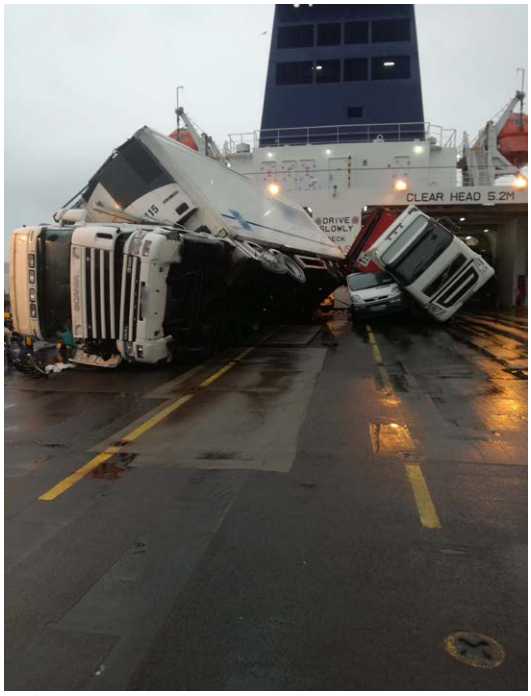
ANNUAL REPORT

MAIB

MARINE ACCIDENT INVESTIGATION BRANCH

# 2019

## Recommendations edition





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

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**June 2020**

# MARINE ACCIDENT INVESTIGATION BRANCH

# ANNUAL REPORT 2019 TO THE SECRETARY OF STATE FOR TRANSPORT

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

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



Front cover image credit: *Priscilla* aground | RNLI

# MAIB ANNUAL REPORT 2019

**Fireball from the *Stolt Groenland* explosion**

***Priscilla* aground on Pentland Skerries**


# CHIEF INSPECTOR'S FOREWORD

I am pleased to introduce MAIB's annual report 2019 . It was a busy and successful year for the Branch improving safety at sea by our sustained output of safety investigation reports, safety digests, safety bulletins, and wider industry engagement. The Branch raised 1222 reports of marine accidents and incidents and commenced 22 investigations in 2019, compared with 1227 reports and 23 investigations started in 2018. Tragically, 13 investigations involved loss of life. As further explained below, 2019 was also a year of significant change as the MAIB prepared to operate independently of the European Maritime Safety Agency (EMSA), introduced a new case management system, and agreed to undertake safety investigations on behalf of the Category 1 Red Ensign Group (REG) registries.

## FISHING VESSEL SAFETY

Investigating commercial fishing vessel accidents continues to be a significant part of the Branch's work, mainly as a result of fatalities and vessel losses. Six people lost their lives in marine accidents, the same number as in 2018. While this number appears low, given the small numbers of professional fishermen it represents, it is still a very high fatality rate compared to other UK industries. A great deal of effort has been expended by the Fishing Industry Safety Group (FISG) to promote the wearing of personal flotation devices (PFDs), and in November 2018 the Maritime and Coastguard Agency (MCA) published Marine Guidance Note 588[1], making clear its expectation that fishermen wear PFDs on the working decks of fishing vessels. That none of the three fishermen who died in the water in 2019 were wearing PFDs is therefore of great concern. Based on recent figures, embedding this behavioural change could halve the fatality rate in the fishing industry.

## RECOMMENDATIONS

In 2019 the Branch made 24 recommendations, of which 20 were promptly and fully accepted, indicating that the Branch continues to make targeted, proportionate recommendations.

The MCA has continued its efforts to complete the actions required to enable recommendations to be closed, as shown in **Figure 1**. Many longstanding recommendations made to the Agency have finally been actioned, including a number aimed at reducing the fatality rate in the fishing industry. Working with the FISG, the MCA has now developed a Fishing Strategy that addresses a number of MAIB recommendations that targeted PFD wear and accidents to persons. However, the elements of the strategy designed to improve small fishing vessel stability, still a contributory factor in many fatal accidents, remain outstanding.

Finally, and exceptionally, the outstanding recommendations made to Clipper Ventures plc have been withdrawn following the flagging to Malta of the company's fleet of Clipper 70 yachts.

[1] https://www.gov.uk/government/publications/mgn-588-ilo-work-in-fishing-convention-health-and-safety-pfds

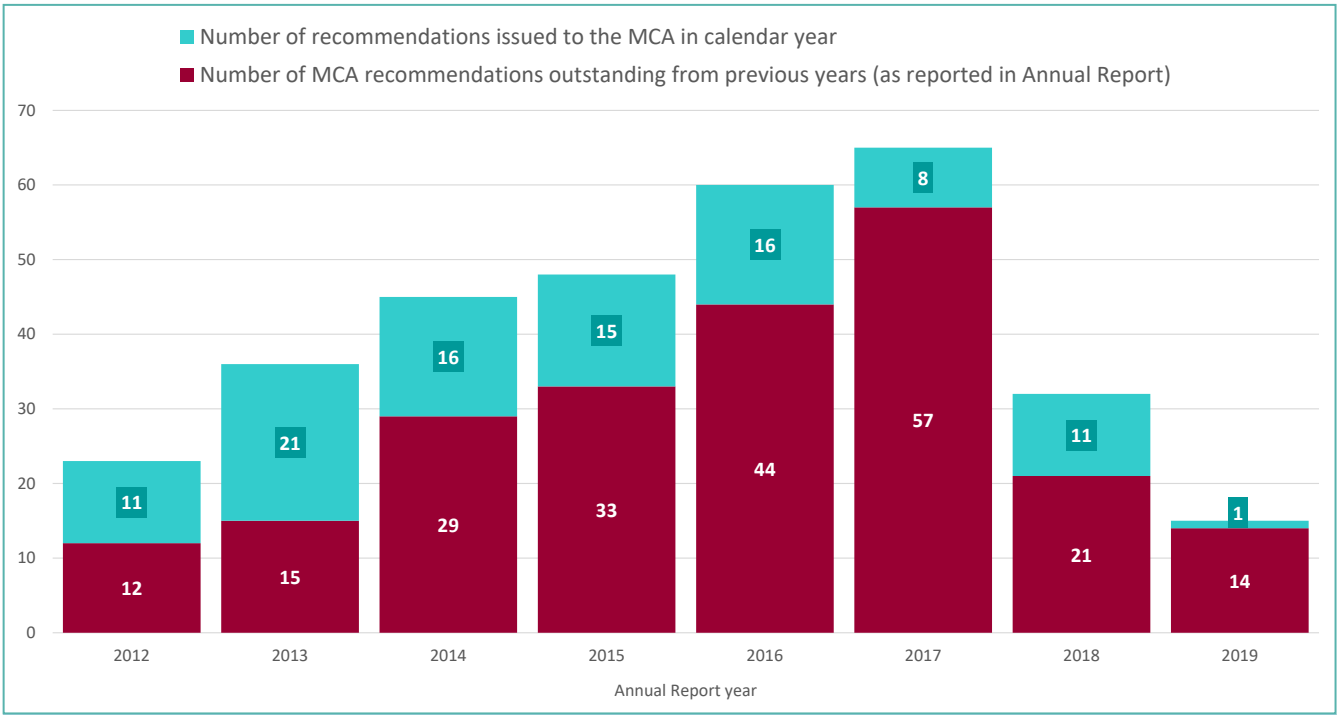



**Figure 1: MAIB recommendations made to Maritime and Coastguard Agency**

## ECDIS SAFETY STUDY

The Safety Study into how Electronic Chart Display and Information Systems (ECDIS) are being used at sea, being conducted in collaboration with the Danish Maritime Accident Investigation Board, is nearing completion. The finishing touches have been delayed by the recent COVID-19 restrictions, but the study should be published during the autumn.

## CHANGE AND CONSOLIDATION

While the UK will continue to report marine casualties to the European Union (EU) until the end of the transition period, preparations have been underway to operate independently of EMSA. This has involved repatriating the UK's historical accident data, some 42,000 cases, into a new database, which has been more time consuming and complicated than anticipated. During this transition, the Branch has had a limited ability to support external requests for data, and the decision has been taken to delay publication of the 2019 accident data until early in the autumn.

To complicate matters, in collaboration with the Air Accidents Investigation Branch and the Rail Accident Investigation Branch, the MAIB has also been developing a new case management system. As this annual report was being prepared the case management system, incorporating the new database, became operational. While these two significant IT projects have absorbed much staff resource and impacted the Branch's work over this last year, completing these projects has equipped the MAIB with a modern system fit for the next decade.

In order to assure that safety investigations are independent of marine regulation, agreement has been reached that the MAIB will carry out investigations into Very Serious Marine Casualties for the Red Ensign Group (REG) Category 1 registers of Bermuda, Cayman Islands, Gibraltar and the Isle of Man. This is an exciting development that will benefit the wider REG family, and the Branch has taken on two additional inspectors to undertake this important work.

A number of retirements and departures have occurred over the year that, alongside the uplift for REG investigations, have created opportunities for internal promotion and recruitment. In total, six new inspectors have joined the Branch since September. These include two nautical inspectors, two engineer inspectors (all experienced mariners), a naval architect inspector and a human factors inspector. Having a dedicated human factors specialist on the staff is a first for the MAIB, but it is considered essential as automation and decision support aids increasingly encroach on traditional human tasks.

Finally, approval has been obtained to increase the capability and capacity of the technical section so the Branch can keep abreast of technological developments and the increasing digitisation of the marine industry. While the MAIB will carry a training burden for a few months as all the new staff learn the ropes, as with the new case management system, the changes are forward looking and designed to position the Branch well to investigate the accidents of the future as well as those of today.

## FINANCE

The annual report deals principally with the calendar year 2019. However, for ease of reference, the figures below are for the financial year 2019/20, which ended on 31 March 2020. The MAIB's funding from the DfT is provided on this basis, and this complies with the Government's business planning programme.

A separate Capital budget was allocated in 2019/20 to cover the cost of developing a case management system for all three DfT accident investigation branches, and the national database referred to above, aimed at addresssing disruption to data access as a result of the UK leaving the EU.

| £ 000s | 2019/20 Budget | 2019/20 Outturn |
|---|---|---|
| Costs – Pay | 2959 | 2828 |
| Costs – Non Pay | 1194 | 1057 |
| **Totals** | **4153** | **3885** |
| | | |
| **Capital** | **664** | **948** |

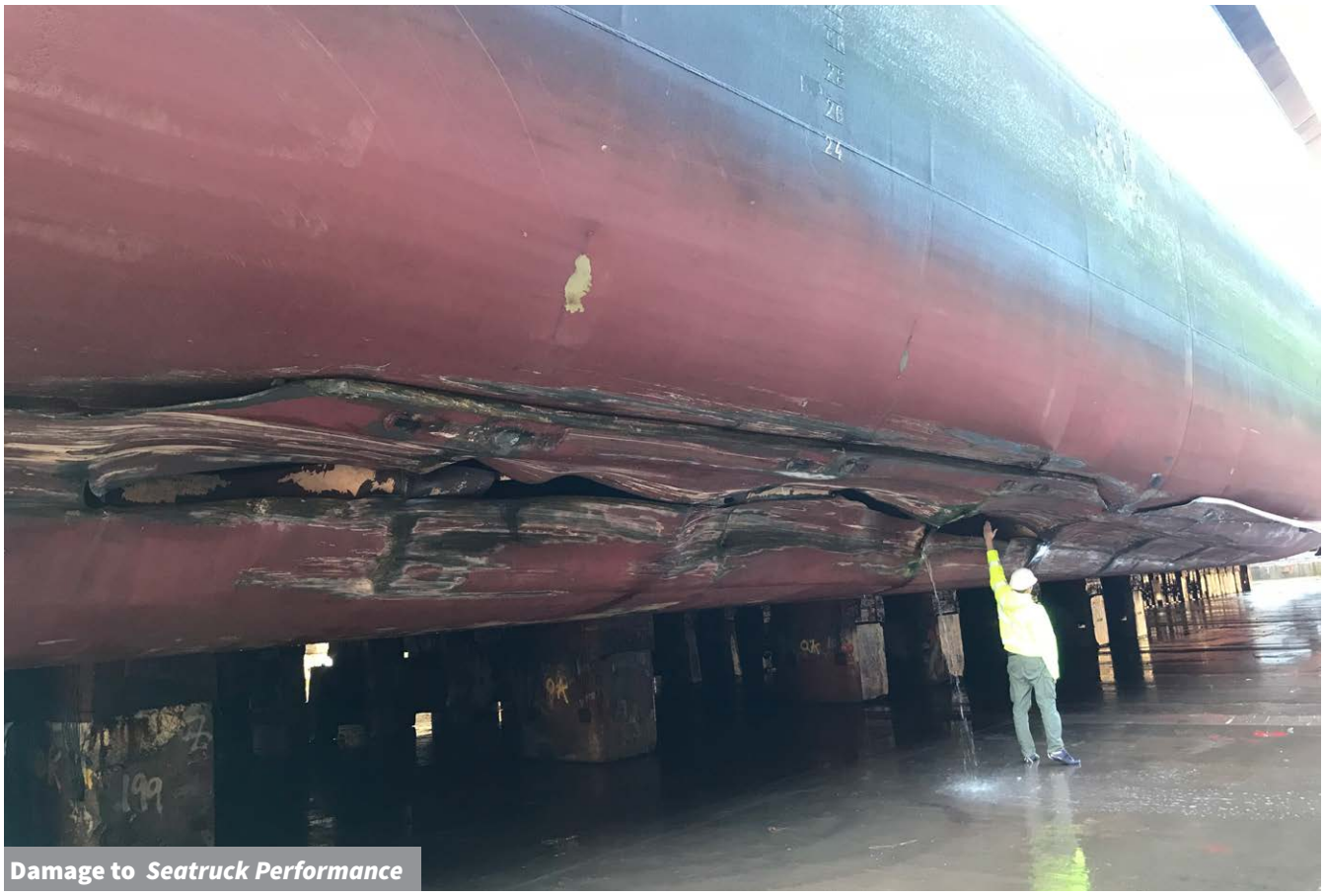
**Captain Andrew Moll**
**Chief Inspector of Marine Accidents**

# PART 1: 2019 OVERVIEW

## 2019: SUMMARY OF INVESTIGATIONS

| Date of occurrence | Occurrence details |
|---|---|
| 17 Jan | Collision of the rigid inflatable boat ***Tiger One*** with a mooring buoy on the River Thames, London, England. |
| 27 Jan | Fatal accident to crewman while boarding the tug ***Millgarth*** at the north oil stage, Tranmere Oil Terminal, Birkenhead, England. |
| 3 Feb | Capsize and sinking of the UK registered fishing vessel ***Investor*** while east of Ardnamurchan Point, Scotland.<br>The investigation was subsequently discontinued in accordance with The Merchant Shipping (Accident Reporting and Investigation) Regulations 2012 Para 11(9). The reason for this decision is that the issues identified by the investigation have already been the subject of MAIB safety recommendations. Nevertheless, the MAIB may, in the future, publish the story as an anonymised safety digest article. |
| 28 Feb | Fatal injury to a crewman on the dredger ***Cherry Sand*** during a berthing operation in Rosyth, Scotland. |
| 2 Mar | Injuries to two crew men during a lifting operation while preparing for cargo loading on the general cargo ship ***Zea Servant*** in Campbeltown, Scotland. |
| 27 Mar | Loss of propulsion on board the Norwegian registered cruise ship ***Viking Sky*** in heavy weather in the Hustadvika area of the Norwegian Coast. A number of UK passengers were on board at the time of the accident.<br>The Accident Investigation Board Norway (AIBN) is the lead investigating authority. The UK and USA are considered Substantially Interested States. As the UK's representative, the MAIB is providing technical assistance during the course of the investigation. |
| 27 Mar | Fatal man overboard from the UK registered fishing vessel ***Sea Mist*** **(BF918)** off Macduff, Scotland. |
| 18 Apr | Collision between the Turkish registered bulk carrier ***Gulnak*** and the moored Panama registered bulk carrier ***Cape Mathilde*** at Redcar bulk terminal on the River Tees, England. |
| 29 Apr | Fatal accident on board the UK registered fishing vessel ***Artemis*** **(FR 809)** while berthed alongside in Kilkeel, Northern Ireland. |
| 8 May | Grounding of the ro-ro freight ferry ***Seatruck Performance*** in Carlingford Lough, shortly after departing from Warrenpoint, Northern Ireland. |

| Date of occurrence | Occurrence details |
|---|---|
| 15 May | Fatal injury to crewman from the ro-ro freight ferry ***Seatruck Progress*** during cargo discharge operations in Brocklebank Dock, Liverpool, England. |
| 24 May | Fatal injury to crewman during cargo operations on board the UK registered general cargo vessel ***Karina C*** in Seville, Spain. |
| 25 May | Fatal injury to crewman from the UK registered motoryacht ***Minx*** after a collision with the Gibraltar registered motoryacht ***Vision*** off Cannes, France. |
| 12 Jun | Capsize of a sailing boat with a retractable keel on Windermere, Cumbria, England resulting in the death of a disabled crewman. |
| 28 Jun | Fatal injury to crewman on board the UK registered fishing vessel ***Olivia Jean*** **(TN35)** off the east coast of Aberdeen, Scotland. |
| 24 Jul | Fatal man overboard from the UK registered fishing vessel ***May C*** **(SY213)** off Benbecula in the Outer Hebrides, Scotland. |



**Damage to *Seatruck Performance***

| Date of occurrence | Occurrence details |
|---|---|
| 4 Aug | Stranding of the Spanish owned UK registered fishing vessel ***Coelleira* (OB 93)** on Ve Skerries, a low-lying reef off the west coast of the Shetland Islands, Scotland. |
| 18 Aug | Flooding and sinking of the UK registered fishing vessel ***Ocean Quest* (FR375)** while 75nm north-east of Fraserburgh, Scotland. All crew were rescued safely. |
| 17 Sep | Fatal injury to a crewman following a collision between two Fire and Rescue Service boats during an exercise in the Cleddau Estuary, Pembrokeshire, Wales. |
| 23 Sep | Capsize of the UK registered 6m fishing vessel ***Anna-Marie II* (WK837)** near Brora in the Scottish Highlands, with the loss of one life. |
| 28 Sep | Explosion and fire on board the Cayman Islands registered chemical tanker ***Stolt Groenland*** while berthed at the port of Ulsan in the Republic of Korea.<br>The MAIB is investigating the accident on behalf of the Maritime Authority of the Cayman Islands. |
| 15 Nov | Fatality on board the UK registered fishing vessel ***Resurgam* (PZ1001)** following the accidental activation of an engine room fire suppression system while alongside at Newlyn Harbour, Cornwall, England. |
| 22 Dec | While acting as a stern tug at Southampton container terminal, a towline parted causing injuries to the crew on board the tug ***Svitzer Mercurius***. |

***Coelleira* post-salvage attempt**

# PART 2: RECOMMENDATIONS AND PUBLICATIONS

## INVESTIGATIONS PUBLISHED IN 2019 INCLUDING RECOMMENDATIONS ISSUED

The following pages list the accident investigation reports and safety bulletins published by the MAIB during 2019. 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 51.

***Status as of 31 May 2019**

### BACKGROUND

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

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

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

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

## RECOMMENDATION RESPONSE STATISTICS 2019

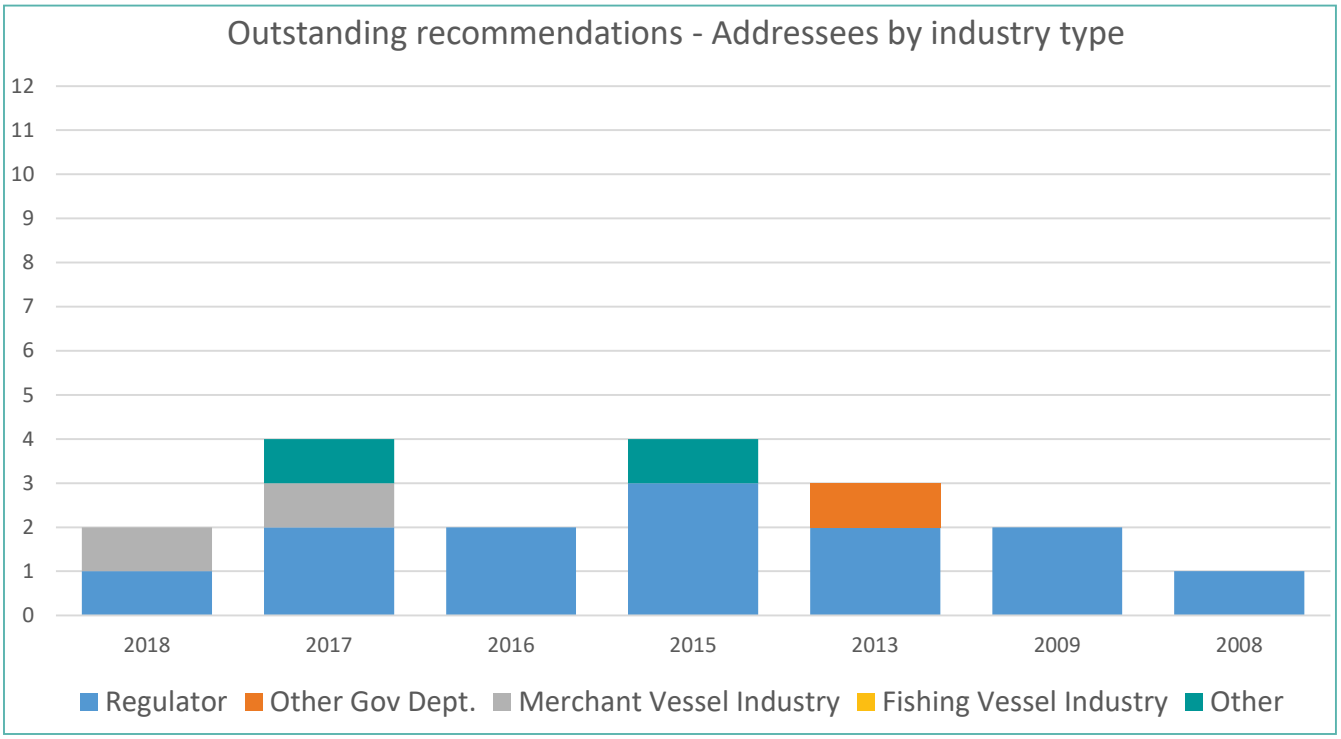
**24** recommendations were issued to **16** addressees in 2019. The percentage of all recommendations that are either ***accepted and implemented*** or ***accepted yet to be implemented*** is **83.9%**.

| Year | Total* | Accepted Action | | Partially Accepted | Withdrawn | Rejected | No Response Received |
|---|---|---|---|---|---|---|---|
| | | Implemented | Yet to be Implemented | | | | |
| 2019 | 24 | 14 | 6 | 1 | 2 | 0 | 1 |

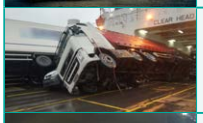
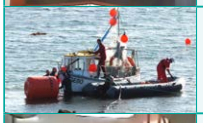
***Total number of addressees**

## RECOMMENDATION RESPONSE STATISTICS 2007 TO 2018

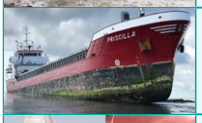
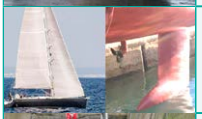
The chart below shows the number of recommendations issued under the closed-loop system that remain outstanding as of May 2019. There are no outstanding recommendations from 2004-2007, 2010-2012 and 2014.



## SUMMARY OF 2019 PUBLICATIONS AND RECOMMENDATIONS ISSUED

| | Vessel name(s) | Category | Publication date (2019) and report number | Page |
|---|---|---|---|---|
|  | ***Celtica Hav*** | Serious Marine Casualty | 24 January<br>No 1/2019 | 11 |
|  | **Unnamed rowing boat (throw bag rescue line)** | Marine incident | 31 January<br>No 2/2019 | 12 |
|  | ***Pride of Kent*** | Serious Marine Casualty | 21 February<br>No 3/2019 | 12 |
|  | ***European Causeway*** | Serious Marine Casualty | 26 March<br>No SB1/2019 | 13 |
|  | ***Red Falcon/Phoenix*** | Serious Marine Casualty | 28 March<br>No 4/2019 | 14 |
|  | ***Laura Jane*** | Very Serious Marine Casualty | 25 April<br>No 5/2019 | 14 |
|  | ***Wight Sky*** | Serious Marine Casualty | 16 May<br>Interim report | 15 |
|  | ***Nancy Glen*** | Very Serious Marine Casualty | 30 May<br>No 6/2019 | 16 |
|  | ***CV30*** | Very Serious Marine Casualty | 20 June<br>No 7/2019 | 17 |
|  | ***Svitzer Victory*** | Serious Marine Casualty | n/a, recommendation issued pre-publication by letter | 19 |

***Laura Jane:*** **RNLI rescue effort | Image: MCA**

| | Vessel name(s) | Category | Publication date (2019) and report number | Page |
|---|---|---|---|---|
|  | **RS Venture Connect sailing boat** | Very Serious Marine Casualty | 27 June<br>No SB2/2019 | 19 |
|  | ***Fram of Shieldaig*** | Very Serious Marine Casualty | 28 June<br>No 8/2019 | 20 |
|  | ***Seatruck Pace*** | Very Serious Marine Casualty | 3 July<br>No 9/2019 | 20 |
|  | ***Tiger One*** | Serious Marine Casualty | 18 July<br>No 10/2019 | 21 |
|  | ***Kuzma Minin*** | Serious Marine Casualty | 1 August<br>No 11/2019 | 21 |
|  | ***Priscilla*** | Serious Marine Casualty | 3 October<br>No 12/2019 | 22 |
|  | ***Tyger of London*** | Very Serious Marine Casualty | 31 October<br>No 13/2019 | 23 |
|  | ***Sea Mist*** | Very Serious Marine Casualty | 15 November<br>No 14/2019 | 23 |
|  | ***Millgarth*** | Very Serious Marine Casualty | 5 December<br>No 15/2019 | 23 |
|  | ***Stolt Groenland*** | Serious Marine Casualty | 16 December<br>Interim report | 25 |

***Kusma Minin*** | **Image: Cornwall live**

## *Celtica Hav*

**Report number:** 1/2019

General cargo vessel

Accident date: 27/3/2018

### Grounding in the approaches to the River Neath, Wales

**Safety Issues**

- **No detailed pilotage plan made**
- **Master/pilot exchange did not cover all potential hazards**
- **Pilot did not fully appreciate the risk of grounding on the training wall**
- **Electronic navigation equipment was not adequately used to monitor vessel's position or progress**

| No | Recommendation(s) to: | Neath Port Authority |
|---|---|---|
| 101 | Amend its pilotage plan to reflect guidance found in Annex G of the Maritime and Coastguard Agency's *Guide to Good Practice on Port Marine Operations*. | |
| | | Appropriate action implemented |
| 102 | Introduce checks to ensure that an effective exchange of information between the pilot and bridge team is carried out as documented in National Operating Standards MP104. | |
| | | Appropriate action implemented |

| No | Recommendation(s) to: | HAV Ship Management NorRus |
|---|---|---|
| 103 | Review its Safety Management System regarding pilotage planning and to include more guidance on the importance of an effective exchange of information with the pilot, and position monitoring using electronic navigation aids. | |
| | | Appropriate action implemented |
| 104 | Amend its pilotage checklist to include master/pilot exchange and comparison of pilotage plans. | |
| | | Appropriate action implemented |

## Unnamed

**Report number: 2/2019**

Rowing boat

Accident date: 24/3/2018

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

**Safety Issues**

- Manufacturing process introduced weak points within the throw lines
- No specific manufacturing safety or quality standards required
- Quality checks by manufacturers lacked the additional safeguard of third party oversight


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

**Appropriate action planned:** Progress Ongoing – NO DATE GIVEN

## *Pride of Kent*

**Report number: 3/2019**

Ro-ro passenger ferry

Accident date: 10/12/2017

### Contact with jetty and subsequent grounding while departing Calais, France

**Safety Issues**

- Control of ferry lost during turn towards harbour entrance due to effect of gale-force winds, and the use and effectiveness of propulsion machinery
- Quality of pre-departure brief and bridge resource management
- Fuel pump issues experienced following a change to ultra-low sulphur fuel


**P&O Ferries Limited, *Pride of Kent*'s owner/operator took action to improve the performance of its bridge teams and to maintain machinery reliability.**

**In view of this, no recommendations were made.**

## *European Causeway*

**Safety Bulletin number:** **SB1/2019**

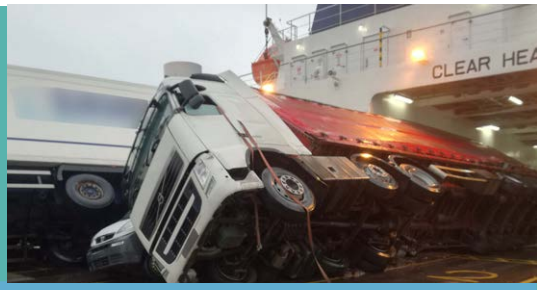
Ro-ro passenger ferry

Accident date: 18/12/2018

### Cargo shift and damage to vehicles during a voyage from Larne, Northern Ireland to Cairnryan, Scotland

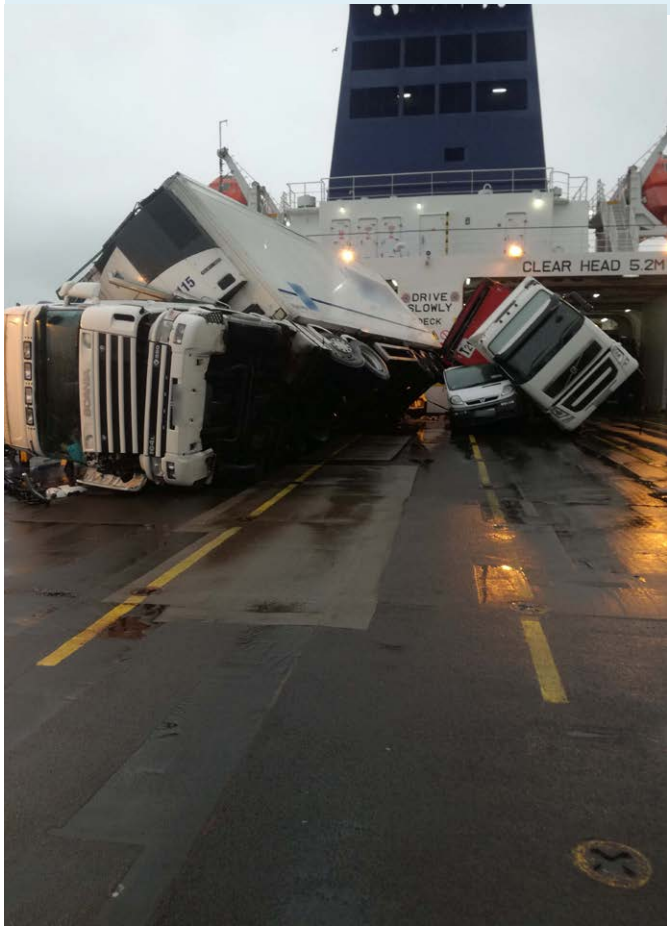
**Safety Issues**

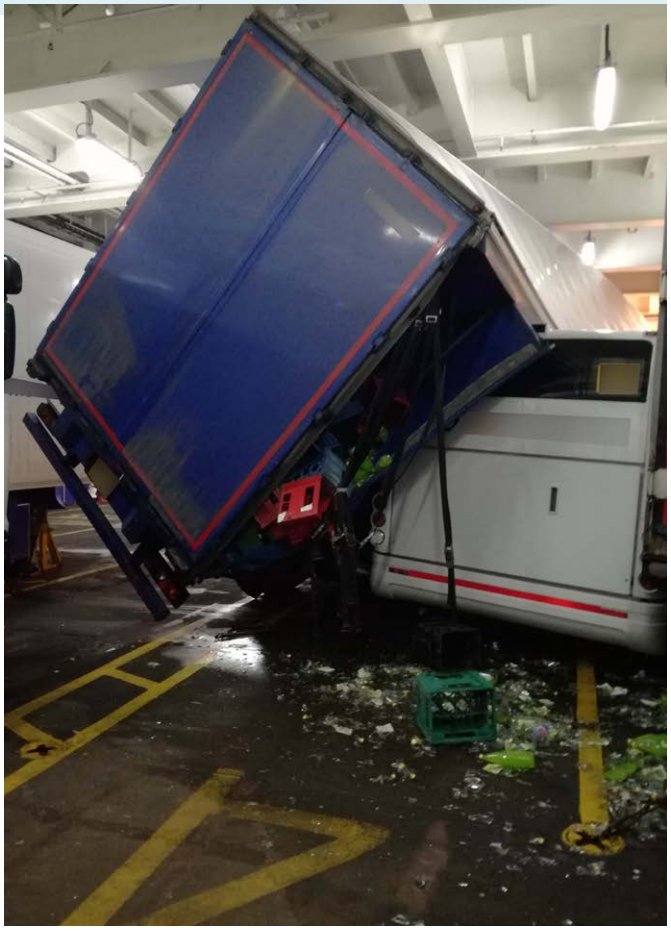
- Vehicles not adequately secured for anticipated wind and sea conditions
- Freight vehicle drivers allowed to remain in their cabs on the vehicle decks during passage
- Decision to sail and ship handling in heavy seas




| No | Recommendation(s) to: | Road Haulage Association Ltd |
|---|---|---|
| S106 | Distribute this Safety Bulletin to its members and encourage them to take robust action to improve and assure driver safety by helping ferry operators eliminate the issue of drivers remaining in the cabs of freight vehicles on ro-ro decks. | |

Appropriate action implemented



## *Red Falcon/Phoenix*

**Report number:** 4/2019

Ro-ro passenger ferry/motor cruiser

Accident date: 29/9/2018

### Collision in the Thorn Channel, Southampton, England

**Safety Issues**

- Lookout on both vessels was solely by eye
- Sun glare and window frame blind arcs on *Red Falcon*'s bridge obscured the motor cruiser on the ferry's starboard bow
- The effectiveness of the ferry's lookout was reduced due to seated positions and unlowered bridge window sun screens
- Owner of motor cruiser had limited knowledge of the COLREGs and local guidance

**Following the accident, an internal investigation by the Southampton Isle of Wight and South of England Royal Mail Steam Packet Company Limited (Red Funnel), *Red Falcon*'s owner, identified several areas of navigational watchkeeping practice to be improved. In view of this, no recommendations were made.**

## *Laura Jane*

**Report number:** 5/2019

Gill netter/potter (SE80)

Accident date: 7/5/2018

### Fatal capsize of a single-handed fishing vessel in Plymouth Sound, England

**Safety Issues**

- Vessel capsized becaused the fishing gear weight had reduced its freeboard and caused water to enter through the freeing ports
- Vessel inspected several times but the presence of low level freeing ports on an open boat was not challenged
- Stability assessment not undertaken
- The skipper had not completed the mandatory Safety Awareness and Risk Assessment training course or any stability awareness training


| No | Recommendation(s) to: Ocean Drifter Ltd |
|---|---|
| 107 | Ensure that crew employed on its vessels possess all mandatory safety training course certificates and to require its skippers to complete the voluntary Seafish <16.5m skipper's certitifcate scheme with a view to enhancing competence, particularly in respect of stability awareness. |

Appropriate action implemented

108 Carry out stability assessment of vessels that it may own which are less than 12m overall length, in accordance with MSN 1871(F), MGN 503(F), and MGN 526(F), and display stability guidance notice (Wolfson Guidance Mark) in a prominent place in the wheelhouse as well as on either side of the hull.

Appropriate action implemented

## *Wight Sky*

**Interim Report issued**

Ro-ro passenger ferry

Accident date: 26/8/2018 and 14/12/2018

### Two catastrophic engine failures

**Safety Issues**

- Assembly error during initial engine manufacture
- Assembly error during periodic engine overhaul
- Quality control during engine manufacture and overhaul


**This interim report was issued in May 2019 to outline the ongoing and technically complex investigation into the series of Volvo Penta D-16 engine failures experienced on board Wightlink's Yarmouth to Lymington ferries, and *Wight Sky* in particular.**

**A number of actions have been taken by Wightlink and the MAIB is continuing to work closely with all the stakeholders involved in order to progress the investigation as swiftly as possible and ensure appropriate action can be taken in order to further reduce the likelihood of similar accidents in the future.**

**A full report will be published once the investigation is complete.**

## *Nancy Glen*

**Report number:** 6/2019

Twin rig prawn trawler (TT100)

Accident date: 18/1/2018

### Capsize and sinking in Lower Loch Fyne, Scotland, with the loss of two lives

**Safety Issues**

- **Vessel's stability was insufficient to overcome a net digging into the seabed during a turn**
- **Recent modifications had a detrimental effect on the vessel's stability**
- **Stability assessment not undertaken**
- **No mandatory requirement for owners of small fishing vessels to carry out stability assessments**

| No | Recommendation(s) to: | Maritime and Coastguard Agency |
|---|---|---|
| 109 | Include in its new legislation addressing the stability of existing fishing vessels of under 15m, a requirement to undertake both a freeboard check and stability check, which should be recorded and repeated at intervals not exceeding 5 years.<br><br>Provide guidance on the conduct of 5-yearly stability checks to ensure the results can be effectively compared to determine whether the vessel's stability has altered.<br><br>Align the text of MSN 1871 (F), The Code of Practice for the Safety of Small Fishing Vessels of less than 15m Length Overall, to mirror Statutory Instruments 2017 No. 943 Merchant Shipping, The Fishing Vessel (Codes of Practice) Regulations 2017. This amendment should be in respect of vessel owners' obligation to notify the MCA of any proposal to alter or modify a vessel's structure, remove or reposition engines or machinery or change the mode of fishing.<br><br>Include in its new legislation introducing stability criteria for all new and substantially modified vessels, a requirement for this to be validated by a 5-yearly lightship check. | |

**Partially accepted - action planned:** 2020 DECEMBER 31

## *CV30*

**Report number: 7/2019**

Commercial racing yacht

Accident date: 18/11/2017

### Fatal man overboard approximately 1500nm west of Fremantle, Australia

**Safety Issues**

- **Unsuitable securing point led to lateral loading and failure of the tether hook**
- **Risk assessment process and application of sufficient control measures to keep crew safe**
- **Tethered MOB recovery was generally only talked through, rather than drilled**
- **A cumulative effect of yacht defects increased the crew's workload and levels of fatigue**


| No | Recommendation(s) to: | British Standards Institute Committee |
|---|---|---|

110 Review and amend ISO 12401 and ISO 15085 at the earliest opportunity in light of lessons learned from this accident to:

- Ensure the danger of snagging of tether hooks is highlighted and suitable precautions are taken for terminating jackstays.
- Clarify that the ISO 12401 standard test assumes that the tether is loaded longitudinally and that the hook must be free to rotate to align with the load, and lateral loading of the hook must be avoided.
- Clarify what force should be applied during an accidental hook opening test.
- Consider including a requirement for a tether overload indicator.

**Appropriate action planned:** 2023 DECEMBER 31

| No | Recommendation(s) to: | World Sailing |
|---|---|---|
| 111 | Raise awareness of the dangers of laterally loading safety tether hooks, including consideration of suitable amendments to World Sailing's Offshore Special Regulations. | |

Appropriate action planned: 2020 DECEMBER 31

| No | Recommendation(s) to: | Spinlock |
|---|---|---|
| 112 | Review and amend its user instructions for safety tethers to emphasise the dangers of tether hooks snagging and becoming laterally loaded. | |

Appropriate action implemented

| No | Recommendation(s) to: | Clipper Ventures |
|---|---|---|
| 113 | Taking account of any safety management guidance and direction provided by the MCA in response to MAIB Recommendation 2018/116, review and, as appropriate, modify its risk assessments and standard operating procedures, with particular regard to foredeck operations, for reducing sail in rough weather and the methods for recovery of both tethered and untethered MOBs. | |

Withdrawn

**MAIB Comment**

**The Clipper Ventures plc fleet of CV70 yachts was re-flagged to Malta before this recommendation was implemented. It is no longer appropriate for the company to work with the UK Maritime and Coastguard Agency to implement an effective safety management system for its Round the World race fleet, so this recommendation has been withdrawn.**

114 Review and amend Clipper 70 yacht maintenance and repair processes to minimise additional workload on crew during the Race, such that:

- Prior to the start of the Race, yachts are free from significant material defects and equipment has been suitably maintained or replaced.
- During stopovers, to the greatest extent practicable, all outstanding repair work and maintenance is completed before a yacht starts the next leg.

Withdrawn

**MAIB comment**

**Since the Clipper CV70 fleet re-flagged to Malta, the MAIB has not received any updates from Clipper Ventures plc on its progress implementing this recommendation so, exceptionally, the decision has been taken to withdraw it.**

## *Svitzer Victory*

**Recommendation issued by letter from the Chief Inspector**

Tug

Accident date: 31/10/2017

### Fall into the water while boarding tug at the Eastern Jetty on the River Humber, England

**Safety Issues**

- The shore workers attempted to step off the tug before it had been made fast and while it was still moving
- The tug's crew did not take control of the shore workers during the berthing operation

| No | Recommendation(s) to: | Svitzer A/S |
|---|---|---|

115 Take urgent steps to ensure that:

- Tug access and egress are conducted in a safe and controlled manner.
- New employees are not permitted to go on board tugs without a proper safety induction.

Appropriate action implemented

## RS Venture Connect

**Safety Bulletin number: SB2/2019**

Sailing boat

Accident date: 12/6/2019

### Capsize on Windermere, Cumbria, England with the loss of one life

**Safety Issues**

- Retractable keel was not secured in place
- Lack of clear guidance and understanding of the use of keel securing device
- Capsize recovery procedure/drill did not consider the retracted keel scenario

**This bulletin was issued to highlight a safety concern for owners and operators of boats with retractable keels or retractable weighted centreboards.**

## *Fram of Shieldaig*

**Report number:** 8/2019

Potter (BRD 679)

Accident date: 7/8/2018

### Fatal man overboard from the tender of a fishing vessel on Loch Torridon off Ardheslaig, Scotland

**Safety Issues**

- The casualty was under the influence of alcohol
- Personal flotation devices not worn
- Crew unable to recover casualty from the water
- Man overboard drills not conducted


| No | Recommendation(s) to: | Owner of *Fram of Shieldaig* |
|---|---|---|

116 Add an alcohol and drugs policy statement, similar to the one provided as an example by Seafish, to *Fram of Shieldaig*'s safety management folder, and ensure it is adhered to.

Appropriate action implemented


## *Seatruck Pace*

**Report number:** 9/2019

Ro-ro freight ferry

Accident date: 17/12/2018

### Fatal fall from height on board ferry while moored at Brocklebank Dock, Liverpool, England

**Safety Issues**

- Crewman crossed a safety barrier protecting an open hatch
- Safe system of work for working at height not followed
- Weak on board safety culture


**Seatruck Ferries Ltd, the ferry's manager, has taken actions aimed at preventing similar accidents, ensuring safe systems of work, and gauging and improving the safety culture among its crews.**

**In view of this, no recommendations have been made.**

## *Tiger One*

**Report number: 10/2019**

Rigid inflatable boat

Accident date: 17/1/2019

### Collision with a mooring buoy on the River Thames, London, England

**Safety Issues**

- **High-speed operation of small passenger craft on the river in darkness**
- **Visibility of buoys and other objects in the water when navigating solely by eye**
- **The benefits of robust RIB construction, seating design, and the use of kill cords**

**Following the accident, the Port of London Authority has, among other things, removed its authorisation for open deck high-speed craft to navigate above 12 knots during the hours of darkness, and taken steps to enable these craft to report passenger numbers via the automatic identification system. The Royal Yachting Association has included guidance on night operations and passenger number reporting in its recently revised guidance on passenger safety on board small commercial high-speed craft and experience rides.**

**In view this, no recommendations have been made.**

## *Kuzma Minin*

**Report number: 11/2019**

Bulk carrier

Accident date: 18/12/2018

### Grounding in Falmouth Bay, England

**Safety Issues**

- **Master's decision to remain at anchor on a lee shore when strong winds were forecast, was influenced by lack of funds to replenish bunkers and lube oil**
- **Lack of P&I insurance cover, and the owner's lack of co-operation in appointing a salvor, caused unexpected pressures**

| No | Recommendation(s) to: | JSC Murmansk Shipping Company |
|---|---|---|
| 117 | Take steps to ensure that its vessels are adequately resourced to operate safely and in accordance with international conventions, taking into account the potential consequences of vessels having insufficient fuel and oils, and the statutory requirement to maintain P&I insurance. | |

**No reply received:** Update requested NO DATE GIVEN

## *Priscilla*

**Report number: 12/2019**

General cargo vessel

Accident date: 18/7/2018

### Grounding on Pentland Skerries, Pentland Firth, Scotland

**Safety Issues**

- **Vessel's position and progress against planned track was not monitored**
- **Passage plan alteration put vessel on unsafe route**
- **Sole watchkeeper/lookout was not appropriate when heading towards Pentland Firth at night**
- **Watchkeeper allowed himself to become distracted from his duties by watching music videos on his mobile phone**
- **The Bridge Navigational Watch Alarm System was switched off**


**Image: RNLI**

| No | Recommendation(s) to: | Owner of *Priscilla* |
|---|---|---|

118 Review and improve the safety management system and standards of watchkeeping on board the vessel, specifically ensuring that:

- All aspects of the passage plan are compliant with IMO guidance.
- An internal audit regime is in place to effectively monitor safety management.
- All methods of fixing the vessel's position are utilised effectively.
- Hours of rest are recorded accurately for all crew.
- Crew are prevented from undertaking duties for which they are not qualified.
- A thorough risk assessment is undertaken prior to making the decision to reduce to a lone watchkeeper.

**Appropriate action implemented**

## *Tyger of London*

**Report number: 13/2019**

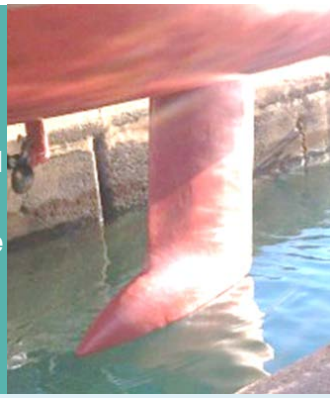
Charter yacht

Accident date: 7/12/2017

### Keel failure and capsize off south of Punta Rasca, Tenerife

**Safety Issues**

- The yacht's keel failed because it had not been manufactured in accordance with the design
- Condition of the keel securing arrangement could not be monitored due to its unusual design
- Swift action of the nearby yacht and the crew's decision to wear life jackets ensured they survived
- Capsize prevented access to the liferaft and emergency equipment on board the yacht



**A number of actions have been taken by the Maritime and Coastguard Agency and British Marine in response to this report, to improve guidance on keel inspection and the stowage of lifesaving appliances and in 2018 a recommendation was made by letter to British Marine to propose changes to the International Standards Organisation, to require, rather than recommend, that manufacturers provide guidance on the inspection and maintenance of keels fitted to their craft. This recommendation was accepted and implemented.**

**In view the actions taken, no further recommendations have been made.**

## *Sea Mist*

**Report number: 14/2019**

Creel boat (BF918)

Accident date: 27/3/2019

### Fatal man overboard off Macduff, Scotland

**Safety Issues**

- Skipper drowned after being dragged overboard by fishing gear
- There was no physical barrier separating the skipper from the fishing gear on the working deck
- The skipper was working alone
- The skipper was not wearing a personal flotation device when he entered the water


| No | Recommendation(s) to: | Fishing Industry Safety Group Co-ordination Group |
|---|---|---|
| 119 | Evaluate and, as appropriate, revise the safety guidance for single-handed fishermen provided by the MCA and Seafish to ensure that it remains fit for purpose and readily available to fishermen. | |

**Appropriate action planned:** 2020 JULY 31

| | |
|---|---|
| 120 | Take action to improve the promulgation of the available safety guidance and safety lessons to single-handed fishermen. |

Appropriate action planned: 2020 JULY 31

## *Millgarth*

**Report number: 15/2019**

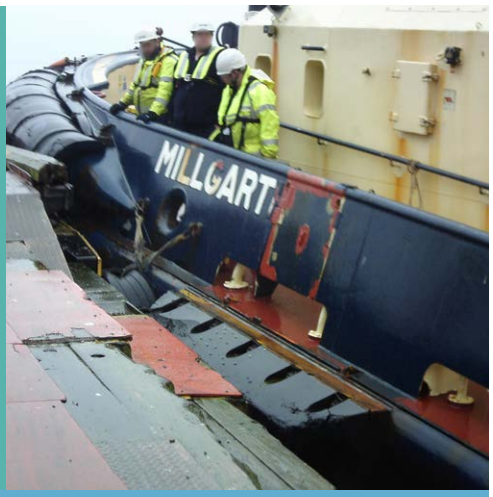
Tug

Accident date: 27/1/2019

### Fatal accident while boarding at the north oil stage at Tranmere Oil Terminal, Birkenhead, England

**Safety Issues**

- **Standing on oil stage fenders to access tugs was an extremely dangerous practice, particularly in poor weather conditions**
- **The lack of safe access to and from tugs was well recognised and had been raised on numerous occasions in the past**
- **The crew had not been fully prepared to deal with the emergency man overboard situation**
- **The shared risks between tug and terminal operators during self-mooring were not formally evaluated or mitigation measures discussed**




| No | Recommendation(s) to: Svitzer A/S |
|---|---|
| 121 | Review and amend its procedures, as necessary, to ensure that observations and non-conformities identified during internal audits are not closed out before corrective actions have been completed and safety lessons disseminated throughout the fleet. |

Appropriate action implemented

| | |
|---|---|
| 122 | Adopt measures to ensure that all crew are trained in the manoverboard recovery equipment on board their vessels and that regular drills are completed by all crews irrespective of the rotas they work. |

Appropriate action implemented

| | |
|---|---|
| 123 | Ensure that a thorough assessment of site-specifc risks, leading to an agreed procedure, is completed for all the locations where Svitzer tugs provide their service. Where shared risks are identifed, work jointly with the asset owners and operators to achieve this. |

Appropriate action implemented

| No | Recommendation(s) to: | Essar Oil UK Limited |
|---|---|---|
| 124 | Ensure that a thorough assessment of site-specifc risks, leading to an agreed procedure, is completed for all locations where tugs provide their services. Where shared risks are identifed, work jointly with the tug owners and operators to achieve this. | |

Appropriate action planned: Update requested NO DATE GIVEN

## *Stolt Groenland*

**Interim Report issued**

Chemical tanker

Accident date: 28/9/2019

### Explosion and fire at Ulsan, Republic of Korea

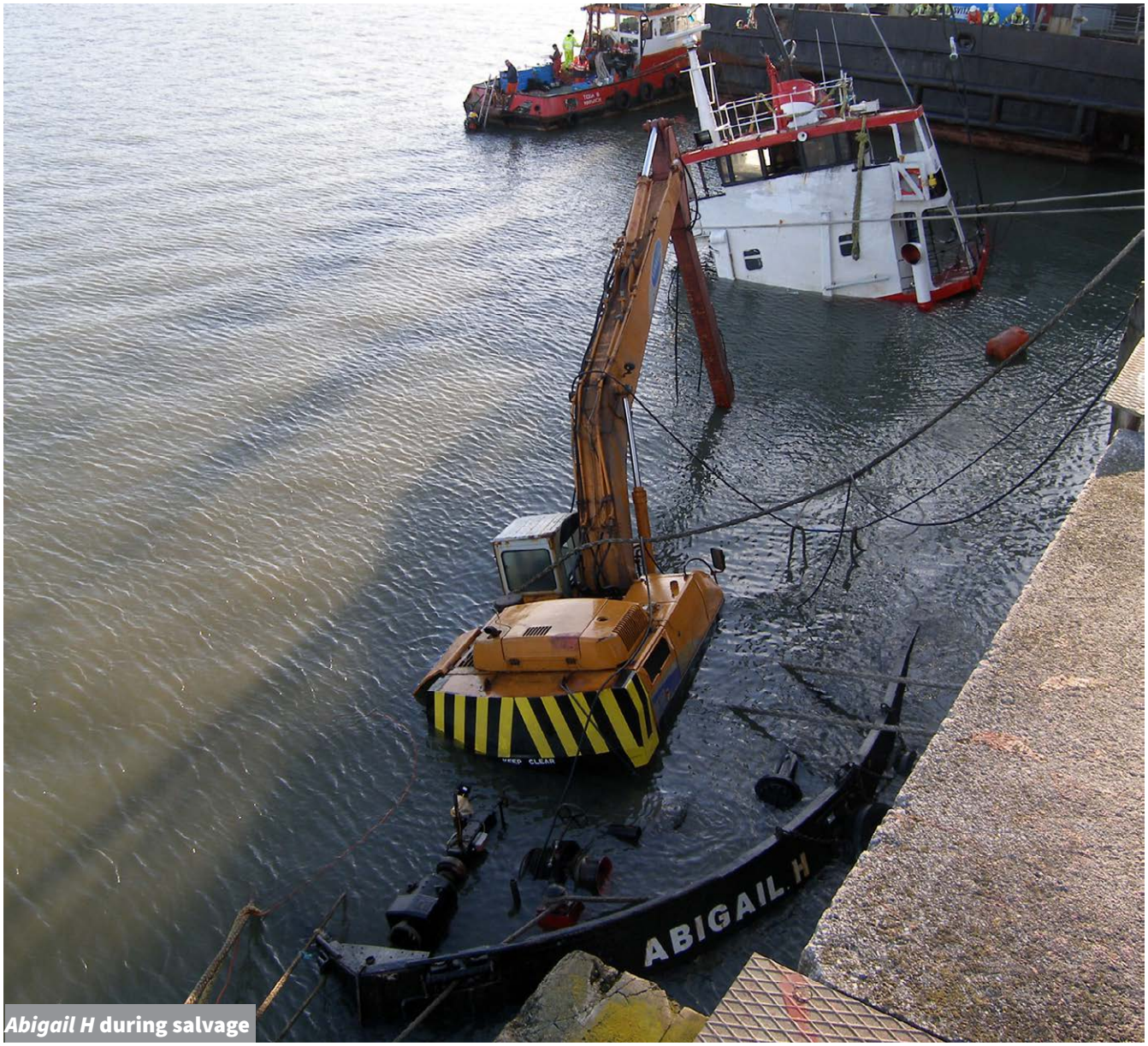
**Safety Issues**

- Explosion due to Styrene Monomer polymerization
- Cargo condition monitoring

**This interim report was issued to highlight safety concerns to chemical tanker owners/ operators and to request information from ship owners, ship and terminal operators, or individuals regarding any accident or 'near-misses' involving the carriage of styrene monomer on board ships, including any actions subsequently taken.**

**A full report will be published once the investigation is complete.**

## PROGRESS OF RECOMMENDATIONS FROM PREVIOUS YEARS




***Abigail H* during salvage**

# 2018 RECOMMENDATIONS - PROGRESS REPORT*

*Status as of 31 May 2019

## *Saga Sky/Stema Barge II*

**Report number: 3/2018**

General cargo vessel/rock carrying barge

Accident date: 20/11/2016

### Collision resulting damage to subsea power cables off the Kent coast

| No | Recommendation(s) to: | Maritime and Coastguard Agency |
|---|---|---|
| 2018/104 | Commission a study to review the full range of emergency response assets available in the Dover Strait area, including a reassessment of the need for a dedicated emergency towing capability. | |

Appropriate action planned: 


| No | Recommendation(s) to: | Maritime and Coastguard Agency/ United Kingdom Hydrographic Office |
|---|---|---|
| 2018/107 | Justify the need for regulatory powers which could be applied, where appropriate, to ensure vessels comply with International Hydrographic Organization recommendations made with respect to anchoring in the vicinity of submarine cables. | |

MCA - partially accepted: action implemented

UKHO: Appropriate action implemented

## *Constant Friend*

**Report number: 4/2018**

Stern trawler (N83)

Accident date: 23/9/2017

### Fatal man overboard in Kilkeel Harbour

| No | Recommendation(s) to: | Maritime and Coastguard Agency |
|---|---|---|
| 2018/110 | Review and amend MGN 413(F) – Voluntary Code of Practice for Employment of non-European Economic Area (EEA) Fishing Crew – to clarify the requirement, or otherwise, to seek Border Force authorisation before allowing non-EEA fishing crew to proceed ashore for local leave. | |

Appropriate action implemented

**MAIB comment**

**MGN 413(F) Amendment 1 was published on 4 May, and includes amendments provided by Border Force in relation to immigration policy with regard to non-EEA fishermen having shore leave. This document has since been further updated[2].**

[2] https://www.gov.uk/government/publications/mgn-413-amendment-2-voluntary-code-of-practice-for-employment-of-non-european-economic-area-eea-fishing-crew

## *Ocean Way*

**Report number:** 10/2018

Stern trawler (LK207)

Accident date: 3/3/2017

### Flooding and sinking off Lerwick

| No | Recommendation(s) to: Maritime and Coastguard Agency |
|---|---|
| 2018/115 | • Update the Fishermen's Safety Guide to include guidance on the emergency preparation and emergency response for flooding emergencies, including stability considerations.<br>• Review and, where appropriate, update its guidance to the fishing industry and its marine surveyors on:<br>– the maintenance of watertight integrity in fishing vessels where drain valves are fitted through watertight bulkheads.<br>– the construction standards of 15 – 24m fishing vessels to ensure that all watertight compartments are fitted with a dedicated bilge suction. A clearer definition of peak compartments should also be considered.<br>**Appropriate action implemented** |

Image: RNLI

## CV24

**Report number: 12/2018**

Commercial racing yacht

Accident date: 31/10/2017

### Grounding and loss at Cape Peninsula, South Africa


| No | Recommendation(s) to: | Maritime and Coastguard Agency |
|---|---|---|
| 2018/116 | Provide guidance and direction on safety management to Clipper Ventures plc in order to assure the safe operation of the company's yachts in accordance with the Small Commercial Vessel Code. | |

**Withdrawn**

**MAIB comment:**
**The Clipper Ventures Fleet is now flagged to Malta and therefore the Maritime and Coastguard Agency no longer has jurisdiction as Flag State to provide guidance and direction to Clipper Ventures plc in respect to Safety Management.**

| No | Recommendation(s) to: | Clipper Ventures plc |
|---|---|---|
| 117 | Review and improve company safety management procedures in co-operation with the Maritime and Coastguard Agency and aligned with the guidance proposed in MAIB recommendation 2018/116 above. This review should ensure that:<br>• Risk assessments for on-water operations identify all hazards and set out appropriate mitigating measures.<br>• Accidents and incidents are thoroughly investigated so that causal factors and lessons are identified in order that, where necessary, changes are made to company procedures to minimise the risk of recurrence.<br>• There is guidance and terms of reference for members of staff with responsibility for safety management. | |

**Withdrawn**

**MAIB comment:**
**The Clipper Ventures plc fleet of CV70 yachts was re-flagged to Malta before this recommendation was implemented. It is no longer appropriate for the company to work with the UK Maritime and Coastguard Agency to implement an effective safety management system for its Round the World race fleet, so this recommendation has been withdrawn.**

| | |
|---|---|
| 2018/118 | Update procedures for the safe navigation of its vessels at all times when underway, including:<br>• Defining the role, responsibility, training and experience necessary of a nominated navigator.<br>• Ensuring that thorough passage plans are prepared, taking into account guidance identified in this report.<br>• Ensuring that procedures include instructions when the nav station should be manned and navigation reporting policies between the nav and helm stations.<br>• Provision of training and guidance for all crew who may have navigation duties in the use of electronic navigational systems and how to identify hazards ahead within the determined fixing interval.<br>**Withdrawn** |

**MAIB comment:**
**Since the Clipper CV70 fleet re-flagged to Malta, the MAIB has not received any updates from Clipper Ventures plc on its progress implementing this recommendation so, exceptionally, the decision has been taken to withdraw it.**

## *CMA CGM Centaurus*

**Report number: 17/2018**

Container vessel — Accident date: 4/5/2017

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

| No | Recommendation(s) to: DP World UAE Region |
|---|---|
| 2018/127 | Review and improve its management of pilotage and berthing operations in respect of large container ship movements within the port of Jebel Ali, with particular regard to the following:<br>• Development of approved pilotage and manoeuvring plans, including optimum use of tugs and ensuring ships do not commit to the buoyed channel until completion of a detailed and effective master/pilot information exchange.<br>• Provision of approved pilotage and manoeuvring plans to a visiting ship as soon as practicable prior to the pilot boarding.<br>• Provision of Bridge Resource Management training specifically tailored to meet the needs of pilots.<br>• Removal of Key Performance Indicators that potentially create inappropriate performance bias towards efficiency against safety.<br>**Appropriate action planned:** Update requested NO DATE GIVEN |

| No | Recommendation(s) to: | International Chamber of Shipping/<br>International Maritime Pilots' Association/<br>International Harbour Masters' Association |
|---|---|---|
| 2018/128 | Conduct a joint campaign of information for ships' bridge teams, pilots and port authorities designed to:<br>• Promote the benefits of adhering to effective bridge resource management procedures during acts of pilotage.<br>• Endorse the BRM-P course as an effective means of providing pilots with the necessary skills to best utilise the resources available during acts of pilotage. | ICS - partially accepted: action implemented<br><br>IMPA - partially accepted: action implemented<br><br>IHMA - partially accepted: action implemented |


## *Solstice*

**Report number: 20/2018**

Scalloper/trawler (PH119)

Accident date: 26/9/2017

### Capsize and sinking off Plymouth with loss of 1 life

| No | Recommendation(s) to: | Maritime and Coastguard Agency |
|---|---|---|
| 2018/132 | Commission an independent review of UK SAR operational capability and HMCG network functionality to assess the effectiveness of the actions taken as a result of the lessons identified in the MAIB and Irish Coast Guard *Solstice* investigation reports. | Appropriate action implemented |

# 2017 RECOMMENDATIONS - PROGRESS REPORT*

*Status as of 31 May 2019

## CV21

Report number: 7/2017

Commercial racing yacht

Accident dates: 4/9/2015 and 1/4/2016

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

| No | Recommendation(s) to: | Royal Yachting Association/ World Sailing/British Marine |
|---|---|---|
| 2017/109 | Work together to develop and promulgate detailed advice on the use and limitations of different rope types commonly used, including HMPE, in order to inform recreational and professional yachtsmen and encourage them to consider carefully the type of rope used for specific tasks on board their vessels. | |

RYA: Appropriate action implemented

World Sailing: Appropriate action implemented

British Marine: Appropriate action planned: Progress Ongoing NO DATE GIVEN

## Osprey/Osprey II

Report number: 10/2017

RIBs

Accident date: 19/7/2016

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

| No | Recommendation(s) to: | Maritime and Coastguard Agency |
|---|---|---|
| 2017/115 | Include in its forthcoming Recreational Craft Code with respect to commercially operated passenger carrying RIBs:<br>• A requirement for the certificated maximum number of passengers to be limited to the number of suitable seats designated for passengers.<br>• Guidance on its interpretation of "suitable" with respect to passenger seating.<br>• A requirement for passengers not to be seated on a RIB's inflatable tubes unless otherwise authorised by the Certifying Authority and endorsed on the RIB's compliance certificate with specified conditions to be met for a particular activity. | |

Appropriate action planned: 2021 JUNE 30

## *Zarga*

**Report number:** 13/2017

LNG carrier

Accident date: 2/3/2015

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

| No | Recommendation(s) to: Bridon International Ltd |
|---|---|
| 2017/117 | Review and enhance its guidance and instructions for the monitoring, maintenance and discard of HMSF mooring ropes, and bring this to the attention of its customers. The revised guidance should emphasise the importance of:<br>• Deck fitting and rope D:d ratios.<br>• Applying appropriate safety factors for given applications.<br>• Understanding the causes of kinking and the potential impact of axial compression fatigue on the working life of HMSF rope.<br>• Rope fibre examination and testing as part of the assessment of fibre fatigue degradation and discard.<br>**Appropriate action planned:** 2020 JUNE 30 |
| 2017/118 | Conduct whole rope break tests, where practicable, to establish accurate realisation factors for its HMSF ropes.<br>**Appropriate action implemented** |

| No | Recommendation(s) to: EUROCORD |
|---|---|
| 2017/126 | Consider the inclusion of the following criteria during the next revision of ISO 2307:2010:<br>• Full load break tests to be applied to all new rope designs/constructions and when the molecular properties of fibre material have been significantly altered.<br>• Clarification that yarn break testing and the resultant realisation factors, as a means of determining rope strength, be treated only as supporting evidence to full rope break testing.<br>• Indicative realisation factors for HMSF.<br>• The effects of yarn twist levels on rope strength and fatigue life under varying operating conditions.<br>**Appropriate action implemented** |

## *Surprise*

**Report number:** 14/2017

Domestic passenger vessel

Accident date: 15/5/2016

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

| No | Recommendation(s) to: | Council of the Isles of Scilly |
|---|---|---|
| 2017/127 | Review its procedures for the examination and issue of Local Authority Boatman's licences. The review should consider the applicability of the licensing scheme and assurance of examination standards. | |

Appropriate action implemented

## *Louisa*

**Report number:** 17/2017

Vivier creel boat (SY30)

Accident date: 9/4/2016

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

| No | Recommendation(s) to: | Maritime and Coastguard Agency |
|---|---|---|
| 2017/130 | Urgently conduct research to confirm or otherwise the effectiveness of SOLAS lifejacket water performance test requirements to ensure approved lifejackets will satisfactorily turn a face-down, unconscious person onto their back with sufficient orientation and buoyancy to maintain their airway clear of the water. Any shortcomings in the water performance test requirements that may be identified should be brought to the attention of the International Maritime Organization for action. | |

Appropriate action implemented

## *Typhoon Clipper/Alison*

**Report number: 24/2017**

High-speed passenger catamaran/workboat

Accident date: 5/12/2016

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

| No | Recommendation(s) to: | Port of London Authority |
|---|---|---|
| 2017/147 | Review and, as necessary, clarify the application of:<br>• General Direction 28 requiring posting of a lookout or a suitable technical means of maintaining an effective lookout in any vessel with limited visibility.<br>• Byelaw 43 requiring the use of sound signals for vessels intending to enter the fairway; this should include consideration of vessels departing from a pier. | |

**Appropriate action planned:** Progress Ongoing – NO DATE GIVEN

**MAIB comment:**
**The implementation of this recommendation has been delayed due to resource issues and Brexit preparation priorities.**


Image: Thames Clipper

## *CV24*

**Recommendation issued pre-publication by letter**

Commercial racing yacht — Accident date: 31/10/2017

### Grounding and loss at Cape Peninsula, South Africa

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

**Partially accepted: action implemented**

## *Nortrader*

**Report number: 26/2017**

General cargo vessel — Accident date: 13/1/2017

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


| No | Recommendation(s) to: | Maritime and Coastguard Agency |
|---|---|---|
| 2017/154 | Update The Merchant Shipping (Carriage of Cargoes) Regulations 1999 with appropriate references to the IMSBC Code. | |

**Appropriate action planned:** 2022 DECEMBER 31

# 2016 RECOMMENDATIONS - PROGRESS REPORT*

*Status as of 31 May 2019

## *Hoegh Osaka*

**Report number: 6/2016**

Car carrier

Accident date: 03/01/2015

### Listing, flooding and grounding on Bramble Bank, The Solent

| No | Recommendation(s) to: | Maritime and Coastguard Agency |
|---|---|---|
| 2016/110 | Promulgate the amended version of IMO Resolution A.581(14) in respect of the minimum MSL of lashings to be used when securing road vehicles:<br>• Through its forthcoming Marine Guidance Note, providing guidance on the safe stowage and securing of specialised vehicles; and<br>• Within the next edition of its publication *Roll-on/Roll-off Ships - Stowage and Securing of Vehicles – Code of Practice*. | |

**Appropriate action implemented**

## *Carol Anne*

**Report number: 11/2016**

Workboat

Accident date: 30/04/2015

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

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

**Appropriate action implemented**

## JMT

**Report number: 15/2016**

Fishing vessel

Accident date: 09/07/2015

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

| No | Recommendation(s) to: Maritime and Coastguard Agency |
|---|---|
| 2016/130 | Include in its intended new legislation introducing stability criteria for all new and significantly modified decked fishing vessels of under 15m in length a requirement for the stability of new open decked vessels, and all existing vessels of under 15m to be marked using the Wolfson Method or assessed by use of another acceptable method. |
| | **Appropriate action planned:** 2020 DECEMBER 31 |
| 2016/131 | Require skippers of under 16.5m fishing vessels to complete stability awareness training. |
| | **Appropriate action planned:** 2020 DECEMBER 31 |

# 2015 RECOMMENDATIONS - PROGRESS REPORT*

*Status as of 31 May 2019

## *Cheeki Rafiki*

**Report number:** 8/2015

Sailing yacht

Accident date: 16/05/2014

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

Image: United States Coast Guard

| No | Recommendation(s) to: | British Marine Federation[3] |
|---|---|---|
| 2015/117 | Co-operate with certifying authorities, manufacturers and repairers with the aim of developing best practice industry-wide guidance on the inspection and repair of yachts where a GRP matrix and hull have been bonded together. | |

Appropriate action planned: Progress Ongoing – NO DATE GIVEN

| No | Recommendation(s) to: | Maritime and Coastguard Agency |
|---|---|---|
| 2015/119 | Issue operational guidance to owners, operators and managers of small commercial sailing vessels, including: | |

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

Appropriate action implemented

[3] British Marine Federation now known as British Marine.

| | |
|---|---|
| 2015/120 | Include in the SCV Code a requirement that vessels operating commercially under ISAF OSR should undergo a full inspection to the extent otherwise required for vessels complying with the SCV Code. |

Appropriate action planned: 2020 JUNE 30

## *Commodore Clipper*

**Report number: 18/2015**

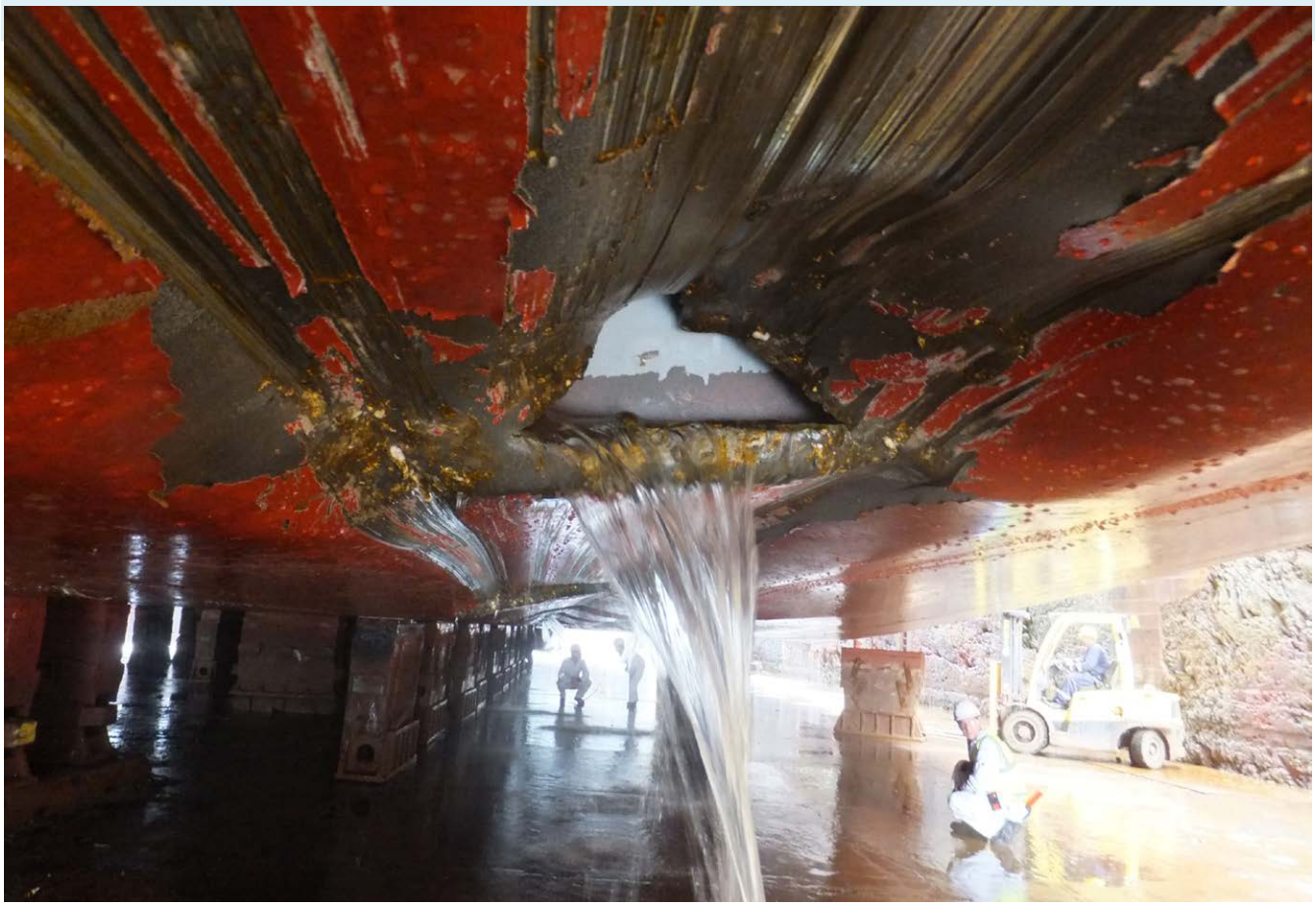
Ro-ro passenger ferry

Accident date: 14/07/2014

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

| No | Recommendation(s) to: | Government of Guernsey |
|---|---|---|
| 2015/146 | Implement measures designed to provide assurance that, post-qualification, its Special Pilotage Licence holders continue to demonstrate the required level of proficiency when conducting acts of pilotage. | |

Appropriate action implemented



## *Stella Maris*

**Report number: 29/2015**

Fishing vessel

Accident date: 28/07/2014

### Capsize and foundering 14 miles east of Sunderland

| No | Recommendation(s) to: | Maritime and Coastguard Agency |
|---|---|---|
| 2015/165 | Introduce intact stability criteria for all new and significantly modified decked fishing vessels of under 15m in length. | Appropriate action planned: 2020 DECEMBER 31 |
| 2015/166 | Revise as necessary and re-issue its guidance to fishing vessel owners and skippers on the application to fishing vessels of:<br>• The Merchant Shipping (Provision and Use of Work Equipment)Regulations 2006, and<br>• The Merchant Shipping (Lifting Operations and Lifting Equipment) Regulations 2006. | Appropriate action implemented |

| No | Recommendation(s) to: | Sea Fish Industry Authority |
|---|---|---|
| 2015/167 | Amend its construction standards for new registered vessels to increase the angle at which downflooding occurs by reviewing the placement of ventilation ducts in or adjacent to the bulwarks. | Appropriate action implemented |

| No | Recommendation(s) to: | Maritime and Coastguard Agency/ Marine Management Organisation |
|---|---|---|
| 2015/171 | Work together to ensure European Commission funded modifications are fully reviewed for their impact on vessel stability and safety by agreeing the remit of such reviews and setting realistic target times to enable such co-operation. | MCA: Appropriate action planned: 2020 JUNE 30<br>MMO: Appropriate action implemented |

# 2014 RECOMMENDATIONS - PROGRESS REPORT*

**There are no outstanding recommendations for 2014.**

# 2013 RECOMMENDATIONS - PROGRESS REPORT*

*Status as of 31 May 2019

## *St Amant*

**Report number:** 1/2013

Fishing vessel (BA101)

Accident date: 13/01/2012

### Loss of a crewman off the coast of north-west Wales

| No | Recommendation(s) to: Maritime and Coastguard Agency |
|---|---|
| 2013/105 | Improve the management of fishing vessel surveys and inspections by ensuring that:<br>• Existing survey and inspection procedures and guidance are reviewed to improve the clarity of the guidance and ensure that it is consistent throughout.<br>• There is an effective and readily accessible system to record and provide information to surveyors on the status of all identified deficiencies.<br>• Existing instructions requiring a photographic record of a vessel's principal features are followed.<br>**Appropriate action implemented** |

## *Purbeck Isle*

**Report number:** 7/2013

Fishing vessel (PH 104)

Accident date: 17/05/2012

### Foundering 9 miles south of Portland Bill with the loss of three lives

| No | Recommendation(s) to: Maritime and Coastguard Agency |
|---|---|
| 2013/204 | Align its hull survey requirements for fishing vessels of <15m length overall with those applied to workboats under the *Harmonised Small Commercial Vessels Code*.<br>**Appropriate action planned:** 2020 DECEMBER 31 |

## *Sarah Jayne*

**Report number: 13/2013**

Fishing vessel (BM 249)

Accident date: 11/09/2012

### Capsize and foundering 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:<br>• The increased risk of capsize from swamping if freeing ports are closed.<br>• The risk of downflooding if flush deck scuttles and fish hold hatch covers are opened at sea. | |

**Appropriate action planned:** 2020 DECEMBER 31

## *Vixen*

**Report number: 16/2013**

Passenger ferry

Accident date: 19/09/2012

### Foundering in Ardlui Marina, Loch Lomond

| No | Recommendation(s) to: | Stirling Council/ West Dunbartonshire Council |
|---|---|---|
| 2013/216 | Take action to:<br>• 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.<br>• 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:** Progress Ongoing NO DATE GIVEN

**West Dunbartonshire Council: Appropriate action implemented**

## *Audacious/Chloe T*

**Report[4] number: 27/2013**

Fishing vessels (BF 83/PZ1186) Accident dates: 10/8/2012 and 1/09 2012

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

| No | Recommendation(s) to: | Maritime and Coastguard Agency |
|---|---|---|
| 2013/250 | 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 implemented


## 2012 RECOMMENDATIONS - PROGRESS REPORT

**There are no outstanding recommendations for 2012.**

## 2011 RECOMMENDATIONS - PROGRESS REPORT

**There are no outstanding recommendations for 2011.**

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

# 2010 RECOMMENDATIONS - PROGRESS REPORT*

*Status as of 31 May 2019

## *Bro Arthur*

**Report number:** 9/2010

Oil/chemical tanker

Accident date: 19/02/2010

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

| No | Recommendation(s) to: | International Chamber of Shipping |
|---|---|---|
| 2010/120 | Include guidance on the following in the respective International Chamber of Shipping publications during their next periodic review:<br>• TSGC - management of contractors and sub-contractors with emphasis on the master's and other officers' and crew members' related health and safety responsibilities.<br>• 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 implemented

## *Olivia Jean*

**Report number:** 10/2010

Fishing vessel (TN35)

Accident date: 10/10/2009

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

| No | Recommendation(s) to: | Maritime and Coastguard Agency |
|---|---|---|
| 2010/123 | Consider the findings of this investigation when assisting the Department for Transport to address MAIB Recommendation 2010/112, including the need to improve fishing vessel standards and occupational safety by:<br>• 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.<br>• Providing clear and robust guidance to its surveyors and the fishing industry at large.<br>• Ensuring that accurate records are maintained such that surveyors are provided with the information required to survey fishing vessels effectively.<br>• Improving its recording of accidents on vessels' SIAS records to identify trends and act upon them. | |

Appropriate action implemented

# 2009 RECOMMENDATIONS - PROGRESS REPORT*

*Status as of 31 May 2019

## *Celtic Pioneer*

**Report number: 11/2009**

RIB

Accident date: 26/08/2008

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

| 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:


**MAIB comment**

**The implementation of this recommendation has been delayed due to a change in strategy for the regulation of small commercial vessels – revised target date mid-2021.**

## *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:

# 2008 RECOMMENDATIONS - PROGRESS REPORT*

*Status as of 31 May 2019

## Fishing Vessel Safety Study

Fishing vessels

Accident dates: 1992-2006

### Analysis of UK Fishing Vessel Safety 1992 to 2006

| No | Recommendation(s) to: | Maritime and Coastguard Agency |
|---|---|---|
| 2008/173 | In developing its plan to address the unacceptably high fatality rate in the fishing industry, identified in its study of statistics for the years 1996 to 2005, in addition to delivering the actions outlined at 6.2, the MCA is recommended to consider the findings of this safety study, and in particular to:<br>• Clarify the requirement for risk assessments to include risks which imperil the vessel such as: environmental hazards; condition of the vessel; stability etc.<br>• Work towards progressively aligning the requirements of the *Small Fishing Vessel Code*, with the higher safety standards applicable under the Workboat Code.<br>• 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.<br>• Ensure that the current mandatory training requirements for fishermen are strictly applied.<br>• Introduce a requirement for under 15m vessels to carry EPIRBs.<br>• 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.<br>• 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.<br>Appropriate action planned: 2020 DECEMBER 31 | |

| 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 implemented<br>MCA: Appropriate action implemented |

# 2007 RECOMMENDATIONS - PROGRESS REPORT*

*Status as of 31 May 2019

## *Danielle*

**Report number:** 5/2007

Fishing vessel (BM 478)

Accident date: 06/06/2006

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


| No | Recommendation(s) to: Maritime and Coastguard Agency |
|---|---|
| 2007/119 | Amplify and expand on current advice contained in MSN 1768 (M&F) such that fishermen are reminded:<br>• Medical scale requirements provide the minimum levels of medical stores only. Additional stores may be provided at the skipper's/owner's discretion.<br>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.<br>**Partially accepted: action implemented** |

# GLOSSARY OF ABBREVIATIONS, ACRONYMS AND TERMS

## ► Abbreviations and Acronyms ◄

| | | |
|---|---|---|
| AIS | - | Automatic Identification System |
| BRM-P | - | Bridge Resource Management training for pilots |
| Co | - | Company |
| CO | - | Carbon monoxide |
| COLREGs | - | Convention on the International Regulations for Preventing Collisions at Sea, 1972 |
| DfT | - | Department for Transport |
| EA | - | Environment Agency |
| ECDIS | - | Electronic Chart Display and Information System |
| EEA | - | European Economic Area |
| EMSA | - | European Maritime Safety Agency |
| EPIRB | - | Emergency Position Indicating Radio Beacon |
| EU | - | European Union |
| FISG | - | Fishing Industry Safety Group |
| GRP | - | Glass Reinforced Plastic |
| HMCG | - | Her Majesty's Coastguard |
| HMPE | - | High Modulus Polyethylene |
| HMSF | - | High Modulus Synthetic Fibre |
| ICS | - | International Chamber of Shipping |
| IHMA | - | International Harbour Masters' Association |
| IMO | - | International Maritime Organization |
| IMPA | - | International Maritime Pilots' Association |
| IMSBC Code | - | International Maritime Solid Bulk Cargoes Code |
| ISAF | - | International Sailing Federation (now World Sailing) |
| ISGOTT | - | International Safety Guide for Oil Tankers and Terminals |
| ISO | - | International Organization for Standardization |
| IT | - | Information Technology |
| LOLER | - | Lifting Operations and Lifting Equipment Reguations |
| LNG | - | Liquefied Natural Gas |
| Ltd | - | Limited (company) |
| m | - | metre |
| MCA | - | Maritime and Coastguard Agency |
| MGN | - | Marine Guidance Note<br>(M+F) - Merchant and Fishing<br>(F) - Fishing |
| MMO | - | Marine Management Organisation |
| MOB | - | Man overboard |
| MSN (M&F) | - | Merchant Shipping Notice (Merchant and Fishing) |
| N/a | - | Not applicable |
| nav | - | navigation |
| No | - | Number |
| nm | - | nautical mile |
| OSR | - | Offshore Special Regulations |
| P&I | - | Protection and Indemnity |
| PFD(s) | - | Personal Flotation Device(s) |

| | | |
|---|---|---|
| PLB | - | Personal Locator Beacon |
| plc | - | Public limited company |
| PUWER | - | Provision and Use of Work Equipment Regulations (1998) |
| REG | - | Red Ensign Group |
| RIB | - | Rigid Inflatable Boat |
| Ro-ro | - | Roll on, roll off vessel |
| RYA | - | Royal Yachting Association |
| SAR | - | Search and Rescue |
| SB | - | Safety Bulletin |
| SCV Code | - | Small Commercial Vessel Code |
| Seafish | - | Sea Fish Industry Authority |
| SIAS | - | Ship Inspections and Surveys |
| SOLAS | - | Safety of Life at Sea |
| TSGC | - | Tanker Safety Guide (Chemicals) |
| UAE | - | United Arab Emirates |
| UK | - | United Kingdom |
| UKHO | - | United Kingdom Hydrographic Office |

## ▶ Terms ◀

| | | |
|---|---|---|
| D:d | - | Bending diameter : diameter of the rope. |
| MSL | - | Maximum Securing Load. MSL can be expressed in kN, kg or t; e.g. a 100kN lashing is also referred to as a 10,000kg or 10t lashing. The variations in quantifier in the report reflects the variation in the source documentation. It is a term used to define the allowable load capacity for a device used to secure cargo to a ship. |

# FURTHER INFORMATION

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**Online resources**

www.gov.uk/maib

https://twitter.com/maibgovuk

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