	0	0	0	**6**
Missing	0	0	0	0	0	0	0	0	0	0	**0**
Non-accidental event	0	0	0	0	0	0	0	0	0	0	**0**
Total	**1**	**0**	**8**	**7**	**13**	**3**	**22**	**0**	**0**	**0**	**54[25]**

[24] Vessel groups include vessels operating on inland waterways.

[25] 54 casualties represent rate of 51 casualties per 1,000 vessels on the UK Fleet sourced from table FLE0100 published by Department for Transport.

Table 5: Deaths and injuries to crew on UK merchant vessels >= 100gt — 2015 to 2024[26]

Year	Number of crew injured	Of which resulted in death
2015	153	2
2016	146	2
2017	163	0
2018	124	0
2019	105	3
2020	78	0
2021	79	0
2022	85	0
2023	133	2
2024[27]	**91**	**0**

[26] MAIB regularly reviews its accident data. On occasion, data from previous years can and will change based on these reviews.

[27] Excluding one minor injury to a crew member that the IMO does not classify as an injury.

Table 6: Deaths and injuries to crew on UK merchant vessels >= 100gt by rank in 2024

Rank/specialism	Number of crew
Hotel service staff	24
Rating as able seafarer deck	14
Engineer officer	6
Rating	5
Second engineer officer	3
Chief mate	2
Deck officer	2
Rating part of engine-room watch	2
Assistant/cadet	1
Chief engineer officer	1
Rating as able seafarer engine	1

Rank/specialism	Number of crew
Master	0
Electro-technical officer	0
Pilot	0
Rating electro-technical	0
Rating part of navigational watch	0
Other crew member	30
Other non-crew member	0
Unknown	0
Total	**91**

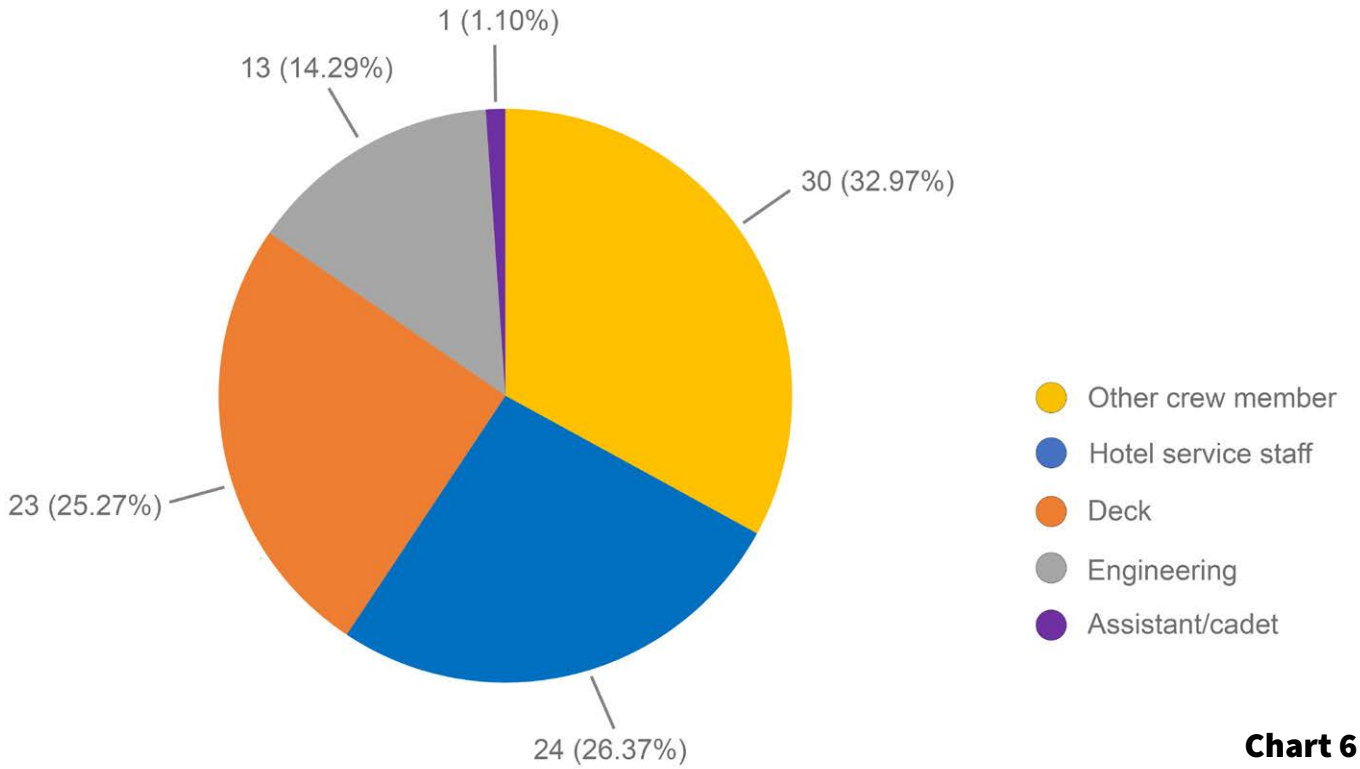


Chart 6

Table 7: Deaths and injuries to crew of UK merchant vessels >= 100gt by place in 2024

Place	Number of crew
Accommodation	
Alleyway	1
Bathroom, shower, toilet	0
Cabin space – crew	7
Cabin space – passengers	5
Casino	0
Elevator/lift	0
Galley spaces	11
Gymnasium	1
Hospital/clinic	0
Laundry	0
Mess room, dayroom	3
Provision room	0
Restaurant/bar	6
Stairway/ladders	4
Swimming pool	1
Theatre	2
Other	2
Bridge	
Wheelhouse	0
Other space	0
Cargo and tank areas	
Cargo control room	0
Cargo elevator/lift	0
Cargo hold	1
Chain locker	0
Closed deck cargo space	0
Cofferdam/void space	1
Open deck cargo space	3
Ro-ro vehicle deck ramp	2
Tanks	0
Vehicle cargo space	1
Other	0
Engine department	
Auxiliary engine room	1
Boiler room	0
Compressor room	1
Control room	0
Engine room	7
Reefer plant room	0
Steering gear room	0
Tunnel/duct keel	0
Workshop/stores	1
Other	0
Pump room	
Pump room	0
Other	0
Ship	
Aloft	0
Amidships	0
Bow	0
Bulbous	0
Deck	20
Forecastle	1
Gangway	2
Keel	0
Over side	1
Propeller/rudder/thruster	0
Quarter	1
Stairs/ladders	2
Stern	0
Other	0
Unknown	3
Total	**91**

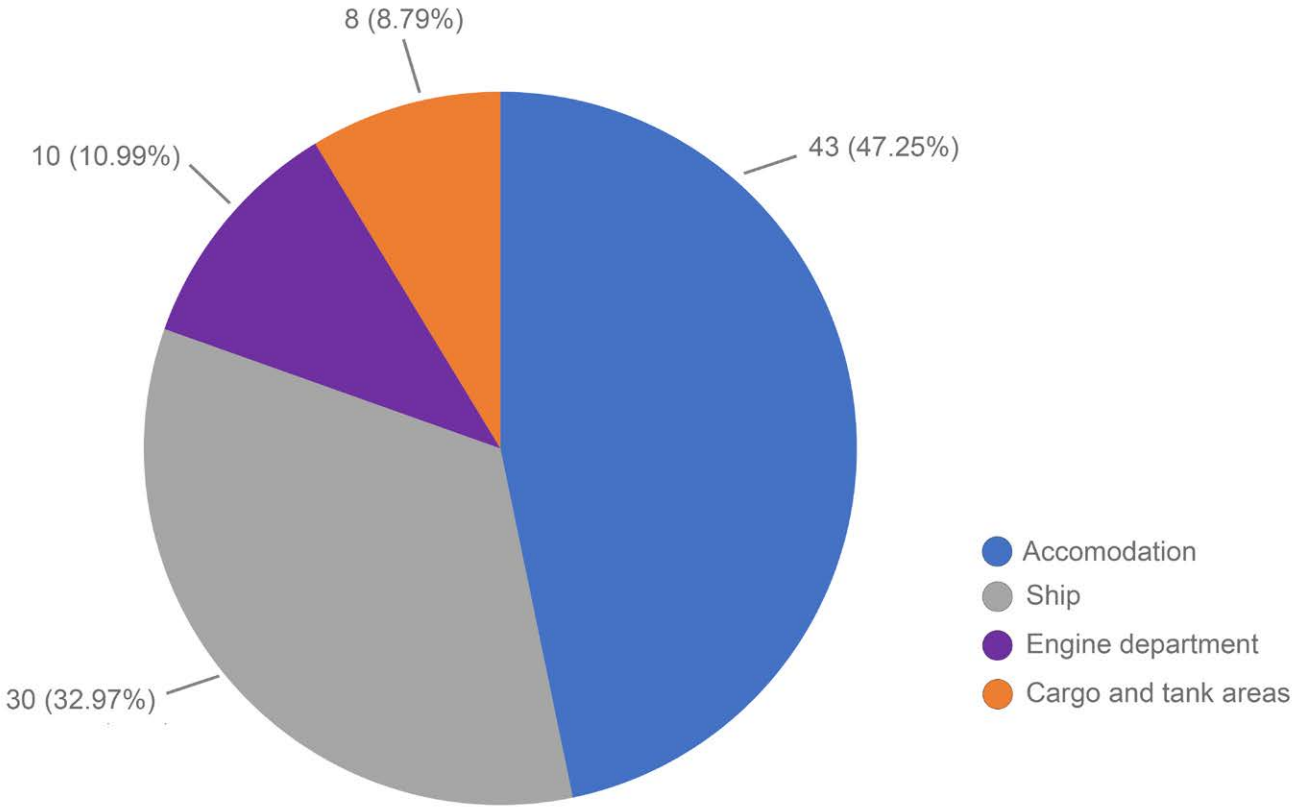

8 (8.79%)
43 (47.25%)
10 (10.99%)
30 (32.97%)
Accomodation
Ship
Engine department
Cargo and tank areas

Chart 7

Table 8: Deaths and injuries to crew on UK merchant vessels >= 100gt by part of body injured in 2024

Part of body injured	Number of crew
Whole body and multiple site	
Multiple sites of the body affected	2
Whole body (systemic effects)	1
Head	
Ear(s)	1
Eye(s)	2
Facial area	0
Head (Caput), brain and cranial nerves and vessels	5
Head, multiple sites affected	1
Head, other parts not mentioned above	0
Teeth	0
Neck, inclusive spine and vertebra in the neck	
Neck, inclusive spine and vertebra in the neck	1
Neck, other parts not mentioned above	0
Upper limbs	
Arm, including elbow	5
Finger(s)	18
Hand	11
Shoulder and shoulder joints	5
Upper extremities, multiple sites affected	0
Upper extremities, other parts not mentioned above	0
Wrist	4
Back, including spine and vertebra in the back	
Back, including spine and vertebra in the back	11
Back, other parts not mentioned above	1

Part of body injured	Number of crew
Torso and organs	
Chest area including organs	0
Pelvic and abdominal area including organs	2
Rib cage, ribs including joints and shoulder blade	3
Torso, multiple sites affected	0
Torso, other parts not mentioned above	0
Lower limbs	
Ankle	5
Foot	2
Hip and hip joint	0
Leg, including knee	9
Lower extremities, multiple sites affected	0
Lower extremities, other parts not mentioned above	0
Toe(s)	2
Other parts of body injured, not mentioned above	
	0
Unknown	
	0
Total	**91**

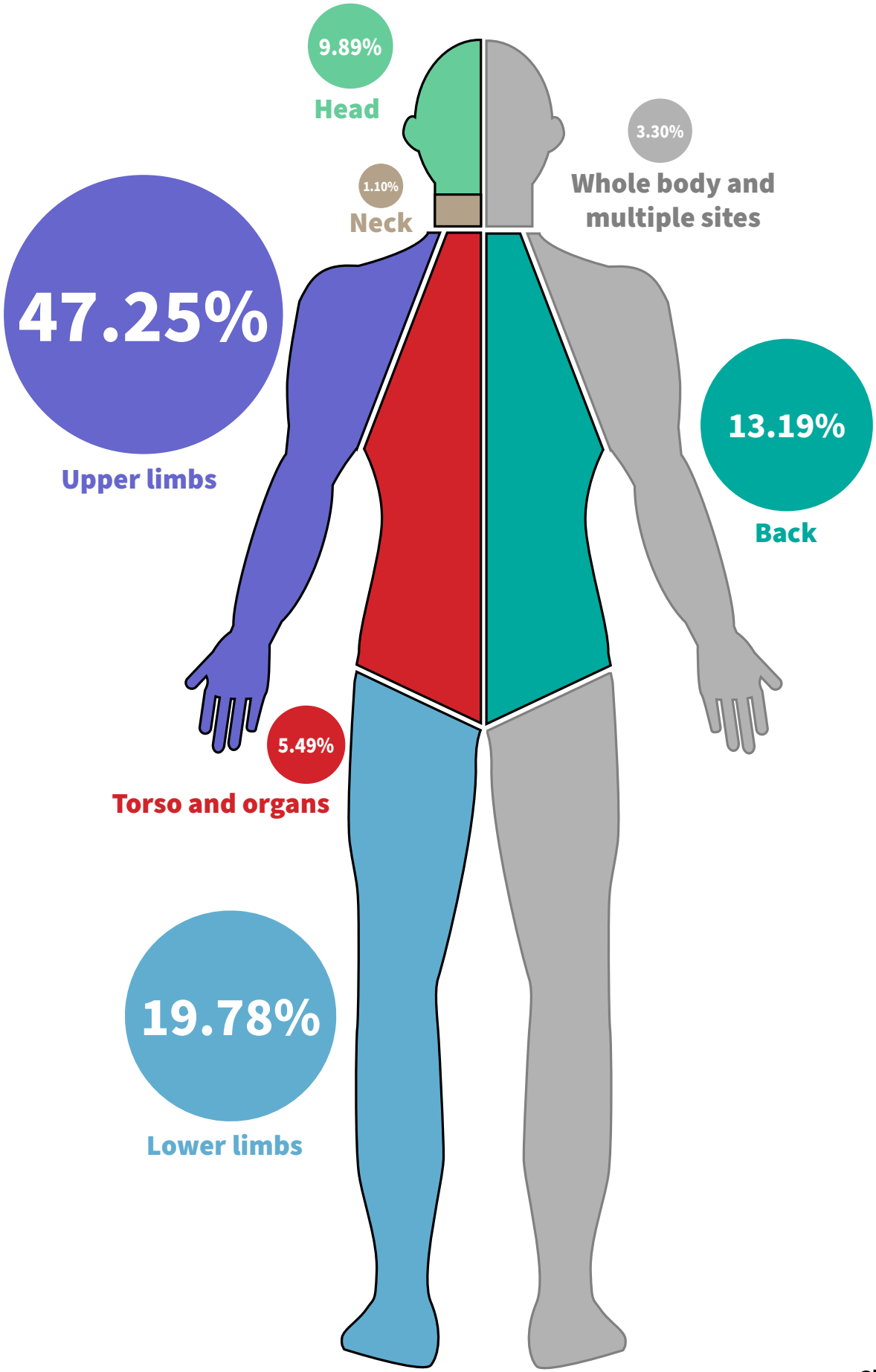

9.89%
Head
3.30%
Whole body and multiple sites
1.10%
Neck
47.25%
Upper limbs
13.19%
Back
5.49%
Torso and organs
19.78%
Lower limbs

Chart 8

Table 9: Deaths and injuries to crew of UK merchant vessels >= 100gt by deviation* in 2024

Deviation*		Number of crew
Body movement under or with physical stress (generally leading to an internal injury)	Lifting, carrying, standing up	8
	Pushing, pulling	1
	Putting down, bending down	0
	Treading badly, twisting leg or ankle, slipping without falling	0
	Twisting, turning	1
	Other	0
	Subtotal	**10**
Body movement without any physical stress (generally leading to an external injury)	Being caught or carried away, by something or by momentum	5
	Kneeling on, sitting on, leaning against	0
	Uncoordinated movements, spurious or untimely actions	25
	Walking on a sharp object	0
	Other group 60 type deviations not listed above	0
	Subtotal	**30**
Breakage, bursting, splitting, slipping, fall, collapse of Material Agent	Breakage of material – at joint, at seams	0
	Breakage, bursting – causing splinters (wood, glass, metal, stone, plastic, others)	3
	Slip, fall, collapse of Material Agent – from above (falling on the victim)	1
	Slip, fall, collapse of Material Agent – from below (dragging the victim down)	0
	Slip, fall, collapse of Material Agent – on the same level	0
	Other	0
	Subtotal	**4**
Deviation by overflow, overturn, leak, flow, vaporisation, emission	Gaseous state – vaporisation, aerosol formation, gas formation	2
	Liquid state – leaking, oozing, flowing, splashing, spraying	1
	Pulverulent material – smoke generation, dust/particles in suspension/emission of	0
	Solid state – overflowing, overturning	0
	Other	0
	Subtotal	**3**

Deviation*		Number of crew
Deviation due to electrical problems, explosion, fire	Electrical problem – leading to direct contact	0
	Electrical problem due to equipment failure – leading to indirect contact	1
	Explosion	0
	Fire, flare up	1
	Other	0
	Subtotal	**2**
Loss of control (total or partial) of machine, means of transport or handling equipment, handheld tool, object, animal	Loss of control (total or partial) – of animal	0
	Of means of transport or handling equipment, (motorised or not)	0
	Of object (being carried, moved, handled, etc.)	2
	Of hand-held tool (motorised or not) or of the material being worked by the tool	3
	Of machine (including unwanted start-up) or of the material being worked by the machine	1
	Other	0
	Subtotal	**6**
Shock, fright, violence, aggression, threat, presence	Aggression, jostle – by animal	0
	Shock, fright	0
	Presence of the victim or of a third person in itself creating a danger for oneself and possibly others	0
	Violence, aggression, threat - from people external to the company towards victims performing their duties (bank hold-up, bus drivers, etc.)	0
	Between company employees subjected to the employer's authority	0
	Other	0
	Subtotal	**0**
Slipping – stumbling and falling – fall of persons	Fall of person – to a lower level	15
	Fall overboard of person	0
	Slipping – stumbling and falling – fall of person – on the same level	21
	Other	0
	Subtotal	**36**
Unknown		**0**
Other		**0**
	Total	**91**

* See glossary on page 87

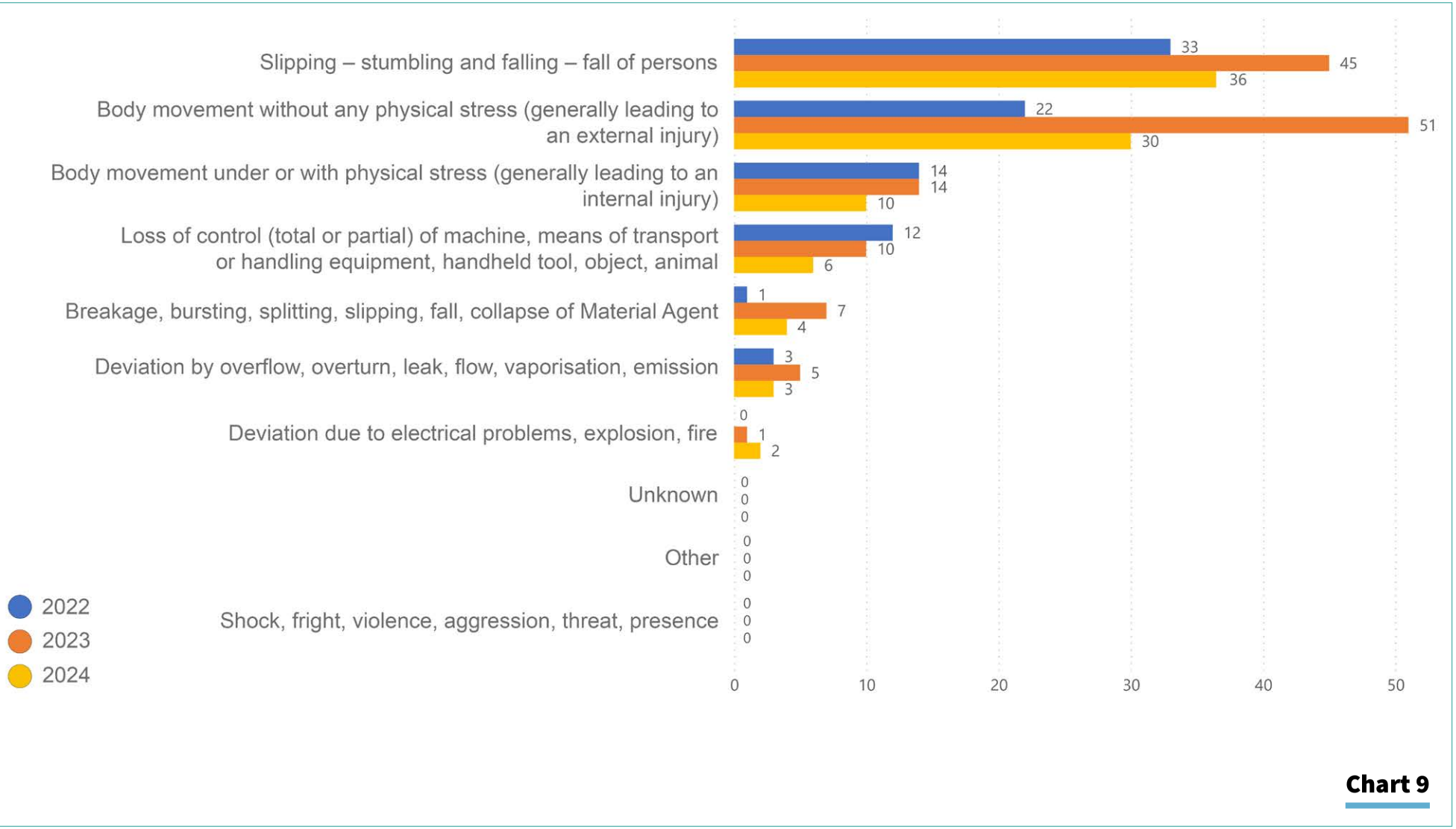

Slipping – stumbling and falling – fall of persons
33
45
36
Body movement without any physical stress (generally leading to an external injury)
22
51
30
Body movement under or with physical stress (generally leading to an internal injury)
14
14
10
Loss of control (total or partial) of machine, means of transport or handling equipment, handheld tool, object, animal
12
10
6
Breakage, bursting, splitting, slipping, fall, collapse of Material Agent
1
7
4
Deviation by overflow, overturn, leak, flow, vaporisation, emission
3
5
3
Deviation due to electrical problems, explosion, fire
0
1
2
Unknown
0
0
0
Other
0
0
0
Shock, fright, violence, aggression, threat, presence
0
0
0
2022
2023
2024
0
10
20
30
40
50

Chart 9

Table 10: Deaths and injuries to crew of UK merchant vessels >= 100gt by type of injury in 2024

Main injury		Number of crew
Bone fractures	Closed fractures	26
	Open fractures	1
	Other types of bone fractures	0
	Subtotal	**27**
Burns, scalds and frostbites	Burns and scalds (thermal)	3
	Chemical burns (corrosions)	0
	Frostbites	0
	Other types of burns, scalds and frostbites	0
	Subtotal	**3**
Concussions and internal injuries	Concussion and intracranial injuries	4
	Internal injuries	1
	Other types of concussion and internal injuries	1
	Subtotal	**6**
Dislocations, sprains and strains	Dislocations and subluxations*	8
	Sprains and strains	17
	Other types of dislocations, sprains and strains	0
	Subtotal	**25**
Drowning and asphyxiation	Asphyxiation	0
	Drowning and non-fatal submersions	0
	Other types of drowning and asphyxiation	0
	Subtotal	**0**
Effects of sound, vibration and pressure	Acute hearing losses	1
	Effects of pressure (barotrauma)	0
	Other effects of sound, vibration and pressure	0
	Subtotal	**1**

Main injury		Number of crew
Effects of temperature extremes, light and radiation	Effects of radiation (non-thermal)	0
	Effects of reduced temperature	0
	Heat and sunstroke	0
	Other effects of temperature extremes, light and radiation	0
	Subtotal	**0**
Poisonings and infections	Acute infections	0
	Acute poisonings	0
	Other types of poisonings and infections	0
	Subtotal	**0**
Shock	Shocks after aggression and threats	0
	Traumatic shocks	0
	Other types of shocks	0
	Subtotal	**0**
Traumatic amputations (loss of body parts)		**2**
Wounds and superficial injuries*	Open wounds	9
	Superficial injuries*	10
	Other types of wounds and superficial injuries	1
	Subtotal	**20**
Multiple injuries		**2**
Other specified injuries not included under other headings		**1**
Unknown		**4**
	Total	**91**

* See glossary on page 87

Table 11: Deaths and injuries to passengers — 2015 to 2024[28]

Year	Number of injured passengers	Of which resulted in death
2015	99	2
2016	134	1
2017	129	0
2018	148	0
2019	125	0
2020	26	0
2021	23	0
2022	73	2
2023	179	3
2024[29]	**151**	**1**

[28] From 2014 to 2019 this table excludes injuries/fatalities that were not in connection with the operation of a ship. MAIB regularly reviews its accident data. On occasion, data from previous years can and will change based on these reviews.

[29] Excluding one minor injury to a crew member that the IMO does not classify as an injury.

Table 12: Deaths and injuries of passengers by type of injury in 2024

Main injury		Number of passengers
Bone fractures	Closed fractures	127
	Open fractures	0
	Subtotal	**127**
Burns, scalds and frostbites	Burns and scalds (thermal)	0
	Chemical burns (corrosions)	0
	Frostbites	0
	Other types of burns, scalds and frostbites	0
	Subtotal	**0**
Concussions and internal injuries (including crush injuries not mentioned above)	Concussion and intracranial injuries	1
	Internal injuries	1
	Other types of concussion and internal injuries	1
	Subtotal	**3**
Dislocations, sprains and strains	Dislocations and subluxations*	8
	Sprains and strains	9
	Other types of dislocations, sprains and strains	0
	Subtotal	**17**
Drowning and asphyxiation	Asphyxiation	0
	Drowning and non-fatal submersions	1
	Other types of drowning and asphyxiation	0
	Subtotal	**1**
Effects of sound, vibration and pressure	Acute hearing losses	0
	Effects of pressure (barotrauma)	0
	Other effects of sound, vibration and pressure	0
	Subtotal	**0**
Effects of temperature extremes, light and radiation	Effects of radiation (non-thermal)	0
	Effects of reduced temperature	0
	Heat and sunstroke	0
	Other effects of temperature extremes, light and radiation	0
	Subtotal	**0**

Main injury		Number of passengers
Multiple injuries		**0**
Poisonings and infections	Acute infections	0
	Acute poisonings	0
	Other types of poisonings and infections	0
	Subtotal	**0**
Shock	Shocks after aggression and threats	0
	Traumatic shocks	0
	Other types of shocks	0
	Subtotal	**0**
Traumatic amputations (loss of body parts)		0
Wounds and superficial injuries	Open wounds	0
	Superficial injuries	3
	Subtotal	**3**
Other specified injuries not included under other headings		**0**
Unknown		**0**
	Total	**151**

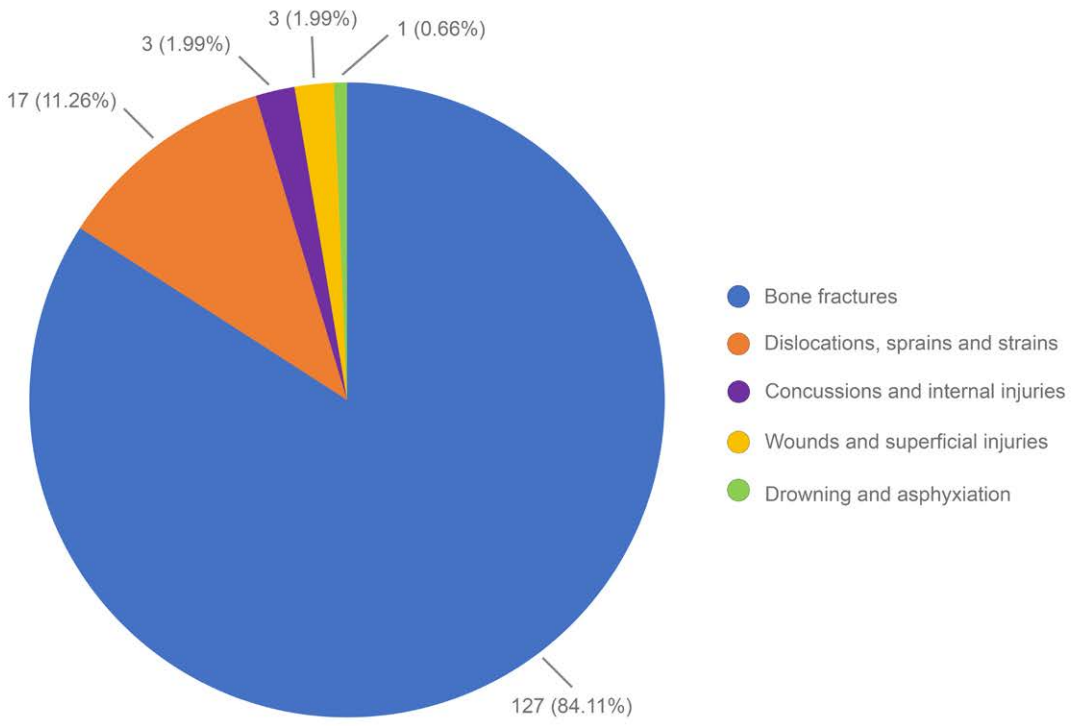


Chart 10

* See glossary on page 86

Table 13: UK merchant vessels < 100gt losses in 2024

Date	Name of vessel	Type of vessel	loa (m)	Casualty event
24 Feb	*Offshore Scout**	Recreational craft	15	Flooding
22 Jul	*Jean Elaine*	Service ship	21.9	Grounding/stranding
14 Aug	*Sapphire Light II*	Recreational craft	13.7	Foundering
27 Nov	*Princess Marina*	Inland waterway vessel	15.5	Fire

* Constructive total loss

Table 14: UK merchant vessels < 100gt by nature of casualty and vessel category in 2024

Casualty event	Liquid cargo	Livestock carrier	Solid cargo	Inland waterway vessel	Passenger ship	Recreationanl craft	Service ship	Submersible	Unknown	Wing-in-the-ground craft	Total
Capsizing/listing	0	0	0	0	0	0	1	0	0	0	**1**
Collision	0	0	0	4	2	4	25	0	0	0	**35**
Contact	0	0	0	1	0	0	2	0	0	0	**3**
Damage/loss of equipment	0	0	0	0	0	0	1	0	0	0	**1**
Explosion	0	0	0	0	0	0	1	0	0	0	**1**
Fire	0	0	1	2	1	0	3	0	0	0	**7**
Flooding	0	0	0	0	0	2	0	0	0	0	**2**
Foundering	0	0	0	0	0	1	0	0	0	0	**1**
Grounding/stranding	0	0	0	3	5	17	41	0	0	0	**66**
Hull failure	0	0	0	0	0	0	0	0	0	0	**0**
Loss of control	0	0	0	0	0	4	1	0	0	0	**5**
Missing	0	0	0	0	0	0	0	0	0	0	**0**
Non-accidental event	0	0	0	0	0	0	0	0	0	0	**0**
Total	**0**	**0**	**1**	**10**	**8**	**28**	**75**	**0**	**0**	**0**	**122**

Deaths	**0**	**0**	**0**	**2**	**0**	**0**	**0**	**0**	**0**	**0**	**2**
Injuries[30]	**0**	**0**	**0**	**6**	**1**	**4**	**25**	**0**	**1**	**0**	**37**

[30] Excluding four injuries to crew members that the IMO does not classify as injuries.

There were 4,728 UK registered fishing vessels at the end of 2024. During 2024, 51 casualties to vessels were recorded by the MAIB. Figures in the following tables show casualties to vessels and injuries to crew involving UK registered vessels that were recorded by the MAIB in 2024.

Ten fishing vessels were reported lost (0.21% of the total fleet) and there were 2 fatalities to crew.

Table 15: UK fishing vessel total losses by vessel length in 2024

Date	Name of vessel	Age	Gross tonnage	Casualty event
Under 15m length overall (loa)				
10 Apr	*Friendly Isle* (TN98)	63	8.54	Fire
16 Apr	*Lady Maureen*	20	11.81	Foundering
25 Apr	*Serinah*	24	13.35	Collision
14 Aug	*Laicey Jai*	32	1.19	Flooding
13 Sep	*Sarah Lena**	17	20.12	Grounding
31 Oct	*Nan*	32	5.58	Grounding
15m length overall – under 24m registered length (reg)				
21 Feb	*Freedom II*	49	74	Flooding
24 Mar	*Opportune*	26	331	Foundering
22 Sep	*Our Heather**	40	100	Fire
29 Oct	*Odyssey*	45	148	Foundering
Over 24m registered length (reg)				
None				

* Constructive total loss

Table 16: UK fishing vessel losses — 2015 to 2024

Year	Under 15m loa	15m loa to <24m reg	24m reg and over	Total lost	UK registered	% lost
2015	8	5	0	13	5,746	0.23
2016	5	2	1	8	5,745	0.14
2017	5	1	0	6	5,700	0.11
2018	8	0	0	8	5,603	0.14
2019	2	2	1	5	5,484	0.09
2020	7	1	0	8	5,443	0.15
2021	6	0	0	6	5,378	0.11
2022	3	3	2	8	5,105	0.16
2023	2	1	0	3	4,956	0.06
2024	**6**	**4**	**0**	**10**	**4,728**	**0.21**

Table 17: UK fishing vessels in casualties — by nature of casualty in 2024

Casualty event	Number of vessels involved	Incident rate per 1,000 vessels at risk (to two decimal places)
Capsizing/listing	0	0
Collision	13	2.75
Contact	0	0
Damage/loss of equipment	1	0.21
Explosion	0	0
Fire	3	0.64
Flooding	4	0.84
Foundering	3	0.64
Grounding/stranding	14	2.96
Hull failure	0	0
Loss of control	13	2.75
Missing	0	0
Non-accidental event	0	0
Total	**51**	**10.79**

Table 18: UK fishing vessels in casualties — by nature of casualty and by length range in 2024

Casualty event	Number of vessels involved	Incident rate per 1,000 vessels at risk (to two decimal places)
Under 15m length overall (loa) – vessels at risk: 4,244		
Capsizing/listing	0	0
Collision	6	1.41
Contact	0	0
Damage/loss of equipment	1	0.24
Explosion	0	0
Fire	1	0.23
Flooding	3	0.71
Foundering	1	0.23
Grounding/stranding	10	2.36
Hull failure	0	0
Loss of control	8	1.89
Missing	0	0
Non-accidental event	0	0
Total under 15m	**30**	**7.07**
15m loa – 24m registered length (reg) – vessels at risk: 375		
Capsizing/listing	0	0
Collision	5	13.33
Contact	0	0
Damage/loss of equipment	0	0
Explosion	0	0
Fire	1	2.67
Flooding	1	2.67
Foundering	2	5.33
Grounding/stranding	1	2.77
Hull failure	0	0

Casualty event	Number of vessels involved	Incident rate per 1,000 vessels at risk (to two decimal places)
Loss of control	3	8
Missing	0	0
Non-accidental event	0	0
Total 15m to 24m	**13**	**34.67**
24m reg and over – vessels at risk: 109		
Capsizing/listing	0	0
Collision	2	18.35
Contact	0	0
Damage/loss of equipment	0	0
Explosion	0	0
Fire	1	9.17
Flooding	0	0
Foundering	0	0
Grounding/stranding	3	27.52
Hull failure	0	0
Loss of control	2	18.35
Missing	0	0
Non-accidental event	0	0
Total 24m or more	**8**	**73.39**

Fleet total[31]	**51**	**10.79**

[31] Total number of UK registered fishing vessels: 4,728.

Table 19: Deaths and injuries to fishing vessel crew by type of injury in 2024

Main injury		Number of crew
Bone fractures	Closed fractures	5
	Open fractures	1
	Subtotal	**6**
Burns, scalds and frostbites	Burns and scalds (thermal)	1
	Chemical burns (corrosions)	0
	Frostbites	0
	Other types of burns, scalds and frostbites	0
	Subtotal	**1**
Concussions and internal injuries (including crush injuries not mentioned above)	Concussion and intracranial injuries	3
	Internal injuries	1
	Other types of concussion and internal injuries	0
	Subtotal	**4**
Dislocations, sprains and strains	Dislocations and subluxations	0
	Sprains and strains	0
	Other types of dislocations, sprains and strains	0
	Subtotal	**0**
Drowning and asphyxiation	Asphyxiation	1
	Drowning and non-fatal submersions	2
	Other types of drowning and asphyxiation	0
	Subtotal	**3**
Effects of sound, vibration and pressure	Acute hearing losses	0
	Effects of pressure (barotrauma)	0
	Other effects of sound, vibration and pressure	0
	Subtotal	**0**
Effects of temperature extremes, light and radiation	Effects of radiation (non-thermal)	0
	Effects of reduced temperature	0
	Heat and sunstroke	0
	Other effects of temperature extremes, light and radiation	0
	Subtotal	**0**

Main injury		Number of crew
Multiple injuries		**0**
Poisonings and infections	Acute infections	0
	Acute poisonings	0
	Other types of poisonings and infections	0
	Subtotal	**0**
Shock	Shocks after aggression and threats	0
	Traumatic shocks	0
	Other types of shocks	0
	Subtotal	**0**
Traumatic amputations (loss of body parts)		**5**
Wounds and superficial injuries*[32]	Open wounds	3
	Superficial injuries	0
	Other types of wounds and superficial injuries	0
	Subtotal	**3**
Other specified injuries not included under other headings		**0**
Unknown or unspecified		**0**
	Total	**22**

* See glossary on page 87

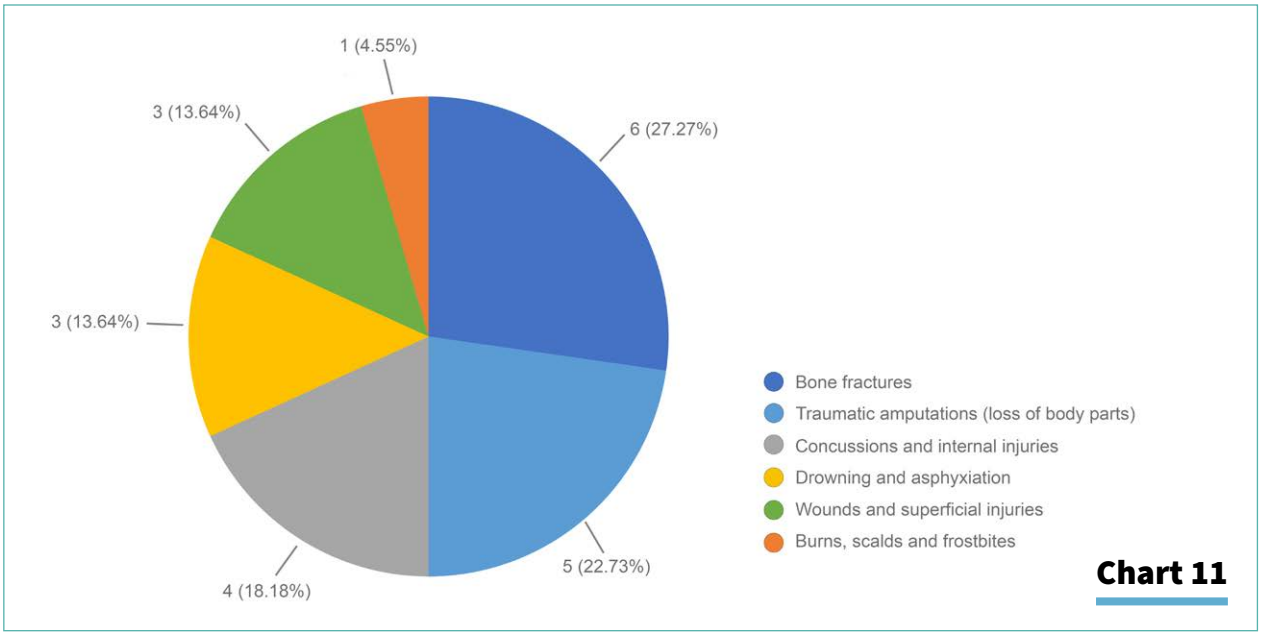


Chart 11

▲ Totals may not add up to 100% due to rounding

[32] Excluding four injuries to crew members that the IMO does not classify as injuries.

Table 20: Deaths and injuries to UK fishing vessel crew by part of body injured in 2024

Part of body injured	Number of crew
Whole body and multiple sites	
Multiple sites of the body affected	2
Whole body (systemic effects)	1
Head	
Ear(s)	0
Eye(s)	0
Facial area	0
Head (Caput), brain and cranial nerves and vessels	3
Head, multiple sites affected	0
Head, other parts not mentioned above	0
Teeth	0
Neck, inclusive spine and vertebra in the neck	
Neck, inclusive spine and vertebra in the neck	0
Neck, other parts not mentioned above	0
Upper limbs	
Arm, including elbow	0
Finger(s)	8
Hand	4
Shoulder and shoulder joints	0
Upper extremities, multiple sites affected	0
Upper extremities, other parts not mentioned above	0
Wrist	0
Back, including spine and vertebra in back	
Back, including spine and vertebra in the back	0
Back, other parts not mentioned above	0

Part of body injured	Number of crew
Lower limbs	
Ankle	0
Foot	0
Hip and hip joint	0
Leg, including knee	1
Lower extremities, multiple sites affected	0
Lower extremities, other parts not mentioned above	0
Toe(s)	0
Torso and organs	
Chest area including organs	2
Pelvic and abdominal area including organs	0
Rib cage, ribs including joints and shoulder blade	0
Torso, multiple sites affected	0
Torso, other parts not mentioned above	0
Other parts of body injured not mentioned above	0
Unknown	1
Total	**22**

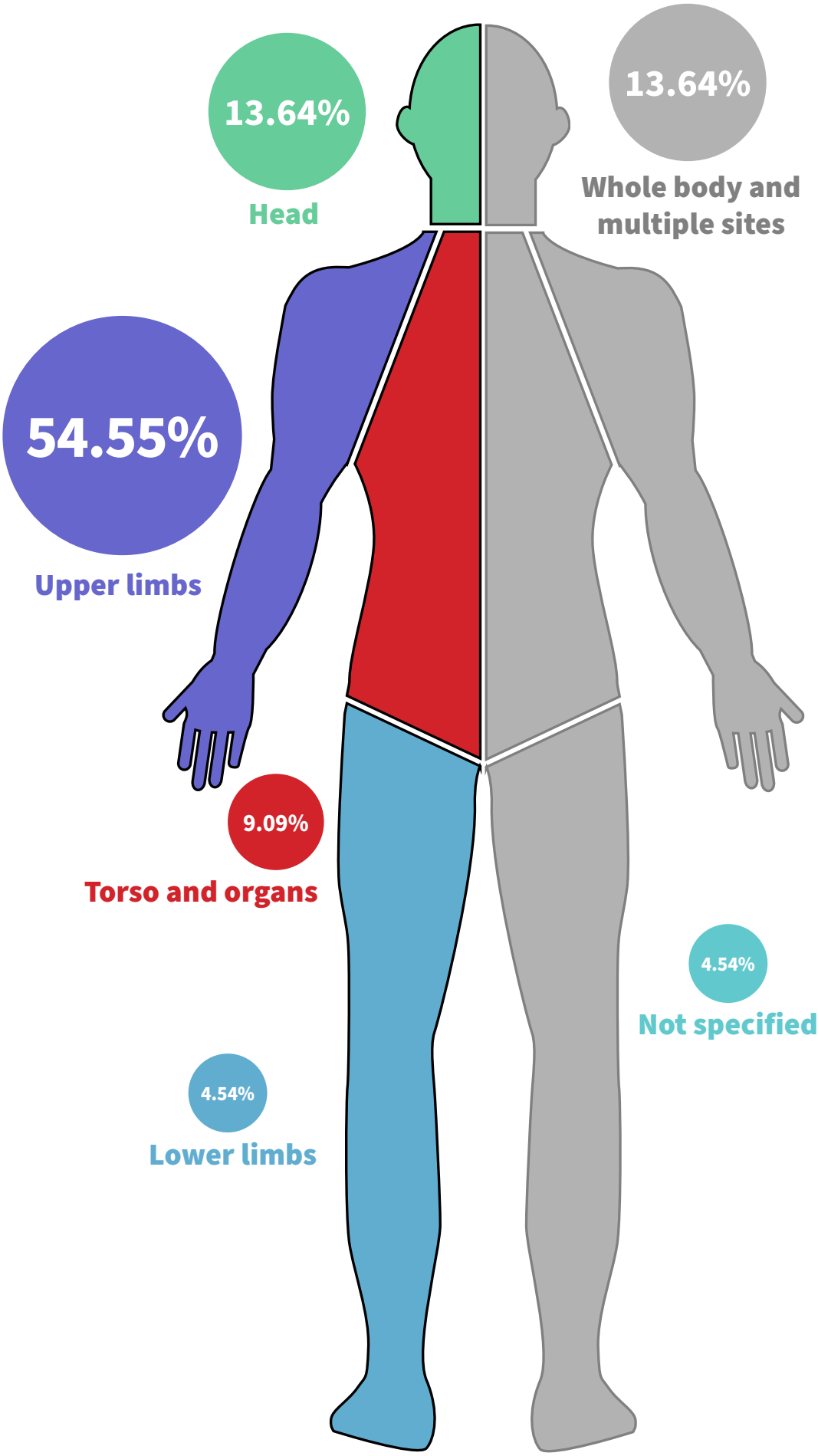

13.64%
Head
13.64%
Whole body and multiple sites
54.55%
Upper limbs
9.09%
Torso and organs
4.54%
Not specified
4.54%
Lower limbs

Chart 12

Table 21: Deaths and injuries of UK fishing vessel crew by deviation* in 2024

Deviation*		Number of crew
Body movement under or with physical stress (generally leading to an internal injury)	Lifting, carrying, standing up	0
	Pushing, pulling	0
	Putting down, bending down	0
	Treading badly, twisting leg or ankle, slipping without falling	0
	Twisting, turning	0
	Other	0
	Subtotal	**0**
Body movement without any physical stress (generally leading to an external injury)	Being caught or carried away, by something or by momentum	5
	Kneeling on, sitting on, leaning against	0
	Uncoordinated movements, spurious or untimely actions	8
	Walking on a sharp object	0
	Other group 60 type deviations not listed above	0
	Subtotal	**13**
Breakage, bursting, splitting, slipping, fall, collapse of Material Agent	Breakage of material – at joint, at seams	0
	Breakage, bursting – causing splinters (wood, glass, metal, stone, plastic, others)	0
	Slip, fall, collapse of Material Agent – from above (falling on the victim)	0
	Slip, fall, collapse of Material Agent – from below (dragging the victim down)	0
	Slip, fall, collapse of Material Agent – on the same level	0
	Other	0
	Subtotal	**0**
Deviation by overflow, overturn, leak, flow, vaporisation, emission	Gaseous state – vaporisation, aerosol formation, gas formation	1
	Liquid state – leaking, oozing, flowing, splashing, spraying	0
	Pulverulent material – smoke generation, dust/particles in suspension/emission of	0
	Solid state – overflowing, overturning	0
	Other	0
	Subtotal	**1**

Deviation*		Number of crew
Deviation due to electrical problems, explosion, fire	Electrical problem – leading to direct contact	0
	Electrical problem due to equipment failure – leading to indirect contact	0
	Explosion	0
	Fire, flare up	1
	Other	0
	Subtotal	**1**
Loss of control (total or partial) of machine, means of transport or handling equipment, handheld tool, object, animal	Of animal	0
	Of means of transport or handling equipment, (motorised or not)	0
	Of object (being carried, moved, handled, etc.)	2
	Of hand-held tool (motorised or not) or of the material being worked by the tool	1
	Of machine (including unwanted start-up) or of the material being worked by the machine	0
	Other	0
	Subtotal	**3**
Shock, fright, violence, aggression, threat, presence	Aggression, jostle – by animal	0
	Shock, fright	0
	Presence of the victim or of a third person in itself creating a danger for oneself and possibly others	0
	From people external to the company towards victims performing their duties (bank hold-up, bus drivers, etc.)	0
	Between company employees subjected to the employer''s authority	0
	Other	0
	Subtotal	**0**
Slipping – stumbling and falling – fall of persons	Fall of person - to a lower level	1
	Fall overboard of person	1
	Slipping - Stumbling and falling - Fall of person - on the same level	0
	Other	0
	Subtotal	**2**
Unknown		**2**
Other		**0**
	Total	**22**

* See glossary on page 87

Chart 13

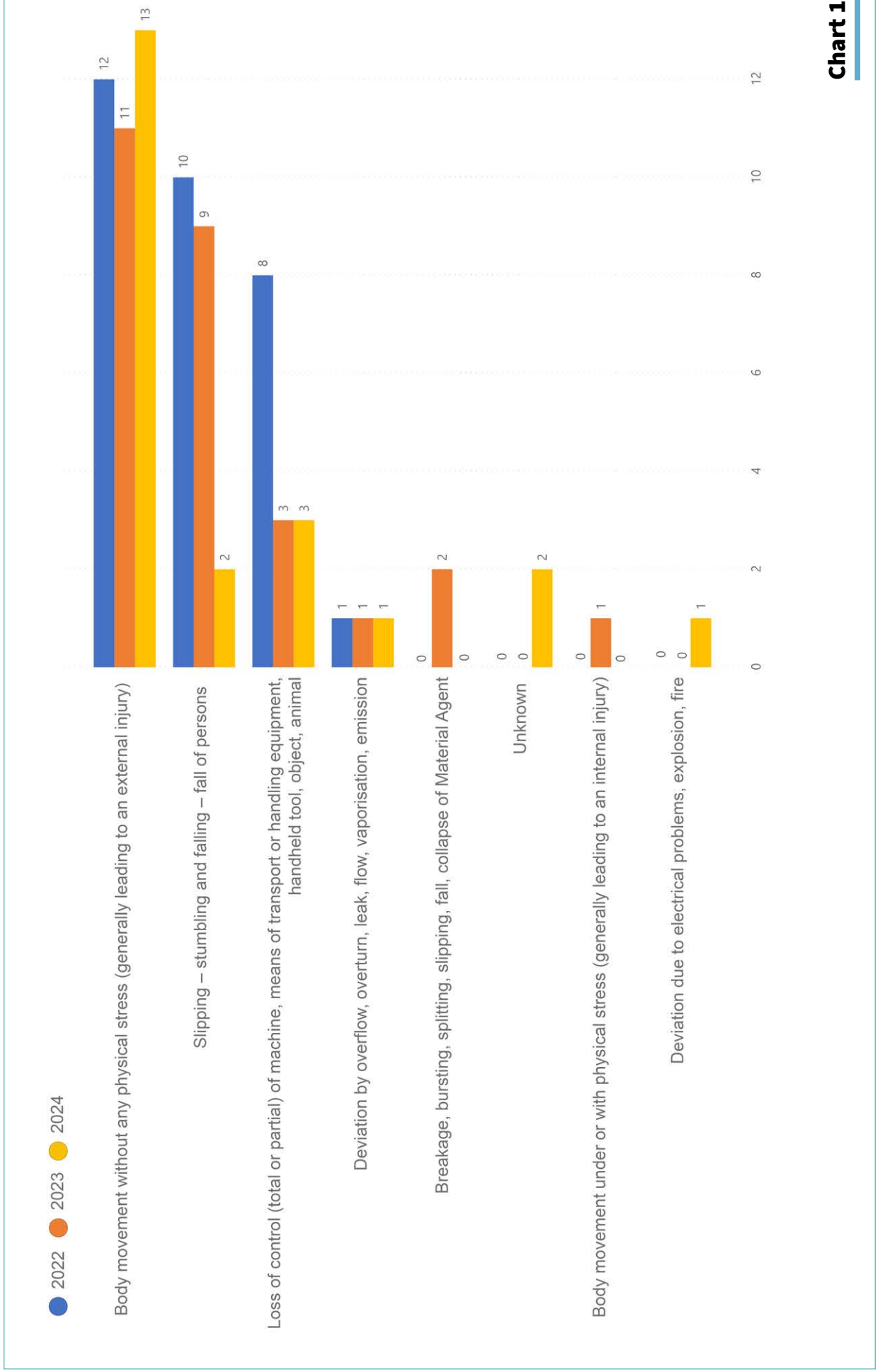

2022
2023
2024
Body movement without any physical stress (generally leading to an external injury)
12
11
13
Slipping – stumbling and falling – fall of persons
10
9
2
Loss of control (total or partial) of machine, means of transport or handling equipment, handheld tool, object, animal
8
3
3
Deviation by overflow, overturn, leak, flow, vaporisation, emission
1
1
1
Breakage, bursting, splitting, slipping, fall, collapse of Material Agent
0
0
2
Unknown
0
0
2
Body movement under or with physical stress (generally leading to an internal injury)
0
0
1
Deviation due to electrical problems, explosion, fire
0
0
1
0
2
4
6
8
10
12

Table 22: Deaths and injuries to UK fishing vessel crew by vessel length (of which deaths) — 2015 to 2024

Year	Under 15m loa	Under 15m loa	15m loa – under 24m reg		24m reg and over		Total	
2015	10	(4)	19	(2)	6	(1)	**35**	**(7)**
2016	17	(7)	19	(2)	6	(0)	**42**	**(9)**
2017	13	(3)	8	(2)	11	(0)	**32**	**(5)**
2018	13	(4)	18	(1)	8	(1)	**39**	**(6)**
2019	12	(3)	18	(1)	5	(1)	**35**	**(5)**
2020	12	(2)	16	(0)	10	(0)	**38**	**(2)**
2021	12	(7)	19	(2)	5	(1)	**36**	**(10)**
2022	5	(0)	16	(1)	9	(2)	**30**	**(3)**
2023	6	(2)	9	(1)	11	(1)	**26**	**(4)**
2024	**4**	**(1)**	**10**	**(1)**	**8**	**(0)**	**22**	**(2)**

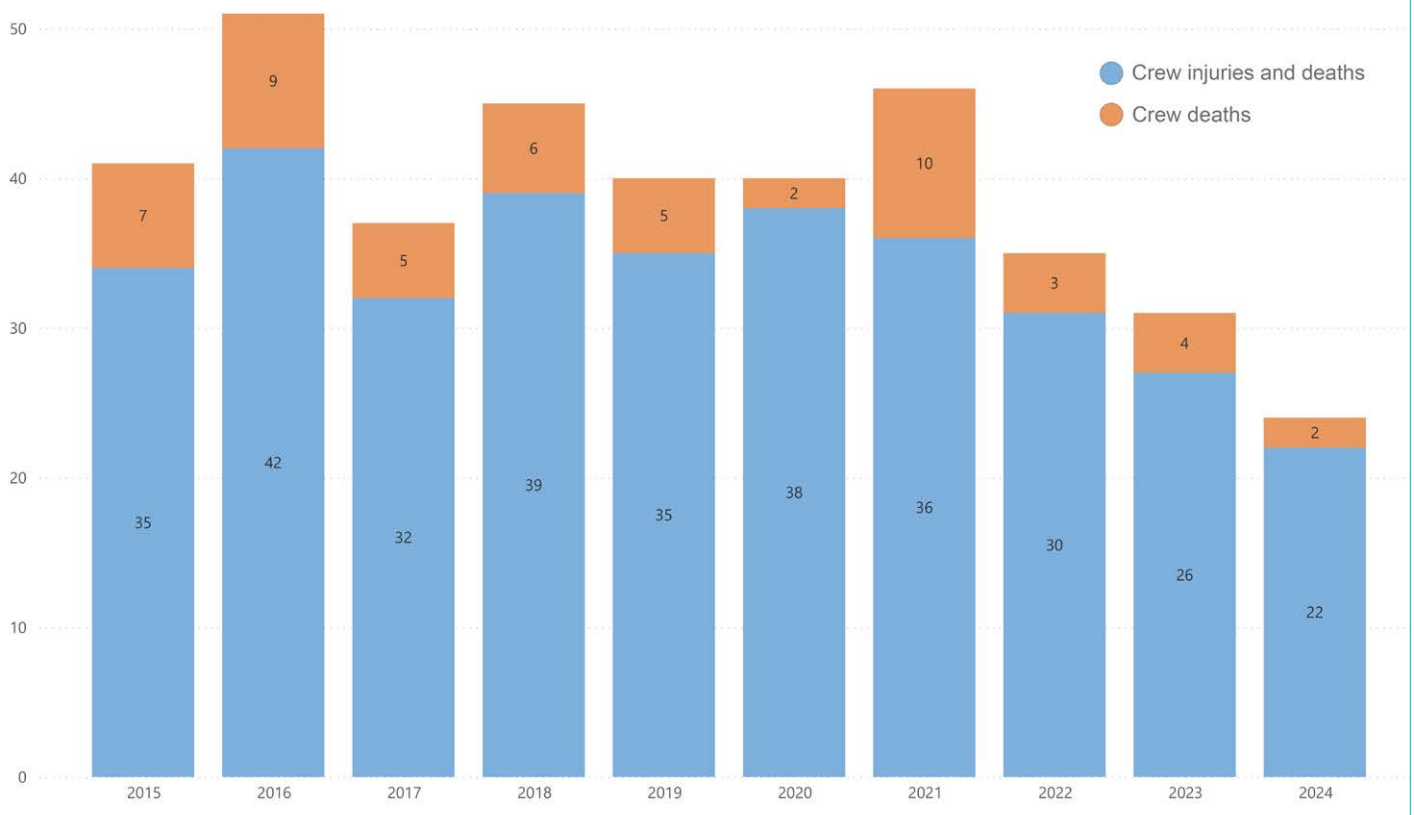


Chart 14

Table 23: All non-UK commercial vessels total losses in UK waters in 2024

Date	Name of vessel	Type of vessel	Flag	loa	Casualty event
None					

Table 24: All non-UK commercial vessels in UK waters — by vessel type and by nature of casualty in 2024

Casualty event	Liquid cargo	Livestock carrier	Solid cargo	Fishing vessel	Inland waterway vessel	Passenger ship	Commercial Recreationl craft	Service ship	Submersible	Unknown	Wing-in-the-ground craft	**Total**
Capsizing/listing	0	0	0	0	0	0	0	0	0	0	0	**0**
Collision	7	0	10	0	0	2	0	1	0	0	0	**20**
Contact	1	0	4	0	0	1	0	0	0	0	0	**6**
Damage/loss of equipment	0	0	0	0	0	0	0	0	0	0	0	**0**
Explosion	0	0	1	0	0	1	0	0	0	0	0	**2**
Fire	1	0	5	0	0	0	0	1	0	0	0	**7**
Flooding	0	0	0	0	0	0	0	0	0	0	0	**0**
Foundering	0	0	0	0	0	0	0	0	0	0	0	**0**
Grounding/stranding	1	0	11	1	0	0	0	4	0	0	0	**17**
Hull failure	0	0	0	0	0	0	0	0	0	0	0	**0**
Loss of control	1	0	1	0	0	1	0	0	0	0	0	**3**
Missing	0	0	0	0	0	0	0	0	0	0	0	**0**
Non-accidental event	0	0	0	0	0	0	0	0	0	0	0	**0**
Total per vessel type	**11**	**0**	**32**	**1**	**0**	**5**	**0**	**6**	**0**	**0**	**0**	**55**
Deaths	0	0	3	0	0	1	1	0	0	0	0	**5**
Injuries[33]	2	0	12	2	1	23	2	3	0	0	0	**45**

[33] Excluding four injuries to crew members that the IMO does not classify as injuries.

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 2012[34] 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 definitions (Annex B) on page 84 or MAIB's Regulations for more information.
5. Details of vessel types and groups used in this annual report are providing as supporting information (Annex B) on page 85.
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 HM Coastguard.
7. The MCA, 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.

[34] Read **The Merchant Shipping (Accident Reporting and Investigation) Regulations 2012**

Definitions

Marine Casualty[35]

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) – A Marine Casualty where there is total loss of the ship, loss of life, or severe pollution.

Serious Marine Casualty (SMC) – A 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).

Accident

Under current regulations 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 sustains a cut while preparing food is considered in connection with the operation of the ship).

[35] Read Section 3 of The Merchant Shipping (Accident Reporting and Investigation) Regulations 2012

Vessel categories

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 not all countries consider to be merchant vessels. It excludes Royal Navy vessels and fixed platforms and rigs.

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, for instance, be 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.

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 search and rescue 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).

Abbreviations and acronyms

°C	-	degrees Celsius
COLREGs	-	Convention on the International Regulations for Preventing Collisions at Sea, 1972
COMAH	-	Control of Major Accident Hazards Regulations 2015
COSWP	-	Code of Safe Working Practices for Merchant Seafarers
DfT	-	Department for Transport
DSMB	-	delayed surface marker buoy
ECDIS	-	Electronic Chart Display and Information System
GRP	-	glass reinforced plastic
gt	-	gross tonnage
HM[36]	-	Her/His Majesty
IBC Code	-	International Code for the Construction and Equipment of Ships Carrying Dangerous Chemicals in Bulk
ICS	-	International Chamber of Shipping
IMO	-	International Maritime Organization
ISO	-	International Organization for Standardization
loa	-	length overall
LSMC	-	Less Serious Marine Casualty
m	-	metre
MAIB	-	Marine Accident Investigation Branch
MCA	-	Maritime and Coastguard Agency
MGN	-	Marine Guidance Note
MI	-	Marine Incident
MOU	-	memorandum of understanding
MPX	-	master/pilot exchange
MSN	-	Merchant Shipping Notice
nm	-	nautical mile
OSR	-	Offshore Special Regulations
PFD	-	personal flotation device
PLA	-	Port of London Authority
PPE	-	personal protective equipment
reg	-	registered length
RIB	-	rigid inflatable boat
SCV Code	-	Small Commercial Vessel Code
SMC	-	Serious Marine Casualty
SMS	-	safety management system
STCW	-	International Convention on Standards of Training, Certification and Watchkeeping for Seafarers 1978, as amended (STCW Convention)
UK	-	United Kingdom
VSMC	-	Very Serious Marine Casualty
VTM	-	vessel traffic monitoring

[36] HM refers to Her Majesty up to 8 September 2022 and His Majesty from 8 September 2022, inclusive.

Terms

Deviation	-	The last event differing from the normal working process and leading to an injury/fatality.
Material Agent	-	A tool, object or instrument.
Subluxation	-	Incomplete, or partial dislocation.
Superficial injuries	-	Bruises, abrasions, blisters, etc.

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