ANNUAL REPORT

2014

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MAIB
MARINE ACCIDENT INVESTIGATION BRANCH

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

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JULY 2015

MAIB ANNUAL REPORT 2014

Chief Inspector

CHIEF INSPECTOR'S REPORT

2014 was another busy year for the MAIB. Thirty-one investigations were started and 33 investigation reports were published. Two Safety Digests and three Safety Bulletins were also published. In comparison to 2013, the average time taken to complete an investigation decreased slightly from 10.9 to 10.2 months.

For the fifth year in succession no UK merchant vessels of >100gt were lost. The overall accident rate for UK merchant vessels >100gt was unchanged from 2013 at 88 per 1000 vessels. There were no crew deaths on UK merchant vessels >100gt, and a review of available records from the last 50 years suggests this has never happened before. The average number of deaths over the last 10 years is 4 per year.

Six small UK vessels (<100gt) were lost in 2014 and five crew lost their lives. Four of these were lost in a single accident when the yacht *Cheeki Rafiki* suffered a detached keel and capsized in the North Atlantic.

Twelve commercial fishing vessels were lost in 2014 compared with 18 in 2013. This compares favourably with the average losses during the last 10 years (19 vessels per year). 75% of the losses were in the small < 15 metre sector.

Eight fishermen lost their lives in 2014 compared with only four lives lost in 2013. The average number of fishermen who lost their lives over the last 10 years is 8.5.

Recommendations

Fifty-nine recommendations were issued during 2014 to 63 addressees. 88.8% were accepted compared with 96.7% in 2013, although substantive responses are still awaited for some of these. The recipients of three MAIB recommendations, domiciled outside of the UK, have not provided a response.

One recommendation was rejected. It was made to the manufacturer of the RIB "*Milly*" following a fatal accident in the Camel Estuary in Cornwall when six people were ejected from the boat, resulting in the loss of two lives and life-changing

injuries to two others. Analysis of the handling characteristics of the boat when making high speed turns during trials conducted by the MAIB suggested the steep angle of heel adopted by the vessel during such turns, could be reduced through design changes to the hull. However, the manufacturer has concluded that the hull design is extremely safe "*in all likely and realistic manoeuvres*". Further detail of their response is contained at page 18 of this report.

Two recommendations were partially accepted. The first, made as a consequence of the grounding of the cargo vessel *Danio* off the Farne Islands, seeks to address the scourge of seafarer fatigue, which continues to blight vessels trading in the short sea sector, by increasing the numbers of qualified watchkeepers on board such craft (MAIB Report 8/2014 – see page 22). A similar measure was proposed by the UK following the MAIB's 2004 Bridge Watchkeeping Safety Study, but the proposal met with considerable opposition from international partners. It is to the credit of the Maritime and Coastguard Agency (MCA) that it is prepared to take this important issue to the IMO again despite misgivings about the likely success of any new proposal due to continued international opposition. The second recommendation to be partially accepted was issued to the manufacturer of the ECDIS fitted to the tanker *Ovit*, which ran aground on the Varne Bank in September 2013 (MAIB report 24/2014 – see page page 36). One of a number of safety issues identified during the MAIB's investigation relating to the display of safety critical information was the failure of an alarm function when the safety contour was about to be crossed. However, the manufacturer's observation that the failure was due to an installation, rather than a design, problem has been accepted and this recommendation has been closed.

One recommendation was withdrawn. This had been made to the owner of the fishing vessel *Prospect*, who has subsequently left the industry (MAIB Report 7/2014 – see page 20).

Of the 224 recommendations that had been accepted, but had not been implemented between 2004 and 2013, 82.4% were reported to be fully implemented at the time this report was published. Of the 45 recommendations accepted, but not yet actioned, more than half (27) were addressed to the Maritime and Coastguard Agency. Some of the commitments the Agency has made in response to MAIB recommendations are becoming quite dated. For example, in 2011, following an accident involving a RIB on the River Thames, the MCA stated it would: "*Prioritise and resource the revision of MGN 280 to ensure the updated code of practice for small commercial vessels is published as early as is possible*" (Recommendation 2011/101 – see page 58). Given the

unequivocal nature of the 2011 response, the fact that nothing has yet been done is disappointing. However, a benefit of the MAIB's recent move to a building we share with the MCA is that the two organisations can address such issues more effectively than in the past and I am reasonably confident that better progress will be made in the future.

FINANCE

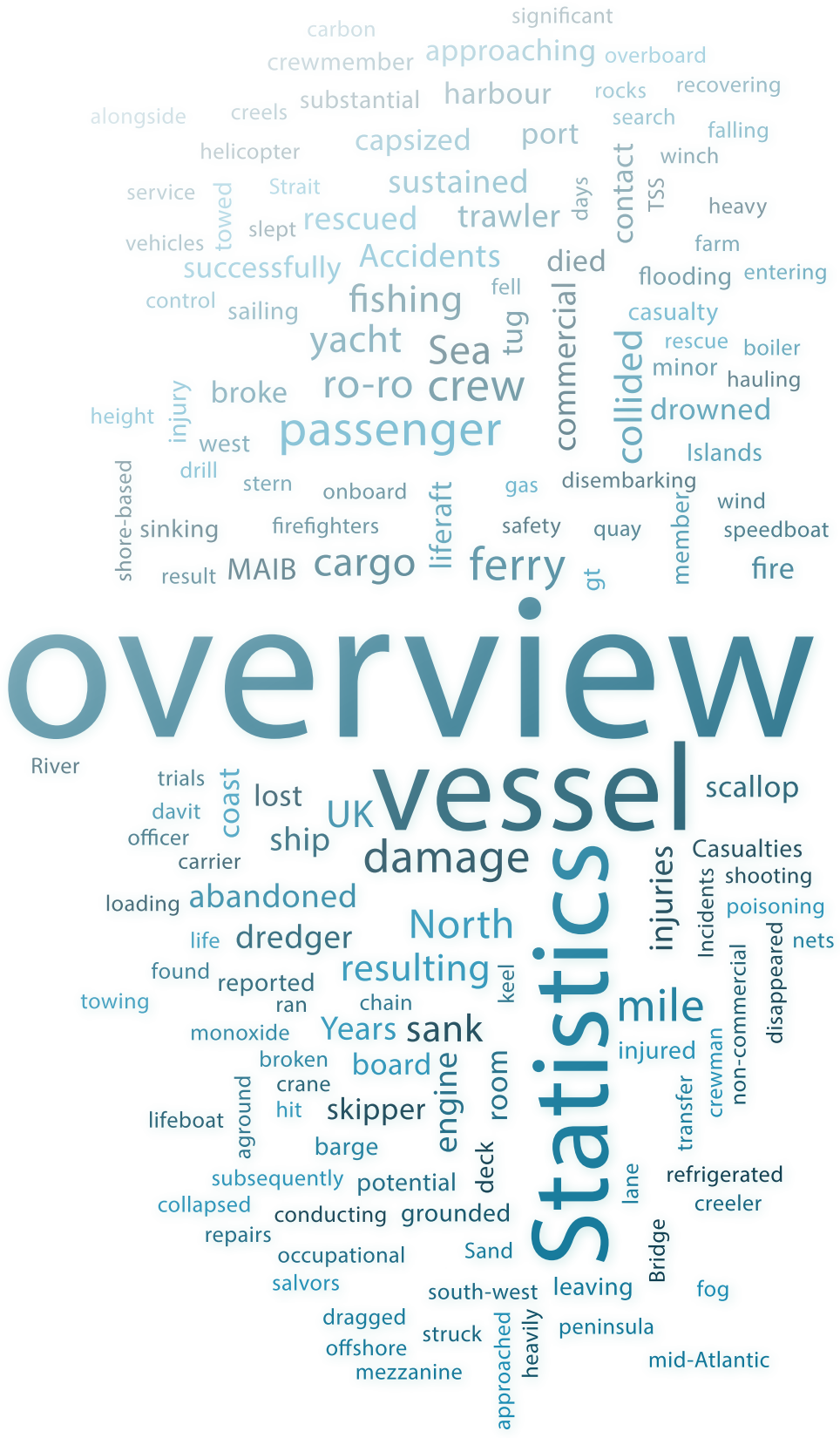
This annual report deals principally with the calendar year 2014. However, for ease of reference, the figures below are for the financial year 2014/15, which ended on 31 March 2015. The MAIB's funding from the Department for Transport is provided on this basis, and this complies with the Government's business planning programme.

£ 000s	2014/15 Budget	2014/15 Outturn
Costs – Pay	2662	2714
Costs – Non Pay	1084	1278
Totals	**3746**	**3992**

The timing of retirement and recruitment led to an overlap on numbers of staff, and a reulting overspend on Pay. The requirement to conduct two significant ROV surveys during the financial year was responsible for the Non-Pay overspend. These included the Cyprus-registered cement carrier *Cemfjord*, which sank in the Pentland Firth in January 2015 with the loss of eight lives, and the fishing vessel *Ocean Way* which was lost in the North Sea in November 2014 with the loss of three lives.

Steve Clinch
Chief Inspector of Marine Accidents

PART 1: 2014 OVERVIEW



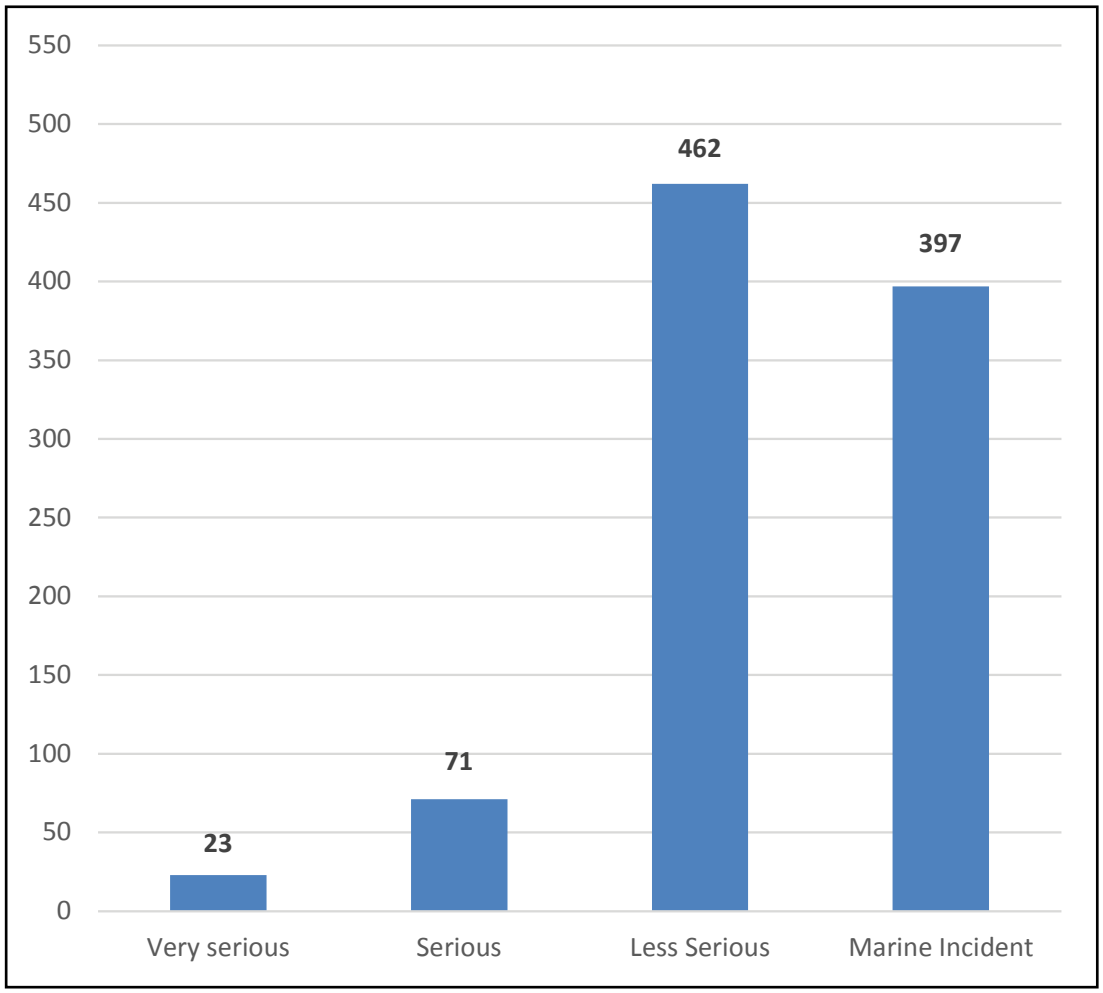
2014: OVERVIEW OF CASUALTY REPORTS TO MAIB

In 2014 1270 accidents (casualties and incidents[1]) were reported to MAIB, these involved 1470 vessels.

33 of these accidents involved only non-commercial vessels, 424 were occupational accidents that did not involve any actual or potential casualty to a vessel.

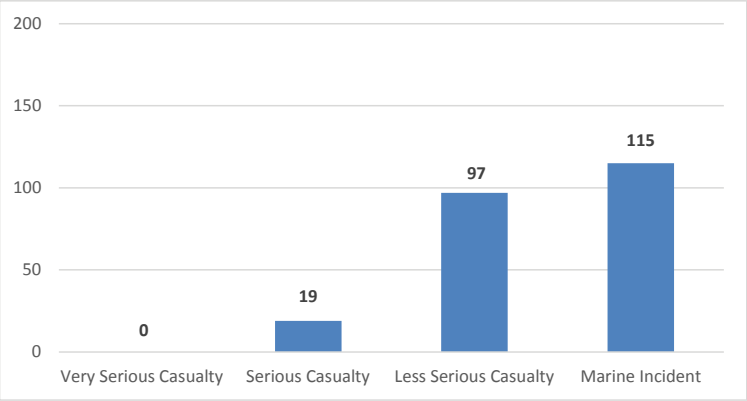
There were 822 accidents involving 953 commercial vessels that involved actual or potential casualties to vessels. These are broken down in the following overview:

All commercial vessels reported to MAIB in 2014

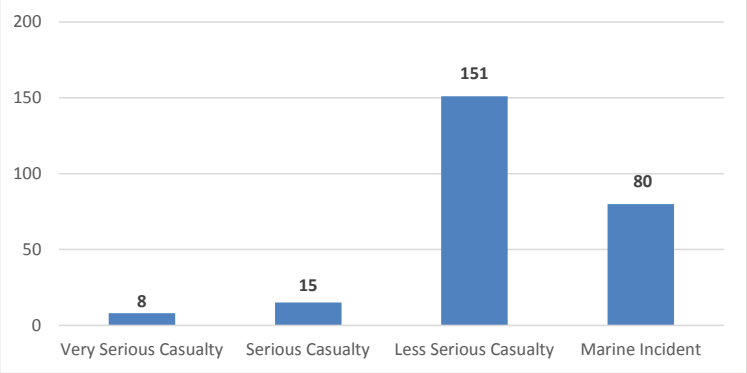


[1] As defined in the supporting documentation available on the MAIB website: https://www.gov.uk/government/publications/maib-annual-report-for-2014

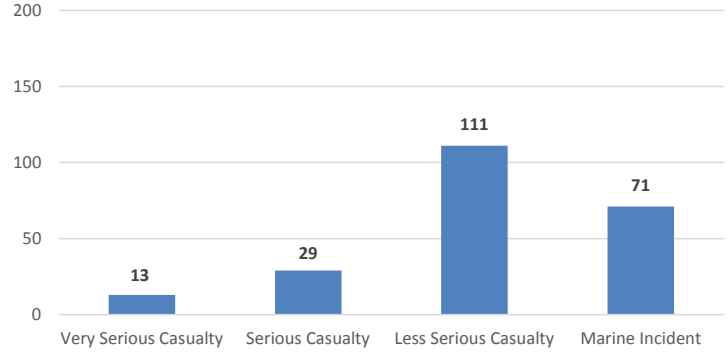
UK merchant vessels of 100gt or more



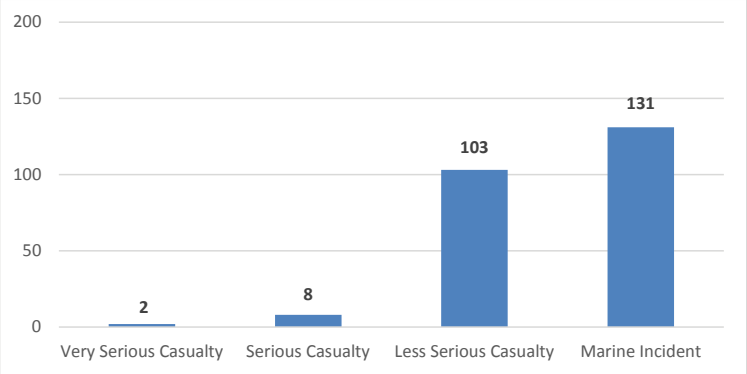
UK commercial vessels of under 100gt (excluding fishing)



UK fishing vessels



Non UK commercial vessels - in UK 12 mile waters



2014: SUMMARY OF INVESTIGATIONS STARTED

Date of occurrence	Occurrence details
3 Jan	The Liberian-registered gas carrier *Navigator Scorpio* ran aground on Haisborough Sand, in the North Sea, England without significant damage.
11 Jan	The Liberian-registered cargo ship *Rickmers Dubai* collided with the crane barge *Walcon Wizard* that was being towed by the tug *Kingston* in the south-west lane of the Dover Strait TSS resulting in damage to both vessels.
14 Jan	The wind farm passenger transfer vessel *ECC Topaz* caught fire and subsequently sank while conducting engine trials in the North Sea 11 miles off Lowestoft, Suffolk. The crew abandoned to a liferaft and were successfully rescued by search and rescue helicopter with no injuries.
15 Jan	Two crewmembers died as a result of carbon monoxide poisoning as they slept onboard the scallop dredger *Eshcol* alongside at Whitby, North Yorkshire.
22 Jan	The fishing vessels *Sapphire Stone* and *Karen* collided in the Firth of Clyde resulting in the sinking of the *Karen*. The crew abandoned to a liferaft and were successfully rescued.
9 Mar	The engine room of the Barbados-registered general cargo vessel *Sea Breeze* began flooding and the vessel had to be abandoned 11.6 miles south of the Lizard. The flooding was brought under control by salvors and the vessel was towed to safety.
10 Mar	A 5.7m Bayliner speedboat capsized resulting in the loss of all three people on board off Lowestoft.
25 Mar	The scallop dredger *Diamond* struck rocks and sank in West Burra Firth, Shetland Islands with the loss of one life.
31 Mar	The skipper of the scallop dredger *Ronan Orla* died after becoming caught in a hauling winch drum off the Lleyn peninsula, North Wales.
9 Apr	A crewman on board the Panama-registered refrigerated cargo vessel *Nagato Reefer* was injured when a lifeboat fell from its davit during a drill in Southampton.

Date of occurrence	Occurrence details
30 Apr	The trawler *Shalimar* made heavy contact with the quay in Scrabster, Scotland. This caused the vessel to sink due to substantial damage to the stern.
1 May	A fire broke out in the engine room boiler on the French-registered ro-ro ferry *Dieppe Seaways* as the vessel approached Dover. Injuries were sustained by members of the ship's crew and shore-based firefighters.
13 May	A crewmember from the creeler *Barnacle III* was dragged overboard and drowned while shooting creels off Tanera Beg on the west coast of Scotland.
16 May	The UK-owned sailing yacht *Cheeki Rafiki* lost its keel and capsized in mid-Atlantic with the loss of her four crew.
20 May	The skipper of the 4.8m fishing vessel *Water-rail* and his grandson became lost in fog and disappeared for two days after leaving Gourdon Harbour, on the east coast of Scotland. They were found and rescued by another fishing vessel 44 miles offshore.
26 May	Three crewmembers died after entering a confined cargo hold access compartment on board the German registered cargo vessel *Suntis* while alongside at Goole. In co-operation with the MAIB, the German Federal Bureau of Maritime Casualty Investigation (BSU) is carrying out the investigation.
4 Jun	The passenger vessel *Millennium Diamond* hit Tower Bridge in London resulting in an injury to one passenger and damage to the vessel.
8 Jun	The Cyprus-registered dredger *Shoreway* collided with the sailing yacht *Orca* seven miles off Harwich. The wife of the yacht's skipper drowned and the yacht sank.
18 Jun	The chief officer of the Luxembourg-registered cargo ship *Norjan* broke both ankles when falling from a height while loading a yacht as deck cargo in the port of Southampton.
14 Jul	The Bahamas-registered ro-ro ferry *Commodore Clipper* grounded heavily off the coast of Guernsey while approaching St Peter Port, and sustained substantial damage.
16 Jul	The French-registered ro-ro ferry *Barfleur* made contact with, and broke, the chain of the Sandbanks ferry while entering Poole Harbour.

Date of occurrence	Occurrence details
17 Jul	The passenger vessel *Millennium Time* collided with a tug that was towing three barges on the River Thames in London. Six passengers sustained minor injuries and both vessels were taken out of service for repairs.
18 Jul	A mezzanine deck on the Isle of Wight ro-ro ferry *St Helen* collapsed while disembarking vehicles. A member of the crew and three passengers were injured.
28 Jul	The trawler *Stella Maris* capsized and sank while recovering its nets in the North Sea 12 miles east of Sunderland. The two crew abandoned to a liferaft from which they were successfully rescued without injury.
7 Aug	A passenger on board the UK-registered passenger ship *Sapphire Princess* died in a swimming pool while the vessel was on passage in the East China Sea.
13 Aug	The master of the UK-registered tug *GPS Battler* drowned when the dinghy he was in was swamped as they returned from shore to the vessel which was anchored off Almeria, southern Spain.
29 Sep	The UK-registered ro-ro ferry *Pride of Canterbury* sustained a fire in the engine room as she was approaching Calais.
2 Nov	The trawler *Ocean Way* sank in the North Sea about 100 miles east of the Farne Islands. Three of the crew of five were lost.
9 Nov	The UK-registered ro-ro ferry *Dover Seaways* made contact with the harbour wall as she was leaving Dover, sustaining damage.
30 Nov	The UK-registered general cargo vessel *Vectis Eagle* grounded while approaching the port of Gijón, northern Spain.
21 Dec	The Gibraltar-registered chemical tanker *Orakai* collided with the UK-registered trawler *Margriet* off the Hook of Holland, with damage to both vessels and some minor pollution. There were no injuries.

PART 2: RECOMMENDATIONS AND PUBLICATIONS

INVESTIGATIONS PUBLISHED IN 2014 INCLUDING RECOMMENDATIONS ISSUED

The following pages list the accident investigation reports and safety bulletins published by the MAIB during 2014. 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 91.

Background

Recommendations are a key element of MAIB investigations. They are issued to promulgate the lessons from accidents investigated by the MAIB, with the aim of improving the safety of life at sea and the avoidance of future accidents. The issue of a recommendation shall in no case create a presumption of blame or liability.

Following an investigation the MAIB will, normally, make a number of recommendations. These will be contained within the published report but will also be addressed in writing to the individuals or senior executives of organisations concerned. Urgent safety recommendations may also be made in Safety Bulletins that can be published at any stage of an investigation.

Recommendations are made to a variety of addressees who might have been involved in, or have an interest in, the accident. These may range from those organisations which have a wider role in the maritime community such as the Department for Transport (DfT), the Maritime and Coastguard Agency (MCA) or an international organisation, through to commercial operators and vessel owners/operators.

It is required by the Merchant Shipping (Accident Reporting and Investigation) Regulations 2012 that the person or organisation to whom a recommendation is addressed, consider the recommendation, and reply to the Chief Inspector within 30 days on the plans to implement the recommendation or, if it is not going to be implemented, provide an explanation as to why not. The Regulations also require the Chief Inspector "*to inform the Secretary of State of those matters*" annually, and to make the matters publicly available. This Annual Report to the Secretary of State for Transport fulfils this requirement.

*Status as of 1 June 2015.

RECOMMENDATION RESPONSE STATISTICS 2014

59 recommendations were issued to **63** addressees in 2014. Of these, the percentage of all recommendations that are either ***accepted and implemented*** or ***accepted yet to be implemented*** is **88.8%**.

Year	Total*	Accepted Action		Partially Accepted	Rejected	No Response Received
		Implemented	Yet to be Implemented			
2014	**63†**	38	18	2	1	3

†**1** recommendation has been withdrawn by the MAIB.

RECOMMENDATION RESPONSE STATISTICS 2004 TO 2013

The following table shows the equivalent status of recommendations issued in 2004 to 2013 as published in the MAIB's previous Recommendations Annual Reports.

Year	Total*	Accepted Action		Partially Accepted	Rejected	No Response Received
		Implemented	Yet to be Implemented			
2013	**90†**	56	31	1	1	-
2012	**54**	41	10	-	1	2
2011	**57**	33	21	2	-	1
2010	**50**	36	14	-	-	-
2009	**117**	74	29	7	-	7
2008	**110**	71	31	5	-	3
2007	**136**	109	23	1	1	2
2006	**139**	103	30	3	3	-
2005	**140**	122	14	1	1	2
2004	**171**	93	52	11	11	4

†**1** recommendation has been withdrawn by the MAIB.

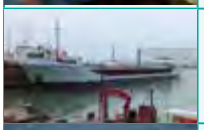
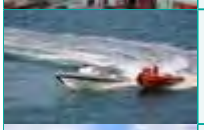
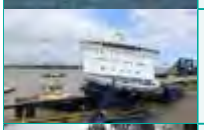
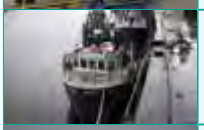
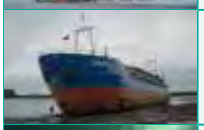
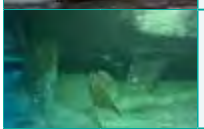
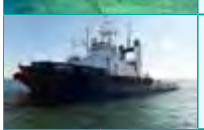
Of the **255** recommendations listed as ***accepted – yet to be implemented*** (at time of publication of relevant annual report):

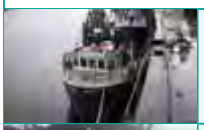
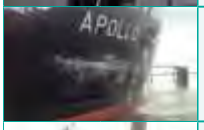
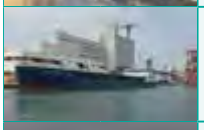
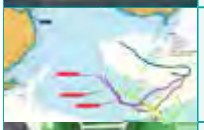
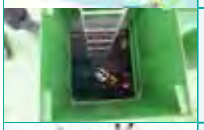
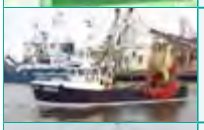
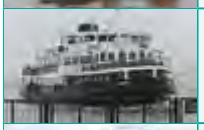
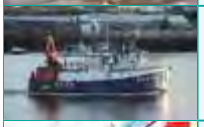
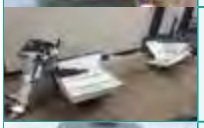
82.4% have now been ***fully implemented***

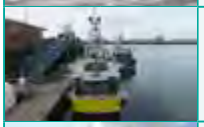
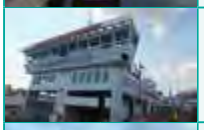
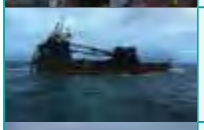
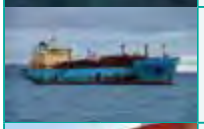
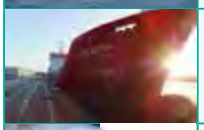
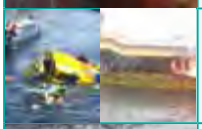
17.6% remain **planned to be implemented**.

***Total number of addressees**

SUMMARY OF 2014 PUBLICATIONS AND RECOMMENDATIONS ISSUED

	Vessel name(s)	Category	Publication date (2014)	Page
	*Speedwell*	Very Serious Marine Casualty	8 January	16
	*JCK*	Very Serious Marine Casualty	9 January	16
	*Achieve*	Very Serious Marine Casualty	10 January	17
	*Douwent*	Serious Marine Casualty	29 January	17
	*Milly*	Very Serious Marine Casualty	30 January	18
	*Sirena Seaways*	Serious Marine Casualty	31 January	19
	*Eshcol* (Safety Bulletin)	Very Serious Marine Casualty	1 February	19
	*Prospect*	Very Serious Marine Casualty	19 February	20
	*EEC Topaz* (Safety Bulletin)	Very Serious Marine Casualty	26 February	21
	*Danio*	Serious Marine Casualty	2 April	22
	*Isamar*	Very Serious Marine Casualty	9 April	23
	*Christos XXII*	Serious Marine Casualty	10 April	23
	*CMA CGM Florida/ Chou Shan*	Serious Marine Casualty	1 May	24
	*Stena Alegra*	Serious Marine Casualty	9 May	25
	*Endurance*	Very Serious Marine Casualty	5 June	26

	Vessel name(s)	Category	Publication date (2014)	Page
	*Eshcol*	Very Serious Marine Casualty	11 June	26
	*Apollo*	Serious Marine Casualty	12 June	28
	*Sea Melody*	Very Serious Marine Casualty	18 June	29
	*Corona Seaways*	Serious Marine Casualty	3 July	29
	*Celtic Carrier*	Serious Marine Casualty	16 July	30
	*Tyrusland*	Very Serious Marine Casualty	16 July	32
	*Karen/Sapphire Stone*	Very Serious Marine Casualty	24 July	32
	*Suntis* (Safety Bulletin)	Very Serious Marine Casualty	1 August	33
	*Sally Jane*	Very Serious Marine Casualty	21 August	33
	*Snowdrop*	Marine Incident	28 August	34
	*Millennium Time/ Redoubt*	Serious Marine Casualty	n/a, recommendation issued pre-publication by letter①	35
	*Horizon II*	Very Serious Marine Casualty	10 September	35
	*Ovit*	Less Serious Marine Casualty	11 September	36
	*Paula C/Dayra Gayatri*	Serious Marine Casualty	17 September	37
	*Amy Jane*	Very Serious Marine Casualty	18 September	38
	*Shalimar*	Very Serious Marine Casualty	8 October	38

	Vessel name(s)	Category	Publication date (2014)	Page
	*Bayliner Capri*	Very Serious Marine Casualty	8 October	38
	*Stella Maris*	Very Serious Marine Casualty	n/a, recommendation issued pre-publication by letter②	39
	*St Helen*	Serious Marine Casualty	n/a, recommendation issued pre-publication by letter③	40
	*Rickmers Dubai/ Kingston/Walcon Wizard*	Serious Marine Casualty	23 October	40
	*Navigator Scorpio*	Less Serious Marine Casualty	6 November	41
	*Key Bora*	Serious Marine Casualty	7 November	41
	*Wacker Quacker 1/ Cleopatra*	Very Serious Marine Casualty/ Very Serious Marine Casualty	17 December	42
	*Cheeki Rafiki*	Very Serious Marine Casualty	n/a, recommendation issued pre-publication by letter④	44

① *Millennium Time/Redoubt* investigation report published on 17 June 2015.

② *Stella Maris* investigation ongoing

③ *St Helen* investigation ongoing.

④ *Cheeki Rafiki* investigation report published on 29 April 2015.

Speedwell

Report number: 1/2014

Fishing vessel | Accident date: 25/04/2013

Foundering with the loss of her skipper in the Firth of Lorn

Safety Issues

- Insufficient and inoperative bilge alarms
- Out of date Life Saving Equipment
- Lifejacket not worn
- Delay in raising alarm

Nº	Recommendation to:	Vessel owner
101	Take steps to ensure that any vessel he may own in the future is operated safely, paying particular attention to: • The importance of watertight and weathertight integrity and the risk of down-flooding. • The fitting and operation of bilge alarm and pumping arrangements. • The provision of serviced and 'in date' lifesaving and other safety equipment. • Applicable regulatory requirements.	

Appropriate action implemented

JCK

Report number: 2/2014

Fishing vessel | Accident date: 28/01/2013

Foundering of fishing vessel with the loss of her skipper in Tor Bay

Safety Issues

- Weather forecast not properly evaluated
- Personal Flotation Device not worn

► No recommendations have been issued as a consequence of this investigation ◄

Achieve

Report number: 3/2014

Fishing vessel | Accident date: 21/02/2013

Foundering of fishing vessel and the death of a crew member north-west of the Island of Taransay, Western Isles

Safety Issues

- Removal of bilge alarm in fish hold
- Fish hold access hatch blocked by creels
- No requirement for EPIRB as the vessel was under 12 metres
- Neither the VHF DSC facility nor the MDB Guardian system were used to raise the alarm

► The MAIB has published a safety flyer on DSC for dissemination within the fishing industry ◄

Douwent

Report number: 4/2014

General cargo vessel | Accident date: 26/02/2013

Grounding on Haisborough Sand

Safety Issues

- Lone watchkeeper
- Passage plan not verified
- Reliance on GPS integrated with radar

Nº	Recommendation to:	Marco Polo Maritime Ltd
102	Take steps to foster and maintain a positive safety culture on board its vessels, taking into account the circumstances of this accident, in particular: • The need to ensure that crews comply with onboard guidance and instructions. • The importance of passage planning and the need for a high standard of bridge watchkeeping practice. • The potential for crew fatigue. • The need for openness and honesty when reporting accidents and near misses.	

Appropriate action implemented

Milly	Report number:	5/2014
Rigid Inflatable Boat	Accident date:	05/05/2013

Ejection of six people from RIB in the Camel Estuary, Cornwall resulting in two fatalities

Safety Issues

- Kill cord not in use at time of accident
- The boat developed an excessive angle of heel when turned at high speed
- Lack of driver experience in high speed turns
- Boat occupants seating positions

Nº	Recommendation to:	Royal Yachting Association
103	Revise the powerboat scheme content and delivery to ensure that more extensive guidance is made available to powerboat drivers covering the additional hazards presented by high powered craft and operations at high speed, and the measures that should be taken to mitigate these risks for passengers and crew. Specific guidance should be provided on the hazard of hooking, and the importance of appropriate seating and handholds when travelling at speed.	

Appropriate action implemented

Nº	Recommendation to:	APV Marine Ltd
104	Review its RCD conformance documentation to ensure these contain consistent references to the relevant ISO standards, particularly with reference to maximum engine power.	

Appropriate action implemented

Nº	Recommendation to:	APV Marine Ltd
105	Review the design of the hull of its Cobra RIB range and make modifications to reduce the steep angle of heel which the boat adopts in tight turns.	

Rejected

MAIB comment:
APV Marine Ltd reports it has carried out subsequent tests on its range of boats and is satisfied 'beyond doubt that our hull design is extremely safe in all likely and realistic manoeuvres". Accordingly the company has "made no change and do not plan to make any changes". There is however, evidence to suggest that appropriate modifications to the hull design would improve the handling characteristics of these craft in tight turns and help to reduce the likelihood of similar fatal accidents in the future. The manufacturer's reluctance to consider undertaking such modifications is extremely disappointing in view of the circumstances of this accident.

Sirena Seaways

Report number: 6/2014

Ro-ro passenger ferry | Accident date: 22/06/2013

Contact with berth at Harwich International Port

Safety Issues

- Propulsion control procedures not followed
- Bridge console ergonomics
- Ineffective procedures for machinery breakdowns
- Passengers not alerted to impending impact

Nº	Recommendation to: DFDS A/S
106	Review the need for regular bridge and crew resource management training to ensure that crew maintain vigilance against the potential for a decline in performance when working on repetitive operating patterns.
	Appropriate action implemented
S107	Consider ways in which passengers and crew can be rapidly informed about an impending accident to minimise the potential for injuries.
	Appropriate action implemented

Eshcol

Safety Bulletin number: 1/2014

Scallop dredger | Accident date: 15/01/2014

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

Safety Issues

- Unserviced gas cooker used as a heater
- No CO alarm fitted
- Vessel not equipped for overnight sleeping and had insufficient ventilation in accommodation area

► No formal recommendations were made ◄

Prospect	Report number:	7/2014
Fishing vessel	Accident date:	05/08/2014

Grounding on Skibby Baas and foundering in the north entrance to Lerwick Harbour, Shetland Islands

Safety Issues

- Skipper did not effectively monitor vessel's passage plan
- VHF radio volume was turned down
- Chart plotter data had not been updated since 1997
- Lack of emergency drills

Nº	Recommendation to:	Vessel skipper
108	Attend a navigation skills refresher/bridge watchkeeping course to update his knowledge of navigation best practice.	

Appropriate action implemented

Nº	Recommendation to:	Vessel owner
109	Improve the safe operation of any vessels it may own in the future by establishing measures to ensure: • Skippers and crew comply with the watchkeeping and navigation best practice guidance promoted in MGN 313 (F) - Keeping a Safe Navigational Watch on Fishing Vessels and with MGN 299 (M+F) Interference with Safe Navigation Through Inappropriate Use of Mobile Phones. • Electronic chart plotting systems, used in lieu of paper charts, are compliant with MGN 319 (M+F) - Acceptance of Electronic Chart Plotting Systems for Fishing Vessels Under 24 metres and Small Vessels in Commercial Use (Code Boats) Up To 24 Metres Load Line Length. • Monthly emergency drills are carried out and recorded.	

Withdrawn

MAIB comment:
Recommendation withdrawn as the vessel's owner is no longer in the fishing industry.

ECC Topaz

Safety Bulletin number: 2/2014

Workboat | Accident date: 14/01/2014

Fire and subsequent foundering 11nm east of Lowestoft

Safety Issues

- Air heater exhaust pipe was not fully insulated and was close to combustible material
- Fire/smoke detectors were not fitted

► Though no formal recommendations were made, advice was given to address the safety issues in the Safety Bulletin ◄

Danio

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

Grounding off Longstone, Farne Islands, England

Safety Issues

- Cumulative fatigue of watchkeeping officers caused by 6 on 6 off watches
- Bridge Navigational Watch Alarm System switched off during navigation
- Not maintaining bridge lookouts
- Internal audit failing to identify deficiencies
- Navigating with an unapproved Electronic Charting System

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

Partially accepted - closed

MCA comment:
The MCA raised the issue at HTW 2 in January and it was ruled out of scope wth regards to seafarer fatigue. At HTW 2 the objections largely came from the same administration that objected when the subject was raised some 5 years ago. The UK has put a paper to MSC requesting that the agenda item for HTW 3 is amended to allow discussion on relevance of manning to fatigue.

MAIB comment:
That there continues to be significant international opposition to ensuring that vessels engaged in short sea trading are manned by two watchkeepers in addition to the master is extremely disappointing. The MCA's approach to broadening the evidence base for change is therefore welcomed, and the MAIB will continue to highlight the issue, when appropriate, until short sea trade manning levels are improved.

Nº	Recommendation to:	Reederei Frank Dahl e.K.
111	Review and amend its internal auditing regime to ensure its auditors verify that documented procedures are being followed by its crew. In doing so, particular emphasis should be given to: • compliance with hours of work and rest regulations • adherence to the fundamental principles of safe navigation • an understanding of the requirements for notifying coastal states • the appropriate use of lookouts and watch alarms at sea.	

Appropriate action implemented

Isamar

Report number: 9/2014

Private pleasure yacht | Accident date: 17/08/2013

Grounding of pleasure vessel off Grand Écueil d'Olmeto, Corsica

Safety Issues

- Navigation was by a single piece of equipment (ECS software) with no contingency available in the event of its failure

► No recommendations have been issued as a consequence of this investigation ◄

Christos XXII

Report number: 10/2014

Tug | Accident date: 13/01/2013

Collision between tug and its tow *Emsstrom* off Hope's Nose, Tor Bay, England

Safety Issues

- Tidal effects on a tow when anchoring
- Insufficient planning

Nº	Recommendation to:	Christos XXII Spanopoulos Tugs
112	Develop a crisis response management cell and associated procedures to provide support to ships' staff in crisis situations.	

No response received

CMA CGM Florida/ Chou Shan

Report number: 11/2014

Container vessel/Bulk carrier | Accident date: 19/03/2013

Collision between container vessel *CMA CGM Florida* and the bulk carrier *Chou Shan* in open water 140 miles east of Shanghai

Safety Issues

- VHF radios used to negotiate actions to avoid close quarters situations
- Cultural influences
- Sub-optimal use of radar and AIS facilities

Nº	Recommendation to:	CMA CGM International Shipping Company PTE Ltd
114	Take appropriate measures to ensure: • Its company shipboard policies and procedures are adhered to. • Its masters recognise the importance of engaging with and motivating crew in the safe and efficient management of its vessels.	

Appropriate action implemented

Nº	Recommendation to:	Sincere Navigation Corporation
115	Review and amend its SMS requirements and verification procedures as necessary to ensure that: • OOWs recognise the dangers of using VHF radio for collision avoidance and that it should not normally be used for that purpose, in accordance with the advice provided in the ICS's Bridge Procedures Guide. • Its masters are empowered to provide in their standing orders their own specific metrics as to when they should be called by the OOW.	

Appropriate action implemented

Nº	Recommendation to:	International Chamber of Shipping
116	Update its Bridge Procedures Guide to highlight the danger of limiting overall situational awareness through over-reliance on radar functions that focus on and prioritise AIS target CPA and TCPA.	

Appropriate action planned — 2015 DECEMBER 31

Nº	Recommendation to:	Maritime and Coastguard Agency
117	Update Appendix IV of MGN 324 (M+F) to: • Acknowledge the growing trend of integrating AIS data with radar systems. • Acknowledge the increased availability and use of radar functions that focus on and prioritise targets for collision avoidance on the basis of AIS target CPA and TCPA rather than radar target tracking information. • Warn of the danger of limiting situational awareness through overreliance on radar functions that focus on and prioritise AIS target CPA and TCPA.	

Appropriate action planned

2016 JANUARY 31

Stena Alegra

Report number: 12/2014

Ro-ro passenger ferry

Accident date: 28/10/2013

Anchor dragging and subsequent grounding at Karlskrona, Sweden

Safety Issues

- Operational design limit of anchoring equipment exceeded
- Insufficient contingency planning
- Lack of early action to prevent anchor dragging

Nº	Recommendation to:	Northern Marine Management Ltd
118	Improve its safety management system by: • Providing specific guidance on the operational limitations of vessels' anchoring equipment. • Providing further guidance to masters on its expectations for anchor planning, including the importance of contingency planning and the need for early action to prevent a vessel dragging its anchor. • Enhancing its masters' handover procedures to ensure that key information regarding a vessel's capabilities and performance while at anchor are discussed during handover periods	

Appropriate action implemented

Endurance

Report number: 13/2014

Tug | Accident date: 05/02/2013

Loss of crewman overboard 23 miles west-south-west of Beachy Head

Safety Issues

- Vessel not suitable for towing at sea
- Inappropriate vessel coding
- Lack of knowledge and experience of towing at sea
- Weather forecast not properly evaluated

Nº	Recommendation to:	Vessel owner/skipper
119	Ensure that any vessel he owns or skippers is operated safely, taking into account the circumstances of this accident including, inter alia: • limitations of his maritime qualifications • limitations and conditions of his vessels' certification • local requirements in the area of operation • the importance of passage and towage planning, and risk assessments • the importance of adequate rest periods • the use of personal protective equipment.	

Appropriate action implemented

Eshcol

Report number: 14/2014

Fishing vessel | Accident date: 15/01/2014

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

Safety Issues

- Unserviced gas cooker used as a heater
- No CO alarm fitted
- Vessel not equipped for overnight sleeping and had insufficient ventilation in accommodation area
- Fatigue

Nº	Recommendation to:	Maritime and Coastguard Agency
120	At the earliest opportunity, include in the Code of Practice for the Safety of Small Fishing Vessels a requirement for a carbon monoxide detector to be fitted in the accommodation on all vessels.	

Appropriate action planned — 2015 OCTOBER 31

121 In developing a Code of Practice for the Safety of Small Fishing Vessels based on the Small Commercial Vessel and Pilot Boat Code, and in implementing the requirements of International Labour Organization Convention C188 in national regulations (when in force), take into account the circumstances of this accident, including, inter alia:

- The disparity in the requirements for Liquid Petroleum Gas installations on board small fishing vessels and other small commercial craft and larger fishing vessels.
- The need for suitable accommodation to be provided when crew are expected or required to stay on board overnight.
- The operating patterns of small fishing vessels and the need to protect fishermen from fatigue.

Appropriate action planned

Nº	Recommendation to:	Seafish Industry Authority

122 Take action to raise the awareness of fishermen to the dangers of carbon monoxide, including its sources, the symptoms of poisoning and the importance of its detection by:

- Broadening the scope of the specifications of the health and safety and safety awareness courses, and
- Include the risks and hazards of carbon monoxide in its fishing vessel safety folder.

Appropriate action implemented

Nº	Recommendation to:	Vessel owner

123 Improve the safety management on board his vessels by using aids such as the online Seafish fishing vessel safety folder and, in addition, ensure that:

- All crew have completed the mandatory safety training.
- Equipment provided is fit for purpose and routinely inspected.
- Equipment requiring inspection and servicing by a specialist is identified.
- Every effort is made to improve the standard of onboard accommodation.
- Work and rest hours of crew are monitored and managed to prevent fatigue.

Appropriate action implemented

Apollo	Report number:	15/2014
Oil product/Chemical tanker	Accident date:	25/07/2013

Contact with the quayside at Northfleet Hope Container Terminal, Tilbury, River Thames

Safety Issues

- Complexity of tidal stream in Tilburyness area
- Propulsion information on vessel's pilot card was not clear
- Conduct of Pilotage examination was not conducive to open communications within the bridge team
- Vessel was too large for pilotage examination undertaken

Nº	Recommendation to:	Port of London Authority
124	Review its procedures for: • The entry of data into its Polaris database to ensure the information is complete, consistent and accurate. • The transit of large vessels in the Tilburyness area at times of strong tidal flow and ensure port users are made aware of the complex tidal flows in the area. • Pilot training, to ensure practical examinations are undertaken on vessels of an appropriate size and are conducted in a manner in which the assessing pilot can intervene if necessary. **Appropriate action implemented**	
125	Clarify the wording of General Direction 18/2011 relating to: members of the crew capable of taking charge of a vessel. **Appropriate action implemented**	

Nº	Recommendation to:	UK Marine Pilots Association and; Port Marine Safety Code Steering Group
126	Develop best practice guidelines for the conduct of practical pilotage examinations. **UK MPA: Appropriate action implemented** **PMSC Steering Group: Appropriate action implemented**	

Sea Melody

Report number: 16/2014

General cargo vessel | Accident date: 18/12/2013

Crewman lost overboard in Groveport, River Trent

Safety Issues

- Crew briefing before mooring operation was ineffective
- Crewman unsupervised during mooring operation
- Communications between ship and shore mooring personnel were ineffective

▶ No recommendations have been issued as a consequence of this investigation ◀

Corona Seaways

Report number: 17/2014

Ro-ro cargo vessel | Accident date: 04/12/2013

Fire on the main deck of ro-ro cargo ferry in the Kattegat, Scandinavia

Safety Issues

- No evidence of crew carrying out vehicle safety checks
- Safety Management System and Risk Assessments did not cover the carriage of used vehicles and equipment

Nº	Recommendation to:	Ellingsen Ship Management AB
127	Review its onboard documentation and the 'Unsafe Cargo' notice to take into account DFDS A/S's revised procedures for the carriage of used and unregistered vehicles: • 'Information to Car Carriers' dated 28 January 2014. • 'Information to Unregistered Second Hand Segment' dated 28 January 2014.	No response received
128	Take appropriate action to: • Ensure that cargo deck ventilation fans are run in accordance with current regulations. • Investigate why the CO_2 fire-extinguishing system apparently failed to discharge the allotted quantity of CO_2 as designed.	No response received

Celtic Carrier

Report number:	**18/2014**	
General cargo vessel	Accident date:	26/04/2013

Fire on board general cargo vessel 24 miles west of Cape Trafalgar, Spain

Safety Issues

- Emergency unpreparedness/ falsified emergency drills
- Smoking on board vessel

No	Recommendation to:	Charles M Willie and Co. (Shipping) Ltd

129 Take appropriate steps to ensure that its masters and crews understand the potential consequences of failing to undertake emergency drills and of falsifying official records, and put in place measures to minimise the opportunities for doing so.

Appropriate action implemented

130 Review and revise its internal audit process to ensure that ISM Code related deficiencies are:

- Properly considered by its masters and crews.
- Robustly addressed with sound evidence to support the action taken to rectify them.
- Considered at both individual ship and fleet wide levels to ensure that any trends in deficiencies are identified quickly.

Appropriate action implemented

131 Taking into account the IMO's approved guidelines for the operational implementation of the ISM Code and near-miss reporting, and the National Maritime Occupational Health and Safety Committee's 'Guidelines to Shipping Companies on Behavioural Safety Systems', review and revise its SMS and crew training requirements to:

- Ensure that crews are fully capable of being involved in meeting the requirements of the ISM Code.
- Establish a company safety culture that empowers and encourages crews to identify and report non-conformities and hazardous incidents, and propose improvements to the company's safety management system.

Appropriate action implemented

Nº	Recommendation to:	Maritime and Coastguard Agency

132 Consider and, where necessary, adapt its procedures for ISM Code related audits to ensure that:

- Any serious shortcomings that are found during audits in respect of 'non-conformities' and 'observations' are consistently documented in an appropriate and proportionate manner and that 'non-conformities' are only cleared after acceptance of reasonable evidence that the underlying problem has been corrected.
- The results of ISM Code related surveys and audits conducted in respect of a company and each of its UK-flagged ships are reviewed on a periodic basis, and prior to conducting an SMC audit of one of those ships, or a DoC audit of the company, to assess the company's safety management performance.
- The PSC inspection history of a ship is reviewed prior to conducting an SMC audit of that ship.
- Positive action is taken by the MCA to inform companies whose safety 66 management performance is not meeting the required standard, or where audits have detected areas of serious concern, and for the MCA to consider instigating a formal process with them to improve performance where such cases have been identified.

Appropriate action implemented

133 Expedite the delivery of the existing information management software project to improve the performance and efficiency of information management, replacing the current paper-based system for monitoring its ISM Code audit activity.

Appropriate action implemented

134 Review its application of the Alternative Compliance Scheme to ensure that ships within the scheme are compliant with the eligibility criteria.

Appropriate action planned 2016 JUNE 30

Tyrusland

Report number: 19/201

Ro-ro cargo vessel | Accident date: 15/05/2013

Fatality of an able seaman on board ro-ro cargo ship in Tripoli, Libya

Safety Issues

- Follow up of non-conformities identified during internal and external audits
- Completing risk assessments which actually identify the hazards
- Complacency in a hazardous working environment
- Failure to use appropriate signallers or safety signals when handling containers inside a ship's main deck

► In view of the actions taken by the vessel's managers, which have been audited by the Maritime and Coastguard Agency, and the previous recommendation made to the Maritime and Coastguard Agency regarding audit management processes, no recommendations were made in this report ◄

Karen/Sapphire Stone

Report number: 20/2014

Fishing vessels | Accident date: 22/01/2014

Collision between fishing vessels resulting in the loss of *Karen* 11 miles south-east of Campbeltown

Safety Issues

- Ineffective visual and radar lookout
- Over-reliance on AIS information
- No DSC alert transmitted

Nº	Recommendation to:	Skippers of *Karen* and *Sapphire Stone*
135	Take steps to improve the standard of watchkeeping on board their vessels, taking particular account of the guidance contained in: • MGN 313 (F) 'Keeping a Safe Navigation watch on Fishing Vessels'; and MGN 324 (M+F) 'Radio: Operational Guidance on the Use of VHF Radio and Automatic Identification Systems (AIS) at Sea'.	

Skipper of *Karen*: Appropriate action implemented

Skipper of *Sapphire Stone*: Appropriate action implemented

Suntis

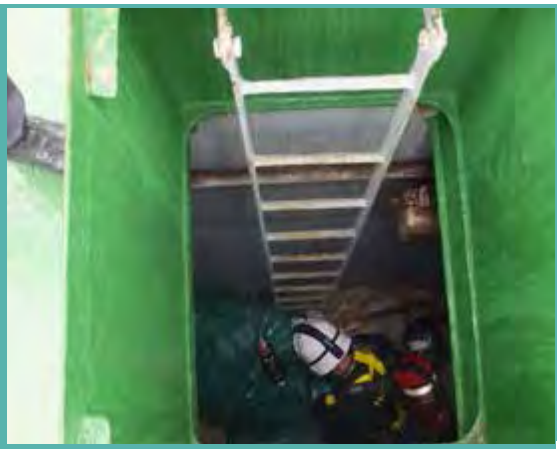
Safety Bulletin number: **3/2014**

General cargo vessel | Accident date: 26/05/2014

Entry of a confined space in Goole Docks Humberside, resulting in three fatalities

Safety Issues

- Crew member died after entering an oxygen deficient atmosphere
- Other crewmen died after entering the space to attempt a rescue
- Confined space entry procedures not followed
- Breathing apparatus not worn correctly



As the German Federal Bureau of Martime Casualty Investigation (BSU) are conducting an investigation no formal recommendations were made, advice was given to address the safety issues in the Safety Bulletin.

Sally Jane

Report number: **21/2014**

Fishing vessel | Accident date: 17/09/2013

Capsize and foundering of the beam trawler *Sally Jane* in Christchurch Bay

Safety Issues

- Stability awareness
- Training

► No recommendations have been made as a result of this investigation ◄

Snowdrop

Report number: 22/2014

Passenger vessel | Accident date: 14/10/2013

The falling overboard and recovery of a young child from the passenger ferry at Seacombe Ferry Terminal, River Mersey

Safety Issues

- Passengers ignored safety warnings
- Ship's emergency response plan not implemented
- Location and design of deck seats

▶ In view of the actions already taken by Mersey Travel and the Maritime and Coastguard Agency no recommendations have been made ◀

Millennium Time/Redoubt

Recommendation issued pre-publication by letter

Passenger vessel/Tug | Accident date: 17/07/2014

Collision between passenger vessel and tug on the Thames

Safety Issues

- Mechanical steering system made maintaining course difficult
- Wheelhouse ergonomics did not assist helmsman
- Passenger count was inaccurate

Nº	Recommendation to:	Maritime and Coastguard Agency
136	Require City Cruises to demonstrate that suitable and sufficient control measures are in place to ensure the safe navigation of the M2 river liners, taking into account, inter alia: • the difficulty in steering the vessels • the ergonomics of the wheelhouse • the numbers of passengers carried • the traffic density and the proximity of navigational dangers on the Thames	

Appropriate action planned, progress is ongoing

Horizon II

Report number:	**23/2014**	
Fishing vessel	Accident date:	09/11/2013

Fatal man overboard while climbing on board the fishing vessel *New Dawn* to access the fishing vessel *Horizon II* at Royal Quays Marina, North Shields

Safety Issues

- No boarding arrangements provided for the vessel
- Difficult access to the quayside and lack of illumination
- Alcohol consumption
- Lack of man overboard recovery equipment

Nº	Recommendation to:	Quay Marinas Ltd
137	Take action to improve the safety of fishermen when moving between the middle pier and their boats by: • Providing a method of access and egress for the berths to eliminate the need for people to climb over its safety railings. **Appropriate action implemented**	
138	Take action to improve the safety of fishermen when moving between the middle pier and their boats by: • Reminding skippers of fishing vessels using Royal Quays marina piers of the need to apply the guidance within MGN 337(M+F). **Appropriate action implemented**	

Ovit

	Report number:	24/2014
Chemical tanker	Accident date:	18/09/2013

Grounding of oil/chemical tanker in the Dover Strait

Safety Issues

- Poor passage planning (ECDIS)
- Inadequate supervision of officer in performance of their duties
- Poor watchkeeping practices
- Poor communication between vessel and the Maritime and Coastguard Agency

Nº	Recommendation to:	Maritime and Coastguard Agency
139	Forward a submission to the IMO Navigation, Communication and Search and Rescue Sub-committee, promoting the concept of carrying out annual performance checks on all ECDIS systems fitted to ships and in use as the primary means of navigation.	

Appropriate action planned

Update requested
NO DATE GIVEN

140 Monitor the measures adopted to improve the quality of the VTS services provided by Dover Coastguard to ensure that vessel safety is not compromised, taking into account the importance of sufficient qualified operators being available.

Appropriate action planned

2016
FEBRUARY
29

Nº	Recommendation to:	Transport Malta in co-operation with the Maritime and Coastguard Agency
141	Propose to the Paris Memorandum of Understanding Committee that a Concentrated Inspection Campaign be conducted of ECDIS-fitted ships to establish the standards of system knowledge among navigators using a list of pre-defined questions.	

Appropriate action planned

Update requested
NO DATE GIVEN

Nº	Recommendation to:	International Chamber of Shipping and; Oil Companies International Marine Forum
142	In conjunction with ECDIS experts, develop and promulgate a set of focused questions for use by surveyors and auditors when conducting audits and inspections on ECDIS fitted ships.	

ICS and OCIMF: Appropriate action planned

2016
DECEMBER
31

OCIMF: Appropriate action planned

2016
DECEMBER
31

Nº	Recommendation to:	Ayder Tankers Ltd
143	Take steps through audit and assessment to monitor the effectiveness of the ECDIS familiarisation provided to its deck officers.	

Appropriate action implemented

Nº	Recommendation to:	Marine Information Systems AS
144	Improve the management of safety critical information in its ECDIS 900 system, focusing on: • The protection of recorded positional data in accordance with IMO standards. • Highlighting the importance of safety contour data to the user. • The activation of an alarm when the safety contour is about to be crossed in accordance with IMO standards.	

Partially accepted - closed

MAIB comment:
Marine Information Systems AS considers that the ECDIS 900 system complies with IMO standards, and that failure of the alarm to function resulted from inadequate installation.

Paula C/Darya Gayatri

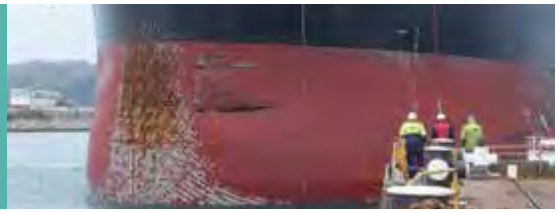
Report number: 25/2014

General cargo vessel/Bulk carrier — Accident date: 11/12/2013

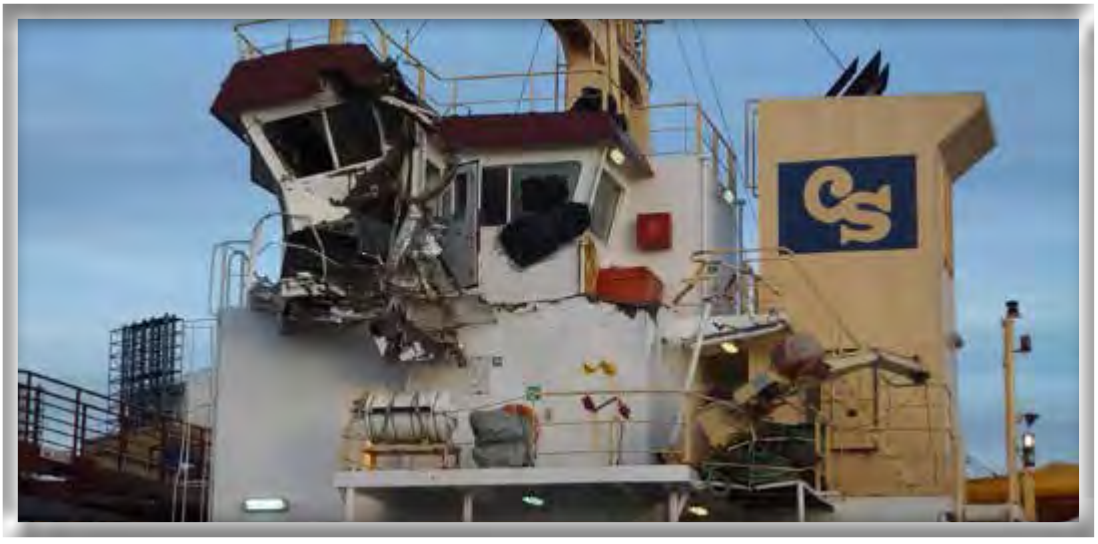
Collision between bulk carrier and general cargo vessel in the south-west lane of the Dover Strait Traffic Separation Scheme

Safety Issues

- Watchkeeping experience



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



Amy Jane

Report number: 26/2014

Fishing boat | Accident date: 04/12/2013

Fatal man overboard from speedboat, near Cadgwith, Cornwall

Safety Issues

- Single handed operations
- Kill cord not used
- No man overboard checklist or process

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

Shalimar

Report number: 27/2014

Fishing vessel | Accident date: 30/04/2014

Contact with quay and subsequent foundering of fishing vessel in Scrabster, Scotland

Safety Issues

- Mechanical failure
- Vessel survivability

► In view of the advancements in the construction standards applicable to wooden fishing vessels, no recommendations have been made ◄

Bayliner Capri

Report number: 28/2014

Powerboat | Accident date: 10/03/2014

Capsize of speedboat, resulting in the loss of three people off Lowestoft

Safety Issues

- Lifejackets not worn
- No radio, flares or personal locator beacon
- Boats design was unsuitable for the unexpected weather conditions

► In view of the actions taken and the guidance available to recreational mariners, no recommendations have been made ◄

Stella Maris

Recommendation issued pre-publication by letter

Fishing vessel | Accident date: 28/06/2014

Vessel capsized while recovering nets

Safety Issues

- Inadequate level of stabilty
- Lack of approval/assessment process for proposed modifications

Nº	Recommendation to:	Vessel owner
145	To commission a full analysis of the stability of Lucia, HL1067[2], including an assessment of any operational limitations that might be required when using the "A" frame gantry and catch hopper.	

Appropriate action implemented

St Helen

Recommendation issued pre-publication by letter

Ro-ro passenger vessel | Accident date: 18/07/2014

Collapse of the starboard forward mezzanine deck while discharging vehicles at the Fishbourne ferry terminal

Safety Issues

- Wire ropes not greased
- Maintenance management system shortfalls
- Ineffective lifting equipment inspection regime

Nº	Recommendation to:	Wightlink Ltd
146	For all Wightlink vessels with wire operated mezzanine decks implement, with immediate effect: • a formal mezzanine deck wire dressing routine. • seek independent assurance that the mezzanine decks and their hoisting/support wires are of sound condition.	

Appropriate action implemented

[2] The owner of *Stella Maris* also owns *Lucia*, HL1067

Rickmers Dubai/Kingston/ Walcon Wizard

Report number: 29/2014

General cargo/Tug/Crane barge | Accident date: 11/01/2014

Collision of general cargo vessel with crane barge being towed by tug, in the south-west lane of the Dover Strait Traffic Separation Scheme

Safety Issues

- Ineffective lookout by lone bridge watchkeeper
- Over-reliance on AIS for collision avoidance
- The tug's gob-rope prevented the tug from girting

Nº	Recommendation to:	Maritime and Coastguard Agency
147	Ensure that CNIS safety broadcasts highlight when AIS information is not being transmitted by vessels that may pose a risk to navigation, such as tugs operating with tows.	

Appropriate action implemented

Nº	Recommendation to:	Reedereiverwaltung Heino Winter GmbH
148	Take action to ensure the behaviour of bridge watchkeepers on board its vessels accords with its instructions and guidance, with particular emphasis on the contents of its recent fleet circular concerning: • Over-reliance on ECDIS and AIS. • The use of additional lookouts. • The potential for low levels of arousal.	

Appropriate action implemented

Nº	Recommendation to:	Griffin Towage and Marine
149	Take action to enhance the operational safety of its vessels, taking into account, inter alia: • The importance of the ability to release a tow both from the tow winch and from the conning position when normal power is not immediately available. • The usefulness of AIS in enabling other vessels to detect and monitor its vessels when towing. • That the gob rope should be regularly inspected and maintained in a serviceable condition. • The need to ensure that all navigation lights are working and are not obscured.	

Appropriate action implemented

Navigator Scorpio

Report number: 30/2014

Liquified gas carrier | Accident date: 03/01/2014

Grounding of liquefied gas carrier on Haisborough Sand, North Sea

Safety Issues

- Passage planning
- OOW competence

► As a result of the actions taken by Bernhard Shulte Shipmanagement, no safety recommendations are made in this report ◄

Key Bora

Report number: 31/2014

Chemical tanker | Accident date: 20/12/2013

Failure of the controllable pitch propeller of chemical tanker, resulting in heavy contact with the jetty in the port of Hull

Safety Issues

- Longstanding defect in CPP Control system
- Inadequate performance standard for CPP response
- Master's lack of familiarity with CPP backup control
- Delay in dropping anchor
- Insufficient propulsion system tests before pilotage

Nº	Recommendation to:	Bureau Veritas
113[3]	Request IACS to include in the forthcoming unified requirement being implemented in response to Recommendation 2012/113 that during commissioning trials of new and existing CPP systems, the response times for ahead and astern pitch demand are also recorded and verified to be in accordance with the values expected by the CPP system manufacturer.	

Appropriate action implemented

Nº	Recommendation to:	V Ships UK Ltd
150	Investigate and rectify the poor astern performance of *Key Bora*'s CPP system.	

Appropriate action implemented

[3] Recommendation 2014/113 issued prior to the publication of report 31/2014 through a Chief Inspector letter to Bureau Veritas.

151 Ensure that the CPP control parameters on its managed vessels are set in accordance with the equipment manufacturer's guidance and that performance standards are available to technical staff responsible for monitoring the systems.

Appropriate action implemented

152 Improve the effectiveness of the safety management systems on board the vessels under its management by:

- Requiring ships' crews to carry out periodic drills to practise the correct response to propulsion system failures and regularly test the associated backup control systems.
- Ensuring that all communication systems are functioning and used appropriately.

Appropriate action implemented

Wacker Quacker 1/ Cleopatra

Report number: 32/2014

Amphibious passenger vehicles

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

Combined report on the investigations of the sinking and abandonment of the DUKW amphibious passenger vehicle *Wacker Quacker 1* in Salthouse Dock, Liverpool and the fire and abandonment of the DUKW amphibious passenger vehicle *Cleopatra* on the River Thames, London

Safety Issues

- Insufficient residual buoyancy once damaged
- Confined nature of the vehicles increased risk of entrapment and hampered crew ability to assist passengers
- Passengers entered the water without lifejackets
- Poor material condition of some vessels

Nº	Recommendation to:	Maritime and Coastguard Agency and Driver and Vehicle Standards Agency

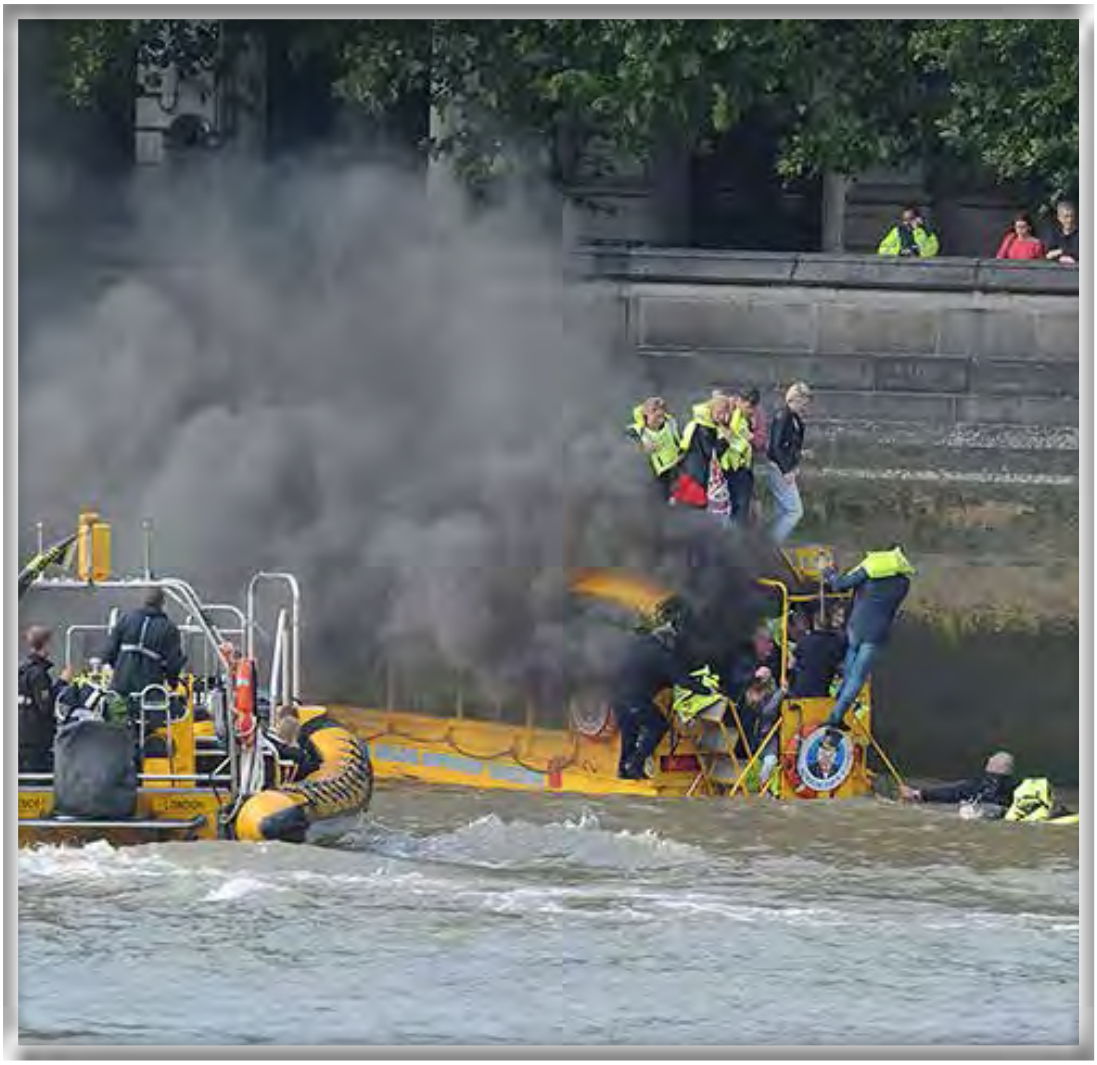
153 Identify single points of contact for amphibious vehicle issues and put processes in place to allow them to work together, in consultation with the industry, to explore potential cross agency synergies, identify regulatory conflicts and agree a coherent approach to the survey and certification of new and existing amphibious passenger vehicles.

MCA: Appropriate action planned, progress is ongoing

DVSA: Appropriate action planned, progress is ongoing

Nº	Recommendation to:	Maritime and Coastguard Agency
154	Provide amphibious vehicle survey guidance and instructions to its surveyors.	Appropriate action planned — 2016 MARCH 31
155	Work with industry to develop an amphibious vehicle operators' code of practice.	Appropriate action planned — 2016 SEPTEMBER 30
156	Ensure that measures to reduce the risk of passenger entrapment and improve the levels of passenger survivability are included in its proposed technical standard for amphibious passenger vehicles.	Appropriate action planned — 2016 MARCH 31
157	Require existing DUKW operators, which may choose to rely on the insertion of buoyancy foam to meet the required damaged survivability standards, to demonstrate through risk based analysis that the foam does not adversely affect the safe operation of the vehicles.	Appropriate action planned — 2016 SEPTEMBER 30

Nº	Recommendation to:	London Duck Tours Ltd
158	Use the safety lessons identified in this report to take further action to ensure, as far as is reasonably practicable, its vehicles, crew and passengers are best prepared to deal with emergency situations. In particular, attention should be given to: • The readiness and use of PFDs: the practicalities of the current arrangements should be reviewed and consideration given to requiring all passengers to wear PFDs whenever DUKWs are waterborne. • Establishing appropriate and achievable emergency procedures: these should include the marshalling of passengers, alerting potential responders and abandonment. • Development of effective training drills. • Engine compartment shut-down and fire-fighting. • Lowering the risk of passenger and crew entrapment: assess in particular whether the current canopy arrangements are appropriate. Appropriate action planned — Update requested NO DATE GIVEN	



Cheeki Rafiki

Issued by letter during investigation

Sailing yacht | Accident date: 16/05/2014

Loss of vessel with all crew on board in mid-Atlantic

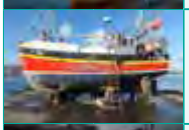
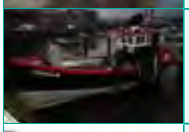
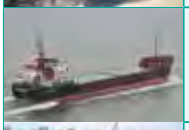
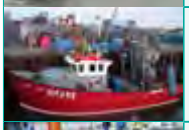
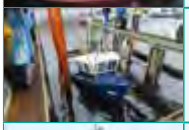
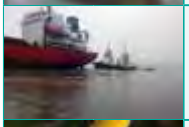
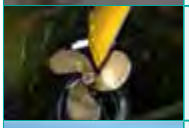
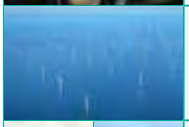
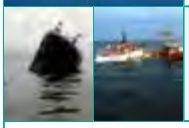
Safety Issues

- Possible matrix detachment
- Potential for grounding to cause hidden damage to vessel's structure
- Liferaft unavailable following capsize

Nº	Recommendation to:	Royal Yachting Association
159	Bring to the attention of its instructors, examiners and other members, the risk posed to yachts of keel failure as a consequence of structural weakening that can occur as a result of repeated minor groundings.	

Appropriate action implemented

PROGRESS OF RECOMMENDATIONS FROM PREVIOUS YEARS

Vessel name		Publication date	Page
2013 RECOMMENDATIONS - PROGRESS REPORT			47
	*St Amant*	9 January 2013	47
	*Heather Anne*	10 January 2013	48
	*Purbeck Isle*	2 May 2013	50
	*Carrier*	22 May 2013	50
	*Alexander Tvardovskiy /UKD Bluefin/Wilson Hawk*	31 May 2013	51
	*Sarah Jayne*	13 June 2013	51
	*Vixen*	20 June 2013	52
	*Arklow Meadow*	3 October 2013	53
	*Amber*	24 October 2013	54
	*Wacker Quacker 1 /Cleopatra* (Combined Safety Bulletin)	24 October 2013	54
	*Windcat 9/Island Panther* (Combined Report)	20 November 2013	55
	*Audacious/Chloe T* (Combined Report)	19 December 2013	55
2012 RECOMMENDATIONS - PROGRESS REPORT			56
	*Tombarra* (parts A and B)	19 July 2012	56

2013 RECOMMENDATIONS - PROGRESS REPORT

St Amant

Report number: 1/2013

Scallop dredger | Accident date: 13/01/2012

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

No	Recommendation(s) to: Maritime and Coastguard Agency
2013/102	Ensure that its current policy of reviewing and deleting exemptions granted to fishing vessels that predate current regulatory requirements is applied robustly. As part of this process, the ambiguity between its Instructions to Surveyors and the 15-24m Code regarding the ongoing acceptance of standard exemptions should be resolved. **Appropriate action planned, progress is ongoing**
2013/103	Provide guidance to the owners and skippers of fishing vessels which operate at sea for more than 24 hours on appropriate accommodation standards. The guidance should also recommend consideration of hygiene and sanitation facilities in a vessel's risk assessments, and the application of appropriate control measures. **Appropriate action planned** 
2013/105	Improve the management of fishing vessel surveys and inspections by ensuring that: • Existing survey and inspection procedures and guidance are reviewed to improve the clarity of the guidance and ensure that it is consistent throughout. • There is an effective and readily accessible system to record and provide information to surveyors on the status of all identified deficiencies. • Existing instructions requiring a photographic record of a vessel's principal features are followed. **Appropriate action planned** 

Heather Anne	Report number:	2/2013
Ring netter	Accident date:	20/12/2011

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

Nº	Recommendation(s) to: Maritime and Coastguard Agency
2013/106	Revise MGN 427 (F) in order to provide clearer and more comprehensive guidance to surveyors and fishermen on the methods available to assess small fishing vessel stability, taking into account, inter alia: • The limitations of the alternatives to a full stability assessment. • The suitability of the alternative stability assessments for small fishing vessels. • A vessel's stability is dependent on several factors including her upright GM, freeboard and hull form. • The need for skippers to be aware of the maximum loading of their vessels and the benefits of a freeboard mark. • The impact of vessel modifications. • Owners' and skippers' awareness of stability considerations while fishing. **Appropriate action planned** — 2015 JUNE 30
2013/107	Expedite its development and promulgation of alternative small fishing vessel stability standards, which will ensure that all new fishing vessels under 15m (L) are subject to appropriate stability assessments, and which will eventually be included in the standards based on the Small Commercial Vessel and Pilot Boat Code scheduled for introduction in 2016. **Appropriate action planned** — 2016 DECEMBER 31
2013/108	Specify the improvement in safety culture/behavioural change that it is seeking with respect to the voluntary wearing of personal flotation devices by individuals working on the decks of fishing vessels, and the timescale within which it is to be achieved; and Make arrangements to rapidly introduce the compulsory wearing of personal flotation devices on the working decks of fishing vessels if the sought after changes are not delivered. **Partially accepted[4]: Action planned** — 2015 JUNE 30

[4] Refer to page 18 of 2013 MAIB Annual Report for MCA and MAIB comments: www.gov.uk/government/uploads/system/uploads/attachment_data/file/359941/MAIB_Annual_Report_2013.pdf

Nº	Recommendation(s) to:	Maritime and Coastguard Agency/ Marine Management Organisation
2013/109	Work together to link the funding provided for modifications to small fishing vessels with a full assessment of the impact such modifications will have on such vessels' stability, particularly where the proposed modifications will substantially alter the method of fishing to be undertaken.	
		MCA: Appropriate action planned — 2015 JUNE 30
		MMO: Appropriate action planned — Update requested NO DATE GIVEN

MAIB comment:
The MAIB will be revisiting this recommendation as part of its investigation into the accident to *Stella Maris*.

Nº	Recommendation(s) to:	Maritime and Coastguard Agency/ Marine Management Organisation/ Cornish Fish Producers Organisation
2013/110	Work together to arrange trials of the 'Wolfson' mark on board a selection of Cornish fishing vessels under 15m (L) in order to gather sufficient data to enable the MCA to provide clear evidence on the mark's practicality, accuracy and usefulness.	
		MCA: Appropriate action planned — 2015 JUNE 30
		MMO: Appropriate action planned — Update requested NO DATE GIVEN

MAIB comment:
The MAIB will be revisiting this recommendation as part of its investigation into the accident to *Stella Maris*.

		CFPO: Appropriate action planned — Update requested NO DATE GIVEN

MAIB comment:
An update on the recommendation's progress has been requested.

Purbeck Isle

Report number: 7/2013

Fishing vessel | Accident date: 17/05/2012

Foundering of fishing vessel 9 miles south of Portland Bill, England, resulting in the loss of her three crew

Nº	Recommendation(s) to: Maritime and Coastguard Agency
2013/203	Take action to implement Recommendation 2008/173, issued in the MAIB's 1992-2006 Fishing Vessel Safety Study, specifically by: • Introducing a requirement for all fishing vessels of <15m (L) overall to carry EPIRBS. • Ensuring that the *Merchant Shipping and Fishing Vessels (Health and Safety at Work) Regulations 1997* apply in respect of all fishermen on board fishing vessels, irrespective of their contractual status. **Appropriate action planned** 
2013/204	Align its hull survey requirements for fishing vessels of <15m (L) overall with those applied to workboats under the *Harmonised Small Commercial Vessels Code*. **Appropriate action planned** 

Carrier

Report number: 8/2013

General cargo vessel | Accident date: 03/04/2012

Grounding at Raynes Jetty in Llanddulas, North Wales

Nº	Recommendation(s) to: Cemex UK Materials Ltd
117	Establish better control of maritime operations at Raynes Jetty by developing and implementing a safety management system, which incorporates logical elements of the Port Marine Safety Code, and: • Provides support to jetty staff when making effective operational decisions about berthing and loading ships safely. • Delivers advice, or access to sources of advice, about maritime operations including weather forecasting, mooring arrangements and ship manoeuvring in the vicinity of the berth. **Appropriate action implemented** 

Alexander Tvardovskiy/UKD Bluefin/Wilson Hawk

Report number: 10/2013

Dry cargo vessel/Trailing suction hopper dredger/General cargo vessel

Accident date: 01/08/2012

Collision in the port of Immingham

Nº	Recommendation(s) to:	International Chamber of Shipping
2013/211	At the next revision of its Bridge Procedures Guide, emphasise the importance of port pilots being notified of all defects which affect a vessel's manoeuvrability, and the potential consequences of failing to do so.	

Appropriate action planned — 2015 DECEMBER 31

Sarah Jayne

Report number: 13/2013

Fishing vessel

Accident date: 11/09/2012

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

Nº	Recommendation(s) to:	Maritime and Coastguard Agency
2013/213	As part of its intended development of new standards for small fishing vessels, review and include additional design and operational requirements as necessary to ensure that a vessel engaged in bulk fishing remains seaworthy throughout its intended loading procedure. Specific hazards that should be addressed include: • The increased risk of capsize from swamping if freeing ports are closed. • The risk of downflooding if flush deck scuttles and fish hold hatch covers are opened at sea.	

Appropriate action planned — 2016 DECEMBER 31

Vixen	Report number:	16/2013
Passenger ferry	Accident date:	19/09/2012

Foundering in Ardlui Marina, Loch Lomond

Nº	Recommendation(s) to:	Argyll and Bute Council
2013/215	Review and amend the requirements of its boat hire licensing scheme to: • Adopt the Inland Waters Small Passenger Boat Code as the standard applied for small passenger boats carrying fewer than 12 passengers on categorised waters. • Require such boats to be regularly surveyed by a competent person employed by a Certifying Authority or similar organisation as may be recommended by the Maritime and Coastguard Agency. **Appropriate action implemented**	

Nº	Recommendation(s) to:	Stirling Council/ West Dunbartonshire Council
2013/216	Take action to: • Establish a boat licensing system for inland waters falling under the Council's area of responsibility and which adopts the Inland Waters Small Passenger Boat Code as the standard applied for small passenger boats carrying fewer than 12 passengers on its categorised waters. • Require such boats to be regularly surveyed by a competent person employed by a Certifying Authority or similar organisation as may be recommended by the Maritime and Coastguard Agency. **Stirling Council: Appropriate action planned** 2015 AUGUST 31 **Dunbartonshire Council: Appropriate action planned** 2015 AUGUST 31	

Nº	Recommendation(s) to:	Maritime and Coastguard Agency
2013/217	Advise and work with the Argyll and Bute Council, the Stirling Council, the West Dunbartonshire Council and appropriate Certifying Authorities to: • Use the Inland Waters Small Passenger Boat Code as a basis for establishing robust licensing schemes on Loch Lomond. • Facilitate the effective survey of small passenger boats operating on Loch Lomond in accordance with the requirements of the Civic Government Act and the Inland Waters Small Passenger Boat Code. **Appropriate action planned,progress is ongoing**	

Nº	Recommendation(s) to:	Transport Scotland
2013/219	Use the lessons from this investigation to provide guidance and encouragement to councils in Scotland on the importance of establishing (where applicable) robust licensing regimes for small passenger vessels carrying fewer than 12 passengers on inland waters.	

Appropriate action implemented

Arklow Meadow

Report number: 21/2013

General cargo vessel — Accident date: 05/12/2012

Release of phosphine gas during cargo discharge, Warrenpoint, Northern Ireland

Nº	Recommendation(s) to:	Maritime and Coastguard Agency
2013/225	In consultation with the Health and Safety Executive, the Port Skills and Safety Organisation, and other industry bodies as appropriate, review, consolidate and reissue the guidance provided to UK stakeholders on the loading, carriage and discharge of fumigated cargoes to highlight the importance of: • The potential for a fumigant to remain active due to factors such as temperature, relative humidity, voyage length, and fumigant method. • The retention of suitably trained and qualified fumigators at both the load and discharge ports. • Ships' crews being aware of their responsibilities. • UK port authorities having robust procedures and contingency plans when receiving vessels with fumigated cargoes.	

Appropriate action planned, progress is ongoing

Nº	Recommendation(s) to:	UK Marine Ports Group/ British Ports Association
2013/226	Through its Marine and Pilotage Working Group, develop a revision of the Guide to Good Practice on Port Marine Operations to reflect the revised guidance to be issued by the MCA, and in the meantime ensure that ports are aware of: • The potential dangers posed by fumigants. • The importance of suitably qualified fumigators certifying, where applicable, that the cargo can be safely discharged and that all fumigant has been removed and safely disposed of. • The importance of developing procedures and emergency plans to cover the inadvertent or unexpected release of fumigant from a fumigated cargo.	

UKMPG: Appropriate action planned — 30 JUNE 2015

BPA: Appropriate action planned — 30 JUNE 2015

Amber

Report number: 22/2013

Bulk carrier | Accident date: 15/11/2012

Contact and grounding at Gravesend Reach, River Thames

Nº	Recommendation(s) to: Svitzer Marine Ltd
2013/231	Review and, where appropriate, revise the roles and responsibilities of bridge teams when its vessels are towing in restricted visibility.

Appropriate action implemented

Nº	Recommendation(s) to: International Chamber of Shipping
2013/232	Include in the review of the Bridge Procedures Guide a reference to: • The need for bridge teams to be sufficiently resourced to provide assistance to embarked pilots through the operation of the vessel's navigational equipment when required. • The need to compare the engine power of a vessel with that of the assisting tug(s), and for this to be discussed during the pilot/master exchange.

Appropriate action planned — 2015 DECEMBER 31

Wacker Quacker 1/Cleopatra

Safety Bulletin number: 3/2013

Amphibious passenger vehicles | Accident dates: 15/06/2013 & 29/09/2013

Sinking of DUKW amphibious vehicle *Wacker Quacker 1* in Salthouse Dock, Liverpool on 15 June 2013

◀▶

Fire on board DUKW amphibious vehicle *Cleopatra* on the River Thames, London on 29 September 2013

Nº	Recommendation(s) to: Maritime and Coastguard Agency
2013/221	Require operators of DUKW passenger vessels in the UK to demonstrate that they are able to provide 110% effective residual intact buoyancy in their vessels, and where buoyancy foam is fitted for this purpose, the quantity installed is measured by volume and the foam does not impede the operation or maintenance of key equipment.[5]

Appropriate action implemented

S2013/233	In addressing recommendation 2013/221, ensure that the means used by DUKW operators to achieve the required standard of buoyancy and stability for their vessels does not adversely impact on their safe operation. Furthermore, these vessels should not be permitted to operate until satisfactory levels of safety can be assured under all feasible operating conditions.

Appropriate action implemented

[5] Recommendation 2013/221 issued prior to the publication of Safety Bulletin 3/2013 through a Chief Inspector letter to the MCA on 5 August 2013.

Windcat 9/Island Panther

	Report number:	**23/2013**
Catamarans	Accident date	21/11/2012[6]

Contact with a floating target by wind farm passenger transfer catamaran *Windcat 9* while transiting Donna Nook Air Weapons Range in the south-west approaches to the River Humber

◀▶

Contact of *Island Panther* with turbine I-6, in Sheringham Shoal Wind Farm

No	Recommendation(s) to:	National Workboat Association/ International Marine Contractors Association
2013/240	Review, develop and expand the National Workboat Association's *Best Practice Guide for Offshore Energy Service Crews*. In addition, develop a complementary document providing operational best practice guidance, specifically directed towards owners and managers of offshore renewable energy passenger transfer vessels.	

NWA: Appropriate action implemented

IMCA: Appropriate action implemented

Audacious/Chloe T

	Report[7] number:	**27/2013**
Fishing vessels	Accident dates:	10/8/2012 & 01/09 2012

Flooding and foundering of fishing vessel *Audacious* 45 miles east of Aberdeen on 10 August 2012

◀▶

Flooding and foundering of fishing vessel *Chloe T* 17 miles south west of Bolt Head, Devon on 1 September 2012

No	Recommendation(s) to:	Maritime and Coastguard Agency
2013/249	Review the conduct of its surveys and inspections of fishing vessels in order to ensure that: • The scope is credible and that it can be achieved in practice. • The whole scope is routinely applied. • Records are accurate and complete.	

Appropriate action planned, progress is ongoing

Note:
MCA will conduct a review in September 2015.

2013/250	Implement a robust system to manage the scheduling of surveys and inspections on fishing vessels. Such a system should be capable of readily identifying vessels that are overdue for any surveys or inspections.

Appropriate action planned, progress is ongoing

Note:
MCA will conduct a review in September 2015.

[6] Both contacts occurred on 21 November 2012.

[7] Due to similiarities between the accidents MAIB took the decision to publish its findings as a combined report.

2012 RECOMMENDATIONS - PROGRESS REPORT

Tombarra

Report number: 19A ◊ 19B/2012

Car carrier | Accident date: 07/02/2011

Fatality to a rescue boat crewman, Royal Portbury Docks, Bristol

Report Part B - The failure of the fall wire

Nº	Recommendation(s) to: Maritime and Coastguard Agency
2012/135	Submit to the IMO proposals to amend MSC.1/Circ.1206/Rev.1 designed to require the annual weighing of rescue boats and lifeboats which use buoyancy foam within internal spaces, as soon as practicable. **Appropriate action planned** 2015 DECEMBER 31
2012/134	Submit to the IMO proposals to amend the LSA Code designed to: • Ensure any water entering foam-filled buoyancy chambers within the enclosed hulls of rescue boats and lifeboats can be easily removed. • Require the actual weight of the rescue boat or lifeboat supplied to the vessel, rather than its prototype, to be provided in its certification. **Appropriate action planned** 2015 SEPTEMBER 30

Report Part A - The weight of the rescue boat

Nº	Recommendation(s) to: Maritime and Coastguard Agency
2012/129	Submit to the IMO a proposal to mandate a maximum height of the davit head used in conjunction with rescue boats and survival craft fitted on board both cargo and passenger ships, based upon: • Recognition of the severe difficulties faced by the crews of high-sided vessels such as *Tombarra* when attempting to launch rescue boats in a seaway. • The increased hazards to which the crews of rescue boats and survival craft are exposed when operating at height. • The action taken by Wilhelmsen Lines Car Carriers Ltd to change the design of its future vessels to lower the height of the rescue boat davit head. • The maximum height of davit heads used in conjunction with survival craft already recommended for passenger vessels in SOLAS III/24; and, • The guidance provided in MSC Circ 1094 regarding the height of davit heads used for fast rescue boats on board passenger ships. **Appropriate action planned, progress is ongoing**

2012/128	Submit to the IMO proposals for the LSA Code to: • Reflect a requirement for a 'system approach' to davit and winch installations with the aim of eliminating the possibility of any component being overstressed to the point of failure. • Provide clarification on the fitting and use of 'safety devices' on davit and winch systems, using a goal-based approach to their application. Appropriate action planned 2015 JUNE 30

MCA comment:
MCA is attempting to push for a "system approach" to the design of these items within the IMO work item on the development of a new framework for safety objectives and functional requirements for the approval of alternative design arrangements and is developing goal-based guidelines on a framework of requirements for ships' life-saving appliances and also through the IMO review of SOLAS Chapter III.

Karin Schepers

Report number		**10/2012**
Container vessel	Accident date:	03/08/2011

Grounding at Pendeen, Cornwall, UK

Nº	Recommendation(s) to: Maritime and Coastguard Agency
2012/115	Assess the desirability of, and, where appropriate, develop operational guidelines for using Automatic Identification Systems (AIS) data to monitor marine traffic movements. Special consideration should be given to using AIS data to monitor marine traffic movement in areas of high traffic concentrations, including traffic separation schemes, where there is limited or no radar coverage. Appropriate action planned 2015 DECEMBER 31

2011 RECOMMENDATIONS - PROGRESS REPORT

Princes Club

Report number: 11/2011

Inflatable banana boat | Accident date: 11/09/2010

Fatal accident at Princes Club Water Sports Park in Bedfont, Middlesex

Nº	Recommendation(s) to: Maritime and Coastguard Agency
2011/121	Take appropriate action to improve the safety of towed inflatable rides by: • Considering the British Water Ski and Wakeboard Club Driver's Award as a standard for commercially operating boats towing inflatables, and including it in the list of suitable alternative qualifications to the Boatmaster's Licence. • At its next review, amending the '*Inland Waters Small Passenger Boat Code*' Annex 5, so that the guidance is relevant to boats operating on inland waters and not just beachcraft. **Appropriate action implemented**

Nº	Recommendation(s) to: Health and Safety Executive
2011/120	Include oversight of the activity of riding on towed inflatables into the arrangements that are currently being considered to replace the Adventure Activities Licensing Authority. **Appropriate action planned, progress is ongoing**

Delta 8.5m RIB

Report number: 1/2011

Rigid-hulled inflatable boat | Accident date: 5/6/2010

Injury to a passenger on the River Thames, London

Nº	Recommendation(s) to: Maritime and Coastguard Agency
2011/101	Prioritise and resource the revision of MGN 280 to ensure the updated code of practice for small commercial vessels is published as early as is possible. **Appropriate action planned, progress is ongoing**

Note:
The Maritime and Coastguard Agency will review the progress of this recommendation in October 2015.

2010 RECOMMENDATIONS - PROGRESS REPORT

Olivia Jean

	Report number:	**10/2010**
Fishing vessel	Accident date:	10/10/2009

Injury to fisherman

Nº	Recommendation(s) to:	Maritime and Coastguard Agency
2010/123	Consider the findings of this investigation when assisting the Department for Transport to address MAIB Recommendation 2010/112, including the need to improve fishing vessel standards and occupational safety by: • Reviewing the application of LOLER, PUWER, risk assessment and working time regulations on board fishing vessels to ensure that they are suitable for the task of improving safety and reducing accidents; and, • Providing clear and robust guidance to its surveyors and the fishing industry at large. • Ensuring that accurate records are maintained such that surveyors are provided with the information required to survey fishing vessels effectively. • Improving its recording of accidents on vessels' SIAS records to identify trends and act upon them. Appropriate action planned 	

Bro Arthur

	Report number:	**9/2010**
Oil/chemical tanker	Accident date:	19/02/2010

Fatality of a shore worker in No 2 cargo tank while alongside at Cargill Terminal, Hamburg

Nº	Recommendation(s) to:	International Chamber of Shipping
2010/120	Include guidance on the following in the respective International Chamber of Shipping publications during their next periodic review: • TSGC - Management of contractors and sub-contractors with emphasis on the master's and other officers' and crew members' related health and safety responsibilities. • TSGC and ISGOTT - The need for the provision of lightweight, portable casualty recovery equipment suitable for recovery from deep cargo tanks and for the crew to be fully trained in its use. Appropriate action planned 	

Nº	Recommendation(s) to:	Maritime and Coastguard Agency
2010/119	Provide additional guidance on the following: • Management of contractors and sub-contractors with emphasis on the master's and other officers' and crew members' related health and safety responsibilities. • The need for the provision of lightweight, portable casualty recovery equipment suitable for recovery from deep cargo tanks, and for the crew to be fully trained in its use.	

Appropriate action planned

2015 SEPTEMBER 30

Korenbloem/Optik/Osprey III

(Combined) Report number: 6/2010

Fishing vessels | Accident dates: November 2009

Fatal manoverboard accidents

Nº	Recommendation(s) to:	Department for Transport
2010/112	Recognise the consistent and disproportionate rate of fatalities in the UK fishing industry and take urgent action to develop a comprehensive, timely and properly resourced plan to reduce that rate to a level commensurate with other UK occupations.	

Appropriate action planned, progress is ongoing

DfT comment:
A 10 year strategy for improving safety was approved by the Minister in 2013. Maritime and Coastguard Agency are progressing with implementing the strategy with a number of significant initiatives ongoing. The Fishing Industry Safety Group (FISG) has been reorganised to concentrate on specific projects, involving joint partnership working, aimed at improving fishing safety. The reorganised FISG group has met twice in the past year and its sub-groups have been tasking project groups as well as identifying projects to move forward with in 2015/16.

2009 RECOMMENDATIONS - PROGRESS REPORT

Abigail H

Report number: 15/2009

Grab hopper dredger | Accident date: 02/11/2008

Flooding and foundering in the Port of Heysham

Nº	Recommendation(s) to: Maritime and Coastguard Agency
2009/141	Introduce a mandatory requirement, for all vessels greater than 24m length and less than 500 gross tons, for the fitting of bilge alarms in engine rooms and other substantial compartments that could threaten the vessel's buoyancy and stability if flooded. These, and any other emergency alarms should sound in all accommodation spaces when the central control station is unmanned. In addition to functioning in the vessel's normal operational modes, alarms should be capable of operating when main power supplies are shut down, and be able to wake sleeping crew in sufficient time for them to react appropriately.

Appropriate action planned — 2018 SEPTEMBER 30

Celtic Pioneer

Report number:	**11/2009**	
Rigid-hulled Inflatable Boat	Accident date:	26/08/2008

Injury to a passenger on board RIB in the Bristol Channel

Nº	Recommendation(s) to:	Local Authorities Co-Ordinators of Regulatory Service / Institute of Licensing
2009/128	When available, promulgate the approved code of practice for thrill-type boat operators, and strongly encourage local authorities within the United Kingdom to require operators to adhere to the code as a condition of licensing.	

LACORS: Appropriate action planned

MAIB Comment:
The approved Code of Practice for thrill-type boat operators has been published. However, a response from LACORS to recommendation 2009/128 is still awaited.

Nº	Recommendation(s) to:	Maritime and Coastguard Agency
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, progress is ongoing

Note:
The Maritime and Coastguard Agency will review the progress of this recommendation in October 2015.

Fishing Vessel Safety Study

Fishing vessels | Accident dates: 1992 to 2006

Analysis of UK Fishing Vessel Safety 1992 to 2006

Nº	Recommendation(s) to:	Maritime and Coastguard Agency
2008/177	Review the current requirements for safety training with particular reference to training assessment and refresher training.	

Appropriate action planned

Nº	Recommendation(s) to:	Department for Transport
2008/175	Work closely together and with fishing industry safety representatives, to ensure pragmatic safety concerns are integrated into conservation policy measures.	

Appropriate action planned

Nº	Recommendation(s) to:	Department for Transport/ Maritime and Coastguard Agency
2008/174	Agree the coherent resourced plan for reducing the fatality rate in the fishing industry (see recommendation 2008/173).	

DfT: Appropriate action planned, progress is ongoing

MCA: Appropriate action planned

Note:
For DfT comment refer to statement under recommendation 2010/112 on page 60.

Nº	Recommendation(s) to:	Maritime and Coastguard Agency
2008/173	In developing its plan to address the unacceptably high fatality rate in the fishing industry, identified in its study of statistics for the years 1996 to 2005, in addition to delivering the actions outlined at 6.2, the MCA is recommended to consider the findings of this safety study, and in particular to: • Clarify the requirement for risk assessments to include risks which imperil the vessel such as: environmental hazards; condition of the vessel; stability etc. • Work towards progressively aligning the requirements of the *Small Fishing Vessel Code*, with the higher safety standards applicable under the Workboat Code. • Clarify the requirements of *The Merchant Shipping and Fishing Vessels (Health and Safety at Work) Regulations 1997* to ensure that they apply in respect of all fishermen on board fishing vessels, irrespective of their contractual status. • Ensure that the current mandatory training requirements for fishermen are strictly applied. • Introduce a requirement for under 15m vessels to carry EPIRBs. • Review international safety initiatives and transfer best practice to the UK fishing industry with particular reference to the use of PFDs and Personal Locator Beacons. • Conduct research on the apparent improvement in safety in other hazardous industry sectors, such as agriculture, construction and offshore, with the objective of identifying and transferring best safety practice from those industries to the fishing industry. **Appropriate action planned** 2016 DECEMBER 31	

MSC Napoli

Report number:	**9/2008**	
Container vessel	Accident date:	18/01/2007

Structural failure

Nº	Recommendation(s) to: International Association of Classification Societies
2008/130	Research and review the technological aids available which would assist masters to measure hull stresses in port and at sea.
	Appropriate action planned — 2016 JUNE 30
2008/128	Review the contents of UR S11 (Longitudinal Strength Standard) to ensure: • Hull girder strength and buckling checks are carried out on all critical sections along the entire length of the hull. • An evaluation of the suitability of current UR S11 design wave bending moment criteria for vessels with low block coefficient is undertaken. • Member societies use common methodologies when complying with the requirements of this rule.
	Appropriate action planned — 2016 JUNE 30

2007 RECOMMENDATIONS - PROGRESS REPORT

Thunder

	Report number:	**12/2007**
General cargo	Accident date:	10/08/2006

Grounding at the approaches to the Dee Estuary

Nº	**Recommendation(s) to:**	**Department for Transport**
2007/144	In considering his decisions on the Harbour Revision Orders submitted by the Environment Agency and Mostyn Docks Limited, take into account the need to clarify the status of the Mostyn Outer Channel, such that the responsible authority has the necessary powers to ensure the safety of navigation in the channel.	

Appropriate action planned — 2015 SEPTEMBER 30

DfT comment:
The decision letter on the respective harbour revision orders for the Dee Conservancy and the Mostyn Docks Ltd was issued on 15 December 2014. It concluded that Mostyn Docks Ltd should be the competent harbour authority for the whole of the Outer Channel and the Statutory Harbour Authority for that part which is outside the jurisdiction of the Dee Conservancy. The Orders will be made in accordance with this decision by Summer 2015.

Danielle

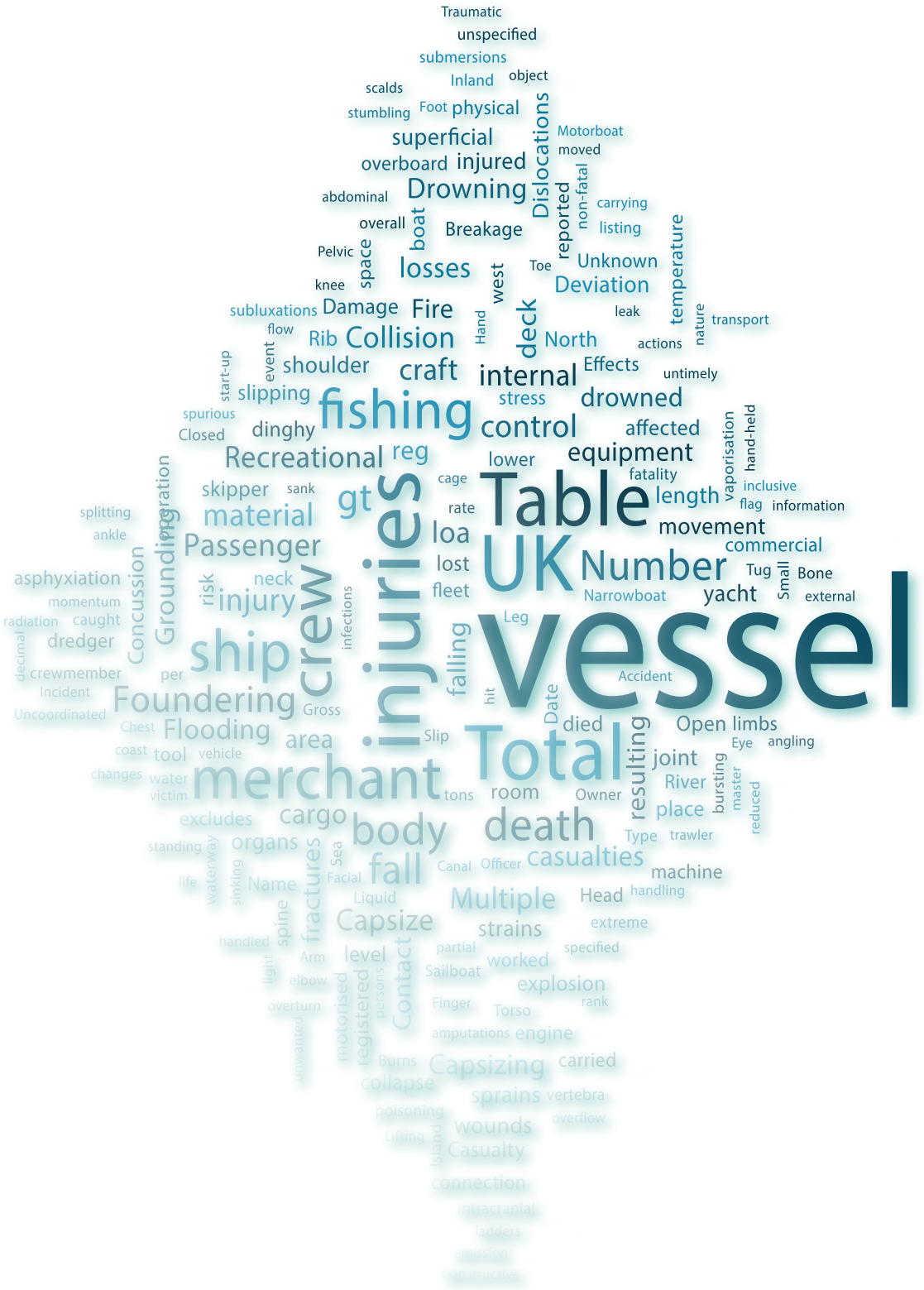
	Report number:	**5/2007**
Scallop dcredger	Accident date:	06/06/2006

Major injuries sustained by a deckhand

Nº	**Recommendation(s) to:**	**Maritime and Coastguard Agency**
2007/119	Amplify and expand on current advice contained in MSN 1768 (M&F) such that fishermen are reminded: • Medical scale requirements provide the minimum levels of medical stores only. Additional stores may be provided at the skipper's/owner's discretion. Such advice should also specify the need for skippers to consider the level of additional medical stores carried on individual vessels as part of the statutory risk assessment process.	

Partially accepted: action planned — 2016 JUNE 30

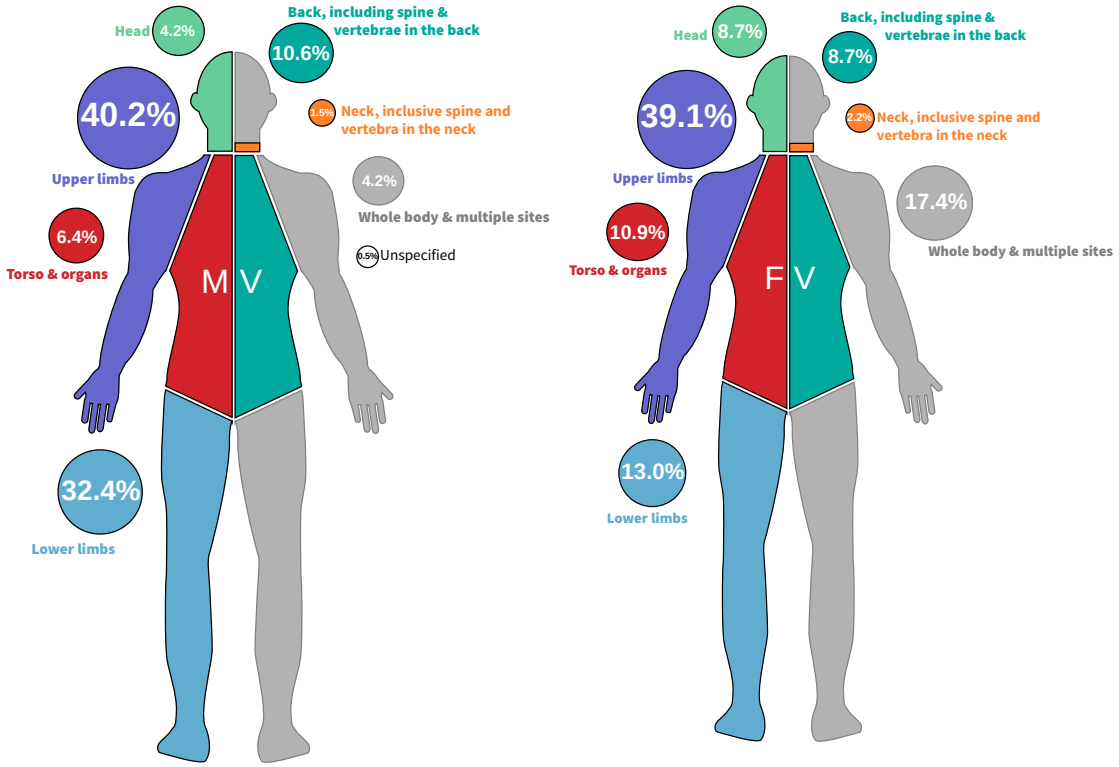
PART 3: STATISTICS



STATISTICS - TABLE OF CONTENTS

For details of reporting requirements and terms used in this section please see Annex - Statistics Coverage on page 90 and Glossary on page 91.

Deaths and Injuries of Merchant Vessel and Fishing Vessel Crew by Part of Body Injured



Go to Table 8 (page 75) and Table 20 (page 85) for further details

UK VESSELS: ACCIDENTS INVOLVING LOSS OF LIFE

Table 1: Loss of life in 2014

Date	Name of vessel	Type of vessel	Location	Accident
Merchant vessels 100gt and over				
7 Aug	*Sapphire Princess*	Passenger ship	East China Sea	Passenger drowned while in swimming pool
Merchant vessels under 100gt				
13 Aug	*GPS Battler*	Tug	Off Almeria, Spain	Tug master drowned following capsize of dinghy being used as tender
Fishing vessels				
15 Jan	*Eshcol*	Scallop dredger	Alongside at Whitby, North Yorkshire	Two crewmembers died from carbon monoxide poisoning while they slept
25 Mar	*Diamond*	Scallop dredger	West Burra Firth, Shetland Islands	Crewman drowned after vessel sank having hit rocks
31 Mar	*Ronan Orla*	Scallop dredger	Off Lleyn peninsula, North Wales	Single-handed skipper died after becoming caught in hauling winch drum
13 May	*Barnacle III*	Creeler	Off Tanera Beg, west coast of Scotland	Crew member dragged overboard and drowned while shooting creels
2 Nov	*Ocean Way*	Stern trawler	North Sea	The skipper and two crewmembers died after the vessel capsized and sank while on passage
Recreational craft				
3 Jan	*Samara*	Narrowboat	Oxford Canal, Banbury	Owner died from carbon monoxide poisoning caused by portable generator
19 Jan	*Abacora*	Angling boat	Egilsay, Orkney Islands	Owner drowned after falling between boat and pontoon
9 Feb	-	Kayak	River Usk, Wales	Capsize and drowning
10 Mar	-	Bayliner Capri 2000 speedboat	Off Lowestoft	Loss of three lives following the capsize of the vessel
18 Apr	*Rosie*	Small angling boat	River Taw near Appledore, North Devon	Capsize resulting in one fatality
11 May	-	Kayaks	River Tyne near Corbridge, Northumberland	Three drownings following capsizes in extreme conditions
16 May	*Cheeki Rafiki*	Sailing yacht	North Atlantic	Capsize following keel detachment resulting in four fatalities
16 May	-	Small aluminium dinghy with outboard	River Erne, N.Ireland	Capsize of dinghy with six people onboard resulting in one fatality

Date	Name of vessel	Type of vessel	Location	Accident
Recreational craft continued				
17 May	-	Small RIB	Near Gometra, off Mull, west coast of Scotland	Boat owner died after entering the water when the engine failed
20 May	*Razz*	Narrowboat	Harecastle Tunnel, Trent and Mersey Canal, Kidsgrove, Staffordshire	Skipper drowned after falling overboard
8 June	*Orca*	Sailing yacht	Approaches to Harwich	Wife of skipper drowned following collision with dredger and sinking of yacht
11 Aug	*Remi*	Sailing yacht	The Solent, west of Cowes	Fatal head injuries to a crewmember when hit by the boom during uncontrolled gybe
20 Aug	-	Sailing dinghy	Newport Bay, Pembrokeshire	Capsize with three people on board resulting in one fatality
18 Sep	*Tabasco II*	Sailing yacht	La Paz, Mexico	Sinking of vessel during hurricane resulting in two fatalities of UK nationals
3 Oct	-	Catamaran sailing dinghy	Stewartby Lake, Bedfordshire	Capsize resulting in the death of the singlehanded sailor
9 Nov	*Stefefree*	Motor yacht	Near Brighton Marina	Vessel found drifting, skipper missing

UK MERCHANT VESSELS >= 100GT

Table 2: Merchant vessel total losses

There were no losses of UK merchant vessels reported to MAIB in 2014.

Table 3: Merchant vessel losses — 2004-2014

	Number lost	UK fleet size	Gross tons lost
2004	2	1406	832
2005	6	1443	1579
2006	-	1480	-
2007	5	1518	54304
2008	2	1578	645
2009	1	1564	274
2010	-	1520	-
2011	-	1521	-
2012	-	1450	-
2013	-	1392	-
2014	-	**1361**	-

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

	Solid cargo	Liquid cargo	Passenger	Service ship	Commercial recreational	Total
Collision	8	2	9	23	-	**42**
Contact	3	1	8	10	-	**22**
Damage to ship or equipment	2	-	5	2	-	**9**
Fire/explosion	-	-	1	2	-	**3**
Flooding/foundering	1	-	-	-	-	**1**
Grounding	9	2	7	5	-	**23**
Loss of control	3	3	5	8	1	**20**
Total	**26**	**8**	**35**	**50**	**1**	**120**

❶ Vessel groups include vessels operating on inland waterways.
Note: 120 Casualties represents a rate of 88 Casualties per 1 000 vessels on the UK Fleet.

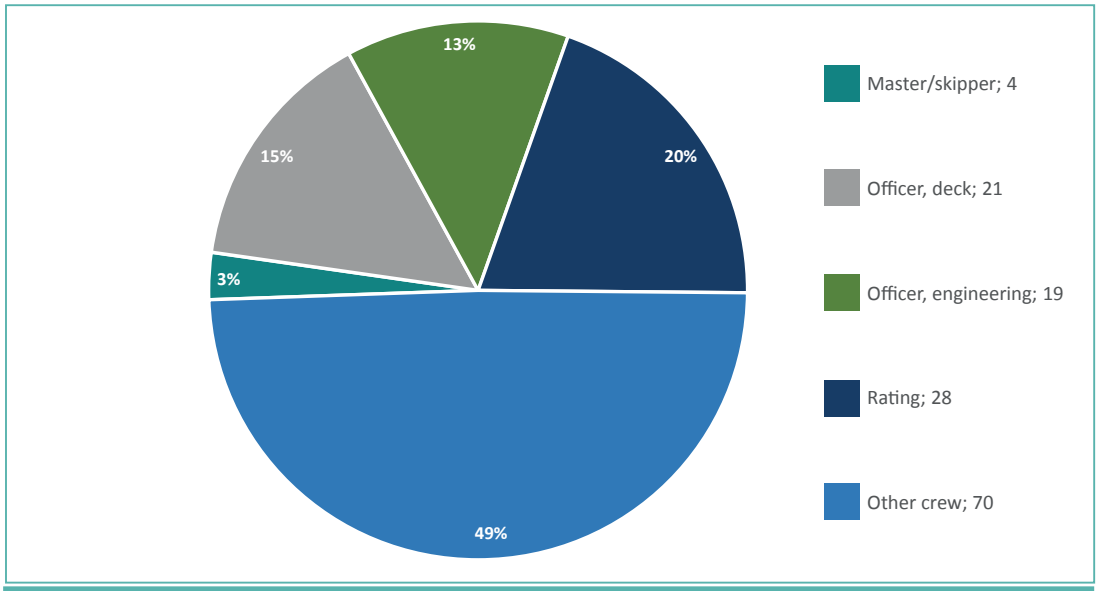
Table 5: Deaths and injuries to merchant vessel crew — 2004-2014❷

	Crew injured	Of which resulted in death
2004	310	4
2005	246	2
2006	233	3
2007	243	12
2008	224	5
2009	199	6
2010	222	3
2011	185	5
2012	186	3
2013	134	1
2014	**142**	-

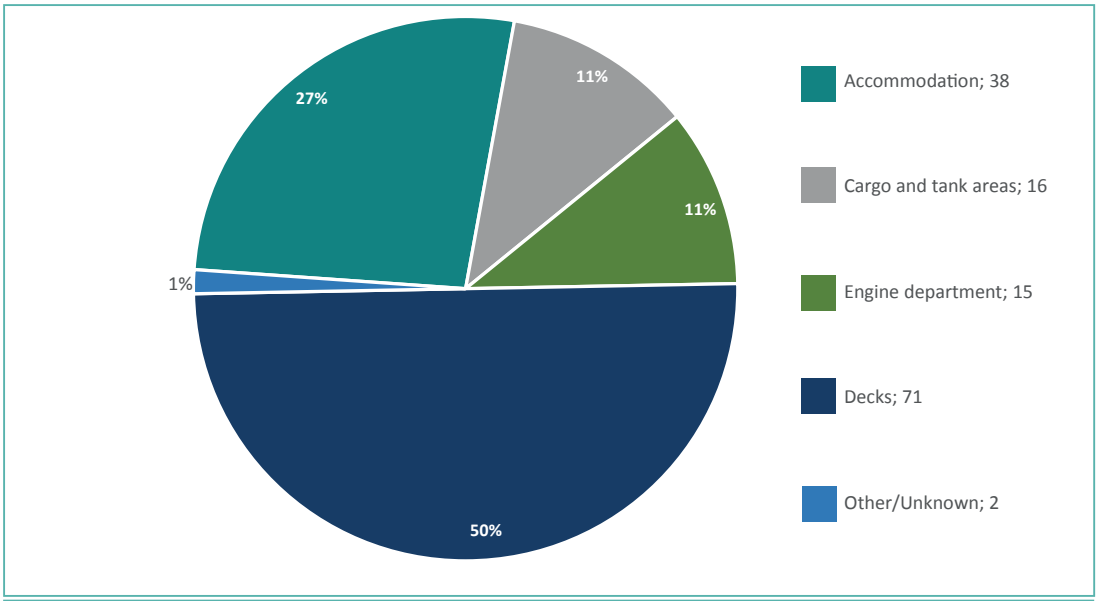
❷ From 2012 this table excludes injuries/fatalities that were not in connection with the operation of a ship

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

Rank/specialism	Number of crew
Master/skipper	4
Officer, deck	21
Officer, engineering	19
Rating	28
Other crew	70
Total	**142**



Deaths and injuries of merchant vessel crew by rank



Deaths and injuries of merchant vessel crew by place

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

Place		Number of crew
Accommodation	Bathroom, shower, toilet	1
	Cabin space - crew	8
	Corridor	1
	Galley spaces	9
	Gymnasium	3
	Mess room, dayroom	1
	Provision room	2
	Restaurant/bar	2
	Stairway/ladders	6
	Theatre	2
	Other	3
Cargo & tank areas	Cargo hold	2
	Open deck cargo space	3
	Ro-Ro vehicle deck ramp	4
	Vehicle cargo space	7
Engine department	Auxiliary engine room	1
	Boiler room	3
	Engine room	7
	Workshop/stores	3
	Other	1

Place		Number of crew
Ship	Boat deck	23
	Forecastle deck	6
	Freeboard deck	12
	Gangway	5
	Over side	4
	Poop deck	5
	Stairs/ladders	9
	Superstructure deck	1
	Other	5
Ashore (during access)		1
Unknown		2
Total		**142**

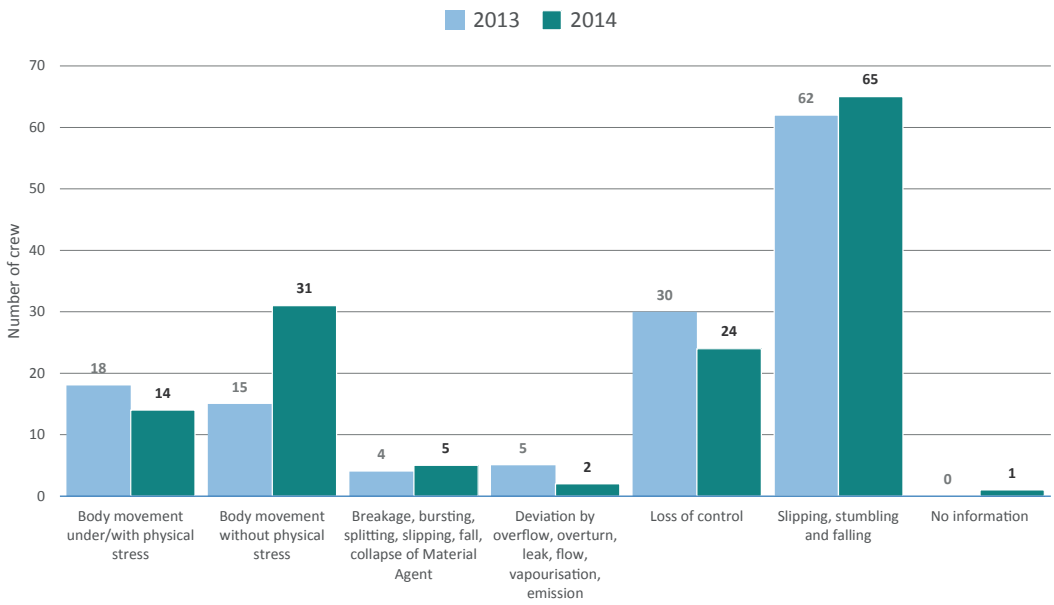
Table 8: Deaths and injuries of merchant vessel crew by part of body injured

Part of body injured		Number of crew
Whole body and multiple sites	Whole body	2
	Multiple sites	4
Head	Eye(s)	1
	Facial area	3
	Brain and cranial nerves and vessels	2
Neck, inclusive spine and vertebra in the neck		2
Upper limbs	Arm, including elbow	7
	Finger(s)	19
	Hand	16
	Shoulder and shoulder joints	10
	Wrist	4
	Multiple sites affected	1
Back, including spine and vertebrae in the back		15
Torso and organs	Chest area including organs	2
	Pelvic and abdominal area including organs	3
	Rib cage, ribs including joints and shoulder blade	4
Lower limbs	Ankle	11
	Foot	10
	Leg, including knee	20
	Toe(s)	4
	Multiple sites affected	1
Not specified		1
Total		**142**

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

Deviation*		Number of crew
Body movement under or with physical stress (generally leading to an internal injury)	Lifting, carrying, standing up	5
	Treading badly, twisting leg or ankle, slipping without falling	7
	Other	2
Body movement without any physical stress (generally leading to an external injury)	Being caught or carried away, by something or by momentum	21
	Uncoordinated movements, spurious or untimely actions	6
	Other	4
Breakage, bursting, splitting, slipping, fall, collapse of Material Agent	Breakage of material - at joint, at seams	1
	Breakage, bursting - causing splinters (wood, glass, metal, stone, plastic, others)	2
	Slip, fall, collapse of Material Agent* - from above (falling on the victim)	2
Deviation by overflow, overturn, leak, flow, vaporisation, emission	Liquid state - leaking, oozing, flowing, splashing, spraying	2
Loss of control (total or partial)	Of hand-held tool (motorised or not) or of the material being worked by the tool	2
	Of machine (including unwanted start-up) or of the material being worked by the machine	6
	Of means of transport or handling equipment, (motorised or not)	4
	Of object (being carried, moved, handled, etc.)	12
Slipping - stumbling and falling - fall of persons	Fall of person - to a lower level	27
	Fall overboard of person	3
	Fall of person - on the same level	34
	Fall of person - other	1
	No information	1
	Total	**142**

*See "Terms" on page 92



Deaths and injuries of merchant vessel crew by deviation

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

Main injury		Number of crew
Drowning and asphyxiation	Drowning and non-fatal submersions	1
Bone fractures	Closed fractures	46
Burns, scalds and frostbites	Burns and scalds (thermal)	5
	Chemical burns (corrosions)	1
Concussion and internal injuries	Concussion and intracranial injuries	2
	Internal injuries	8
Dislocations, sprains and strains	Dislocations and subluxations*	3
	Sprains and strains	30
Effects of temperature extremes, light and radiation	Effects of reduced temperature	1
Poisonings and infections	Acute infections	1
Wounds and superficial injuries	Open wounds	12
	Superficial injuries*	26
Traumatic amputations (Loss of body parts)		1
Other specified injuries not included under other headings		1
Unknown or unspecified		4
Total		**142**

*See "Terms" on page 92

Table 11: Deaths and injuries to passengers — 2004-2014❸❹

	Number of passengers	Of which resulting in death
2004	147	-
2005	110	1
2006	114	1
2007	106	-
2008	170	2
2009	115	1
2010	92	2
2011	109	1
2012	50	-
2013	46	-
2014	**56**	**1**

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

Table 12: Deaths and injuries of passengers by injury

Main injury		Number of passengers
Drowning and asphyxiation	Drowning and non-fatal submersions	1
Bone fractures	Closed fractures	32
	Open fractures	2
Concussion and internal injuries	Concussion and intracranial injuries	1
Dislocations, sprains and strains	Dislocations and subluxations*	5
	Sprains and strains	2
Wounds and superficial injuries	Open wounds	6
	Superficial injuries	1
	Unknown or unspecified	6
	Total	**56**

*See "Terms" on page 92

UK MERCHANT VESSELS < 100GT

Table 13: Merchant vessels < 100gt - losses

Date	Name Of vessel	Type of vessel	loa	Casualty event
14 Jan	*ECC Topaz*	Passenger | Windfarm transfer	14m	Fire

Table 14: Merchant vessels < 100gt

	Inland waterway vessel	Passenger ship	Recreational craft | Sailboat	Recreational craft | Other	Service ship | Offshore	Service ship | Special purpose ship	Service ship | Tug (Towing/Pushing)	Service ship | SAR craft	Service ship | Other	Total
Capsizing/listing	1	-	1	-	-	1	-	-	-	**3**
Collision	7	-	80	5	-	3	2	-	-	**97**
Contact	1	-	-	1	-	2	-	1	-	**5**
Damage to ship or equipment	-	1	3	-	1	1	-	-	-	**6**
Fire/explosion	-	1	1	-	-	2	-	-	-	**4**
Flooding/foundering	1	-	-	2	-	2	1	-	-	**6**
Grounding	5	1	9	4	-	5		2	1	**27**
Loss of control	1	2	6	6	-	7	2	-	2	**26**
Total casualties	**16**	**5**	**100**	**18**	**1**	**23**	**5**	**3**	**3**	**174**
Deaths	-	-	4	-	-	-	1	-	-	**5**
Injuries	13	-	18	3	2	15	4	5	1	**61**

UK FISHING VESSELS

There were 5 715 UK registered fishing vessels at the end of 2014. During 2014, 153 casualties to vessels involving these vessels were reported to the MAIB. Figures in the following tables show casualties to vessels and injuries involving UK registered vessels that were reported to the MAIB in 2014.

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

Table 15: Fishing vessel total losses

	Date	Name of vessel	Age	Gross tons	Casualty event
Under 15m length overall (loa)					
	18 Jan	*Rachael Jayne IV*	34	29.44	Flooding
	25 Mar	*Diamond*	52	16.50	Foundering
*	16 Jun	*Loyal Friend*	49	15.81	Flooding
	19 Jun	*Sea Spray*	25	1.16	Foundering
	10 Jul	*Sulaire*	25	1.15	Capsizing
	23 Jul	*Osprey*	49	21.24	Foundering
	28 Jul	*Stella Maris*	15	12.08	Capsizing
	22 Aug	*Island - Princess*	22	2.98	Capsizing
	20 Nov	*Tussan*	44	8.96	Foundering
15m length overall - under 24m registered length (reg)					
	22 Jan	*Karen*	53	50.00	Collision
*	30 Apr	*Shalimar*	29	168.00	Contact
*	02 Nov	*Ocean Way*	40	80.00	Foundering

* Constructive total loss

Table 16: Fishing vessel losses — 2004-2014❺

	Under 15m loa	15m loa to <24m reg	24m reg and over	Total lost	UK registered	% lost
2004	16	9	-	25	6 693	0.37
2005	20	11	3	34	6 314	0.54
2006	11	7	1	19	6 346	0.30
2007	16	5	-	21	6 330	0.33
2008	14	4	3	21	6 763	0.31
2009	11	4	-	15	6 222	0.24
2010	11	3	-	14	5 902	0.24
2011	17	7	-	24	5 974	0.40
2012	5	4	-	9	5 834	0.15
2013	15	3	-	18	5 774	0.31
2014	**9**	**3**	**-**	**12**	**5 715**	**0.21**

❺ From 2012 this table excludes losses that were not in connection with the operation of a ship.

Table 17: Casualties to fishing vessels

	Number of vessels involved	Incident rate per 1 000 vessels at risk (to one decimal place)
Capsizing/listing	3	0.5
Collision	14	2.4
Contact	3	0.5
Damage to ship or equipment	3	0.5
Fire/explosion	1	0.2
Flooding/foundering	15	2.6
Grounding	13	2.3
Loss of control	101	17.7
Total	**153**	**26.8***

*Figure adjusted to properly reflect fleet size (153/5715 vessels)

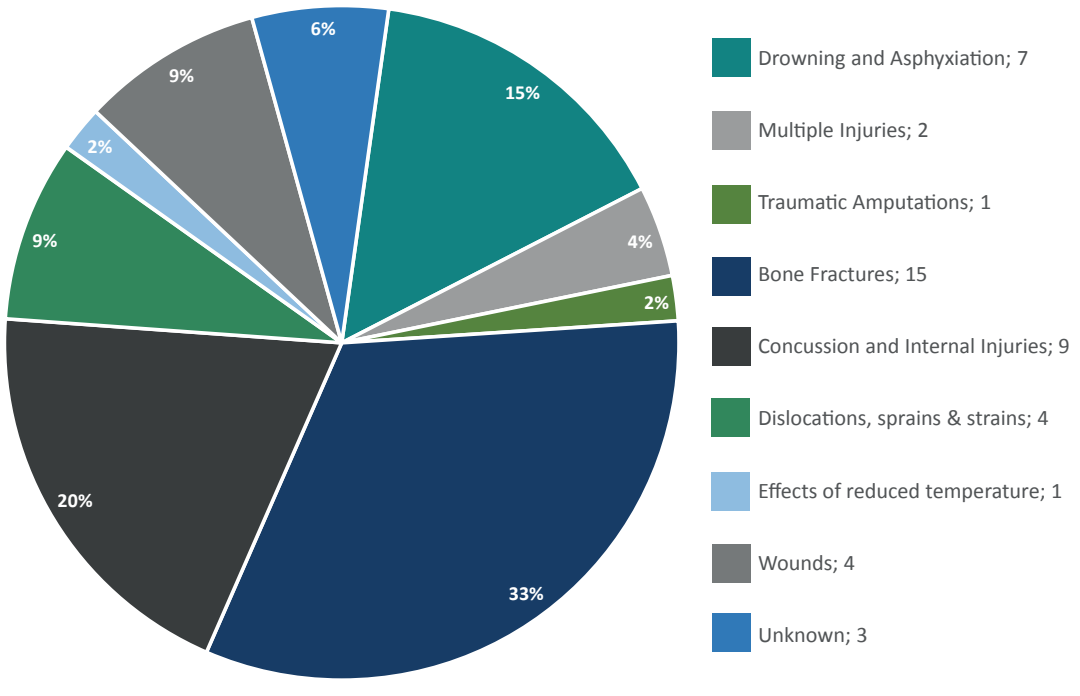
Table 18: Fishing vessels in casualties — by nature of casualty

	Number of vessels involved	Incident rate per 1 000 vessels at risk (to one decimal place)
Under 15m length overall (loa) — vessels at risk: 5 067		
Capsizing/listing	3	0.6
Collision	8	1.6
Contact	1	0.2
Damage to ship or equipment	3	0.6
Flooding/Foundering	11	2.2
Grounding	8	1.6
Loss of control	82	16.2
Total	**116**	**22.9***
15m loa - 24m registered length (reg) — vessels at risk: 495		
Collision	4	8.1
Contact	2	4.0
Fire/Explosion	1	2.0
Flooding/Foundering	4	8.1
Grounding	3	6.1
Loss of control	17	34.3
Total	**31**	**62.6**
24m reg and over — vessels at risk: 153		
Collision	2	13.1
Grounding	2	13.1
Loss of control	2	13.1
Total	**6**	**39.2**
Fleet total	**153**	**26.8**

*Figure adjusted to properly reflect fleet size (153/5715 vessels)

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

Main injury		Number of crew
Drowning and asphyxiation	Drowning and non-fatal submersions	5
	Asphyxiation	2
Multiple injuries		2
Traumatic amputations (Loss of body parts)		1
Bone fractures	Closed fractures	15
Concussion and internal injuries	Concussion and intracranial injuries	1
	Internal injuries	8
Dislocations, sprains and strains	Dislocations and subluxations	1
	Sprains and strains	3
Effects of temperature extremes, light and radiation	Effects of reduced temperature	1
Wounds and superficial injuries	Open wounds	3
	Superficial injuries	1
Unknown or unspecified		3
Total		**46**



Deaths and injuries to fishing vessel crew by injury

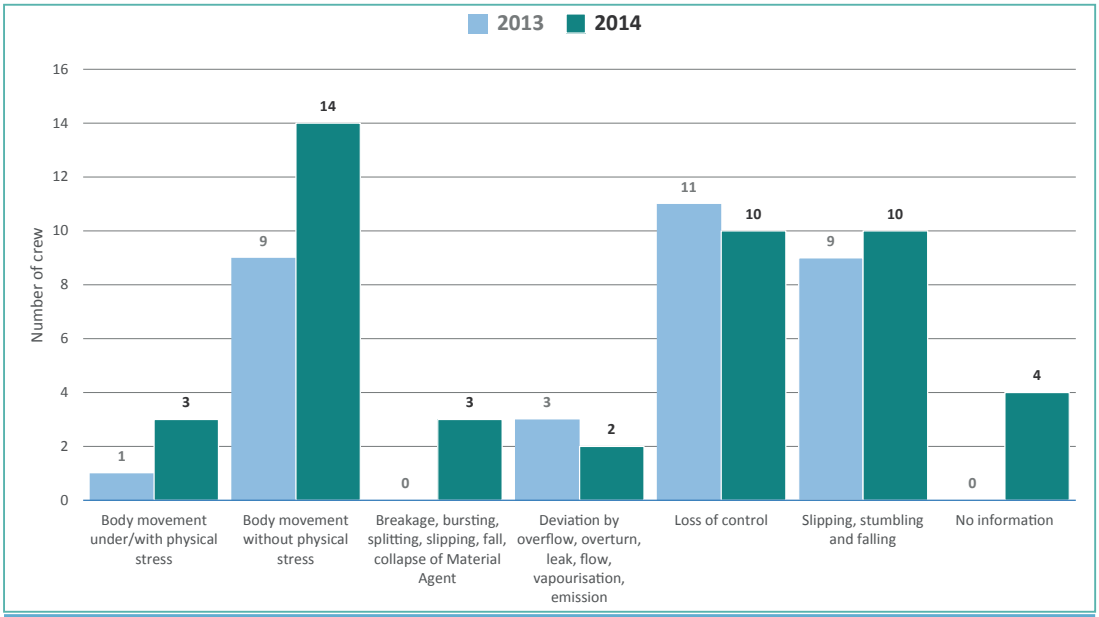
Table 20: Deaths and injuries of fishing vessel crew by part of body injured

Part of body injured		Number of crew
Whole body and multiple sites	Whole body	6
	Multiple sites of the body affected	2
Head	Eye(s)	1
	Facial area	2
	Head, multiple sites affected	1
Neck, inclusive spine and vertebra in the neck		1
Upper limbs	Arm, including elbow	2
	Finger(s)	8
	Hand	5
	Shoulder and shoulder joints	3
Back, including spine and vertebra in the back		4
Torso and organs	Chest area including organs	1
	Pelvic and abdominal area including organs	1
	Rib cage, ribs including joints and shoulder blade	1
	Torso, multiple sites affected	2
Lower Limbs	Foot	1
	Hip and hip joint	1
	Leg, including knee	3
	Toe(s)	1
Total		**46**

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

Deviation*		Number of crew
Body movement under or with physical stress (generally leading to an internal injury)	Lifting, carrying, standing up	1
	Putting down, bending down	1
	Other	1
Body movement without any physical stress (generally leading to an external injury)	Being caught or carried away, by something or by momentum	12
	Uncoordinated movements, spurious or untimely actions	2
Breakage, bursting, splitting, slipping, fall, collapse of Material Agent	Slip, fall, collapse of Material Agent - from above (falling on the victim)	1
	Slip, fall, collapse of Material Agent* - on the same level	2
Deviation by overflow, overturn, leak, flow, vaporisation, emission	Gaseous state - vaporisation, aerosol formation, gas formation	2
Loss of control (total or partial)	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	1
	Of means of transport or handling equipment, (motorised or not)	1
	Of object (being carried, moved, handled, etc.)	7
Slipping - stumbling and falling - fall of persons	Fall of person - to a lower level	1
	Fall overboard of person	4
	Fall of person - on the same level	5
	No information	4
	Total	**46**

*See "Terms" on page 92

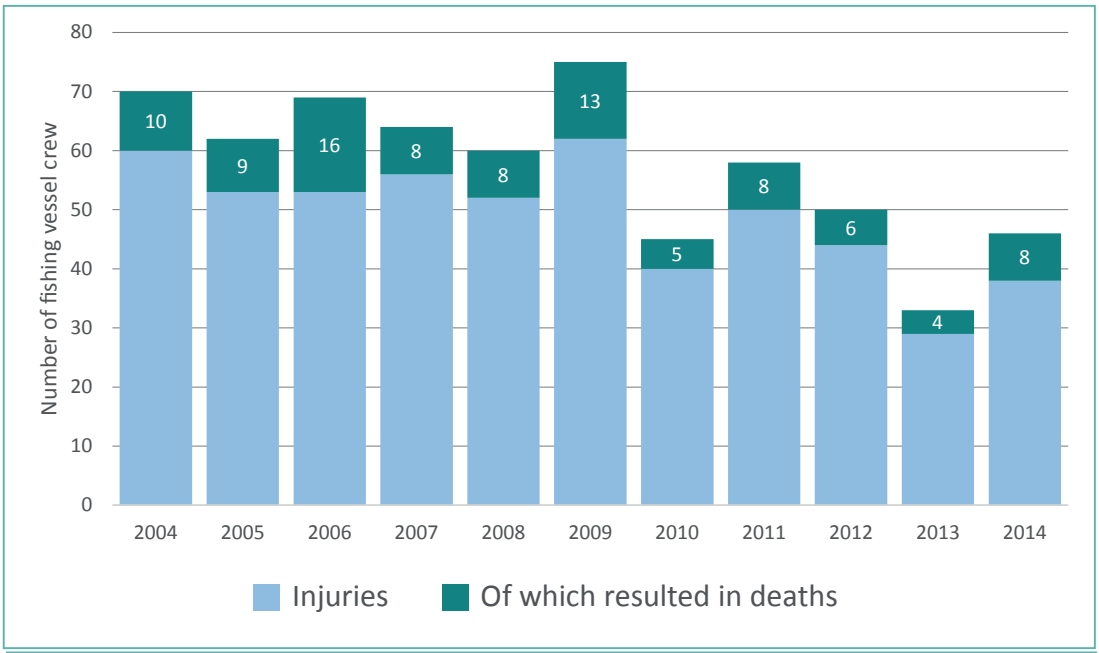


Deaths and injuries of fishing vessel crew by deviation

Table 22: Deaths and injuries to fishing vessel crew by vessel length (of which, deaths shown in brackets) 2004-2014 ❷

	Under 15m loa		15m loa - under 24m reg		24m reg and over		Total	
2004	27	(9)	20	(1)	23	-	70	(10)
2005	20	(3)	27	(3)	15	(3)	62	(9)
2006	21	(6)	30	(8)	18	(2)	69	(16)
2007	25	(4)	24	(3)	15	(1)	64	(8)
2008	19	(3)	22	(4)	19	(1)	60	(8)
2009	32	(5)	30	(7)	13	(1)	75	(13)
2010	22	(4)	10	-	13	(1)	45	(5)
2011	20	(7)	27	(1)	11	-	58	(8)
2012	21	(4)	22	(2)	7	-	50	(6)
2013	13	(3)	13	(1)	7	-	33	(4)
2014	**22**	**(5)**	**14**	**(3)**	**10**	**-**	**46**	**(8)**

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



Deaths and injuries to fishing vessel crew

NON-UK COMMERCIAL VESSELS

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

Date	Name of vessel	Type of vessel	Flag	Gross tons	loa	Casualty event
1 Feb	*Le Sillon*	Fishing vessel | Trawler	France	160	23m	Loss of control - heavy weather damage causing emergency evacution of vessel which subsequently broke up on rocks on south coast of Cornwall

Table 24: Non UK commercial vessels in UK waters

	Cargo solid	Liquid cargo	Passenger	Service ship	Fishing vessel	Total
Collision	15	5	4	8	-	**32**
Contact	11	2	5	3	-	**21**
Damage to ship or equipment	2	-	1	-	1	**4**
Fire/explosion	-	-	3	-	-	**3**
Flooding/foundering	1	-	-	-	-	**1**
Grounding	17	3	-	4	1	**25**
Loss of control	16	3	-	5	3	**27**
Total	**62**	**13**	**13**	**20**	**5**	**113**
Deaths	4	-	-	-	-	**4**
Injuries	9	4	15	10	2	**40**

ANNEX - STATISTICS COVERAGE

1. Data is presented by the year in which the incident was reported to the MAIB. Historic data tables contain information from the past 10 years.
2. Not all historical data can be found in this report. Further data is contained in previous MAIB Annual Reports.
3. United Kingdom ships are required by the Merchant Shipping (Accident Reporting and Investigation) Regulations 2012[8] to report Accidents to the MAIB.
4. Accidents are defined as being Marine Casualties or Marine Incidents, depending on the type of event(s) and the results of the event(s). See Casualty definitions[9] or MAIB's Regulations[8] for more information.
5. Details of vessel types and groups used in this Annual Report can be found in the document: Vessel types used in MAIB Annual Reports (2013 onwards)[9].
6. Non-UK flagged vessels are not required to report accidents to the MAIB unless they are within a UK port/harbour or within UK 12 mile territorial waters and carrying passengers to or from a UK port. However, the MAIB will record details of, and may investigate, significant accidents notified to us by bodies such as H.M. Coastguard.
7. The Maritime and Coastguard Agency, harbour authorities and inland waterway authorities have a duty to report accidents to the MAIB.
8. In addition to the above, the MAIB monitors news and other information sources for relevant accidents.

[8] https://www.gov.uk/government/organisations/marine-accident-investigation-branch/about#regulations-and-guidance

[9] Supporting documents can be found on the MAIB website: https://www.gov.uk/government/publications/maib-annual-report-for-2014

GLOSSARY OF ABBREVIATIONS, ACRONYMS AND TERMS

▸ Abbreviations and Acronyms ◂

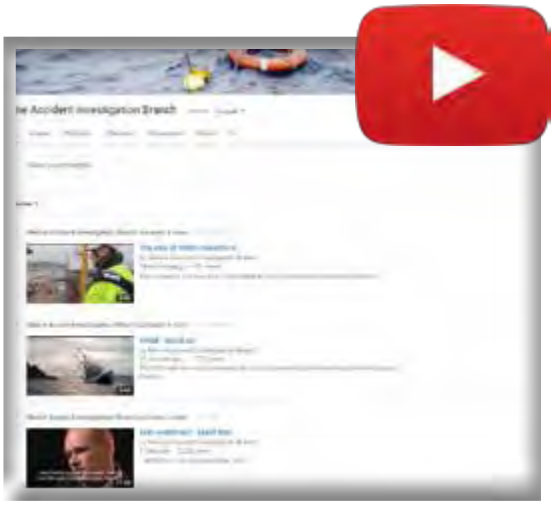
AIS	-	Automatic Identification System
BSU	-	Bundesstelle für Seeunfalluntersuchung (Federal Bureau of Maritime Casualty Investigation (Germany))
Circ	-	Circular
CNIS	-	Channel Navigation Information Service
CO	-	Carbon monoxide
Co.	-	Company
CO_2	-	Carbon dioxide
CPA	-	Closest Point of Approach
CPP	-	Controllable Pitch Propeller
DfT	-	Department for Transport
DoC	-	Document of Compliance
DSC	-	Digital Selective Calling
ECDIS	-	Electronic Chart Display and Information System
ECS	-	Electronic chart system
EPIRB	-	Emergency Position Indicating Radio Beacon
EU	-	European Union
(f)	-	fishing
FISG	-	Fishing Industry Safety Group
GM	-	Metocentric height
GPS	-	Global Positioning System
GT	-	Gross tonnage
HTW	-	Human Elements, training and watchkeeping
IACS	-	International Association of Classification Societies
ICS	-	International Chamber of Shipping
IMO	-	International Maritime Organization
ISGOTT	-	International Safety Guide for Oil Tankers and Terminals
ISM	-	International Safety Management Code
ISO	-	International Standards Organization
(L)	-	Length
LACORS	-	Local Authority Coordinators of Regulatory Services
LOLER	-	Lifting Operations and Lifting Equipment Regulations
LSA	-	Life Saving Appliance
Ltd	-	Limited
m	-	metre
(M+F)	-	Merchant and Fishing
MCA	-	Maritime and Coastguard Agency
MGN	-	Marine Guidance Note
MSC	-	Maritime Safety Committee
MSN	-	Merchant Shipping Notice
nm	-	nautical mile

OCIMF	-	Oil Companies International Marine Forum
OOW	-	Officer of the Watch
PFD	-	Personal Flotation Device
PSC	-	Port State Control
PUWER	-	Provision and Use of Work Equipment Regulations (1998)
UK	-	United Kingdom
UKMPA	-	United Kingdom Maritime Pilots' Association
UR	-	Unified Requirements
VTS	-	Vessel Traffic Services
RCD	-	Recreational Craft Directive
Rev	-	Revision
RIB	-	Rigid-hulled Inflatable Boat
Ro-ro	-	Roll on, roll off vessel
SCV Code	-	Small Commercial Vessel Code
SIAS	-	Ship Inspections and Surveys
SMS	-	Safety Management System
SOLAS	-	Safety of Life at Sea
TCPA	-	Time to Closest Point of Approach
TSGC	-	Tanker Safety Guide (Chemicals)
TSS	-	Traffic Separation System
VHF	-	Very High Frequency

▸ Terms ◂

DUKW	-	A DUKW (commonly pronounced “duck”) is an amphibious landing vehicle that was designed to transport military personnel and supplies for the US Army during World War 2. The acronym DUKW indicates that it was designed in 1942 (D), it is an amphibious (U) vehicle and has both front-wheel and rear-wheel drive capability (K and W, respectively).
Material Agent	-	A tool object or instrument.
Subluxation	-	Incomplete, or partial dislocation.
Superficial injuries	-	Bruises, abrasions, blisters etc.
Deviation	-	The last event differing from the normal working process and leading to an injury/fatality.

MAIB ONLINE RESOURCES



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MAIB Annual Report

INVESTORS IN PEOPLE