

Marine Accident Recommendations and Statistics



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

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MARINE ACCIDENT INVESTIGATION BRANCH

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

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



INVESTIGATION PROCESS

The MAIB receives 1,200 to 1,500 reports of accidents and incidents each year. The simplified schematic on this page shows the sequence of events involved in investigating an accident.

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

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

Details of all accidents and incidents received are recorded on the branch's case management system and database (COMPASS). In addition, the findings and reports of all published investigations are uploaded to the International Maritime Organization's Global Integrated Shipping Information System (GISIS) database.

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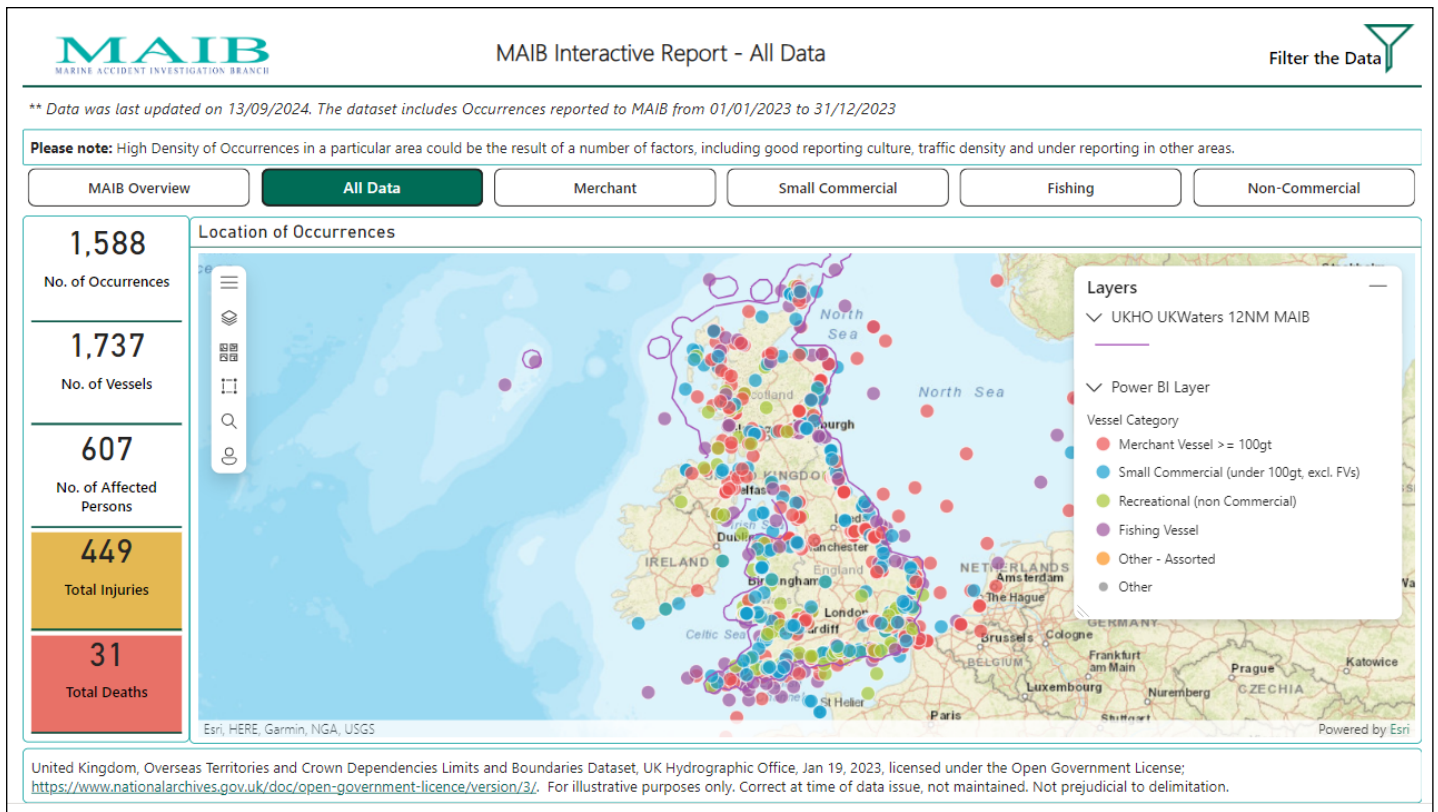
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MAIB's new data portal goes live

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

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

An example of the interactive dashboard



Occurrences table

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

Vessels table

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

Affected persons table

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

Download a pre-configured Power BI data set

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

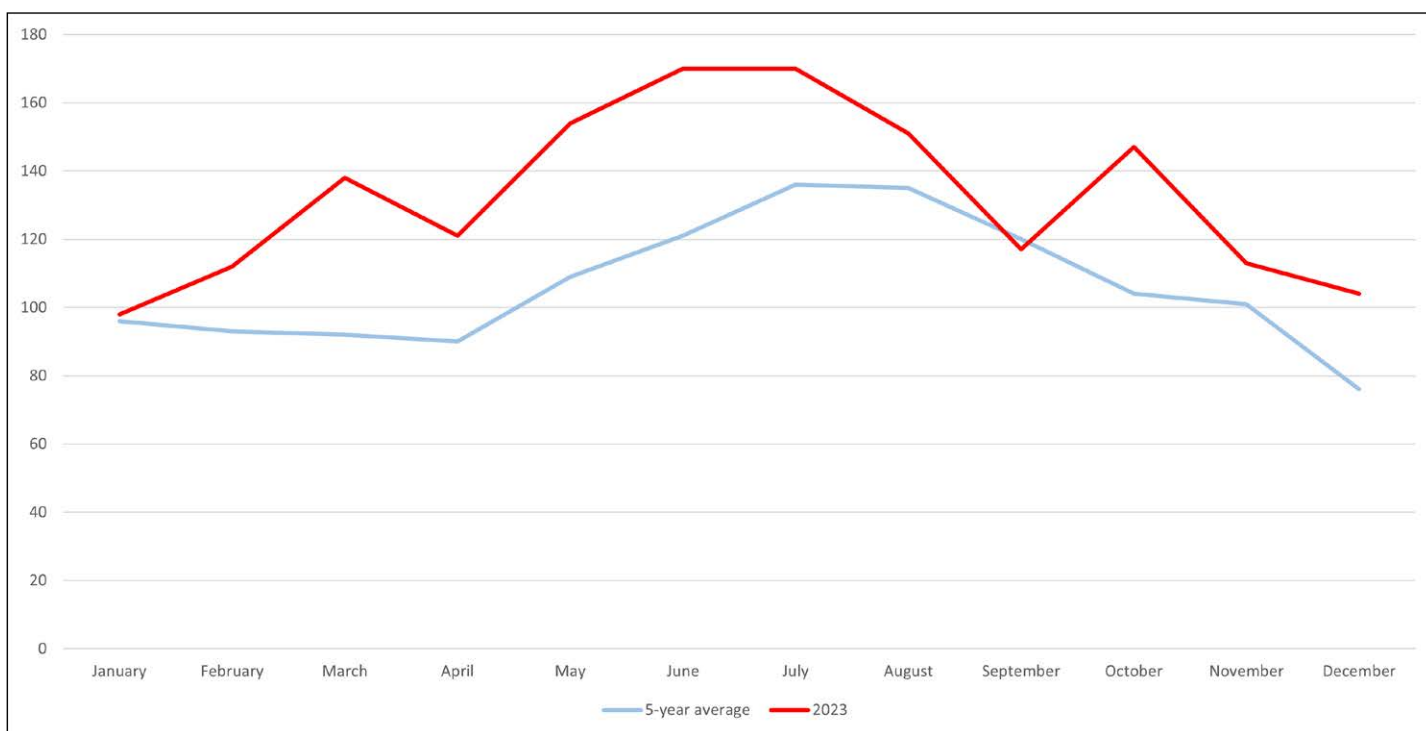
Users will need Microsoft Power BI Desktop installed on their workstation to open and edit the respective file. The free version of Power BI Desktop can be downloaded directly from Microsoft's website.

INTRODUCTION



I am pleased to introduce the MAIB Annual Report for 2023. As usual I will comment on safety matters before moving on to the work of the branch, but first the usual statistics:

Year	Marine Casualties and Marine Incidents	Investigations started	Investigations started involving loss of life
2023	1,592	19	12
2022	1,263	16	8
2021	1,530	22	14
2020	1,217	19	10
2019	1,090	22	13
2018	1,227	23	7
Average ¹	1,320	20.2	10.6



From the table above it can be seen that while the number of occurrences raised by the branch was higher than usual, in other respects 2023 was a fairly average year.

The acceptance rate for MAIB recommendations remains healthy at 96.3%. Some 27 recommendations were issued in 2023, of which 26 were accepted and 13 have already been implemented. One recommendation (2023/107) to the Maritime and Coastguard Agency (MCA) was rejected, and this is commented upon in the report. Unfortunately, the problem of some recipients being unable to commit to implementation timescales persists.

Less positive is that the branch only published 10 investigation reports in 2023 for reasons I explain below. The 2:1 ratio of investigations started to investigations published is unsustainable as it creates a backlog and delays the promulgation of safety learning. While we are making good use of safety bulletins

¹ Rounded to the first decimal place.

to circulate urgent safety messages, our top priority for this year continues to be reducing the backlog and improving the timeliness of reports. As I write we are achieving a 1:1 ratio of investigations started to investigations published, but we have commenced a number of challenging investigations this year with the ever-present risk of more to come.

SAFETY ISSUES

Merchant Ships

The investigations started in 2023 represent a fairly broad spread of safety issues but two accidents stand out.

The first was the girting of the tug *Biter* in February while assisting *Hebridean Princess*, which resulted in the deaths of the skipper and deckhand. As Azimuth Stern Drive and Voith propelled tugs have become more common there has been a tendency to relegate conventional tugs to tasks such as cold moves or shifting barges. However, when conventional tugs are involved in ship-assist towage the risks today are the same as they always were. The report into this tragic accident should be published later this autumn, and will be accompanied by a short safety video that stresses the importance of using a gob rope on conventional tugs to mitigate against the risks of girting.

The second was the collision between the general cargo vessel *Verity* and the bulk carrier *Polesie* in the German Bight traffic separation scheme that resulted in *Verity* sinking with the loss of five crew. I will not pre-empt here the findings of the MAIB's investigation and will contain myself to observing that had the vessels involved planned a greater passing distance from the outset the accident would likely not have occurred.

Commercial Fishing Vessels

There is a temptation to measure safety in the fishing industry by the annual tally of fatalities. Each death is a tragedy and fortunately there are few of them, though four lives were lost in 2023. This is below six, which is the average number of fatalities per year taken over the last decade but, as Table 22 in the report shows, the variation year-to-year is significant, making it hard to determine a firm trend.

A better metric for measuring fishing safety should be the total number of accidents reported to MAIB each year.

Accident type*	2017	2018	2019	2020	2021	2022	2023
VSMC	6	9	7	7	6	7	2
SMC	9	6	11	34	20	11	14
LSMC	129	120	142	121	64	42	51
MI	68	88	39	44	49	56	25
Total	212	223	199	206	139	116	102

* As defined in Annex B on page 62

Taken at face value the table above would indicate a sustained improvement in safety, but I am concerned that there is significant under-reporting of fishing vessel accidents. Twice in the last year, the branch has been contacted by lawyers supporting fishers pursuing personal injury claims but we have found no record of their accident. In both cases the injuries were significant, would have required hospital treatment, and the individuals had to give up their career in fishing. These were reportable accidents, and that they were 'hidden' speaks volumes about the safety culture on the vessels involved. The MAIB's reports aim to improve future safety, but we can only fulfil this task if accidents are reported to us.

BRANCH ACTIVITY AND DEVELOPMENT

The outflow of experienced staff that I reported on in the Annual Report 2022 continued into 2023 and also into this year. On the positive side, this has resulted in a number of internal promotions and some enthusiastic new members joining the team. The opposite side of the coin has been the high recruitment and training overhead and the pressure on existing staff as new members of the team learn their trade. This has resulted in some bottle-necking, which has choked the flow of reports out to consultation and publication. The flow has been restored, but the backlog persists and it will be some months yet before normal service is resumed.

The data portal I wrote about last year has now gone live and is available via the branch's website (see the advert at the front of this report). At present it contains just 2023 data, but over the next few months the service will be back-populated with data from 2022 to 2019. Given time, we aspire to provide data from 2011, a year that marked a shift in recording, and will of course provide future data on a periodic basis once it has been validated. I do hope that this resource is of use to the industry, researchers and the public.

The plan to refresh The Merchant Shipping (Accident Reporting and Investigation) Regulations 2012 has, regrettably, slipped still further. In 2022, it was delayed by other higher priority legislation and this year the consultation was imminent when the General Election was called. It is my sincere hope that next year's annual report will announce that the MAIB's enabling legislation has been successfully updated.

FINANCE

The annual report deals principally with the calendar year 2023. However, for ease of reference, the figures below are for the financial year 2023/24, which ended on 31 March 2024. The MAIB's funding from the DfT is provided on this basis, and this complies with the government's business planning programme.

£k	2023/24 Budget	2023/24 Outturn
Costs – Pay	3,593	3,489
Costs – Non Pay	1,999	1,449
Totals	5,592	4,938

Captain Andrew Moll OBE
Chief Inspector of Marine Accidents



PART 1: CASUALTY REPORTS TO MAIB IN 2023

The MAIB received reports of 1,592 accidents (casualties and incidents²) to UK vessels worldwide or any vessels within UK coastal waters during 2023. A total of 1,741 vessels were involved.

Of the reports received, 641 accidents were outside the scope of this overview; as an example, accidents to people that did not involve any actual or potential casualty to a vessel have been omitted.

Chart 1 represents the 951 accidents that were in scope, involving 1,207 commercial vessels, reported in 2023 according to severity. Charts 2 to 5 further subdivide the data by vessel type.

² As defined in Annex B on page 62.

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

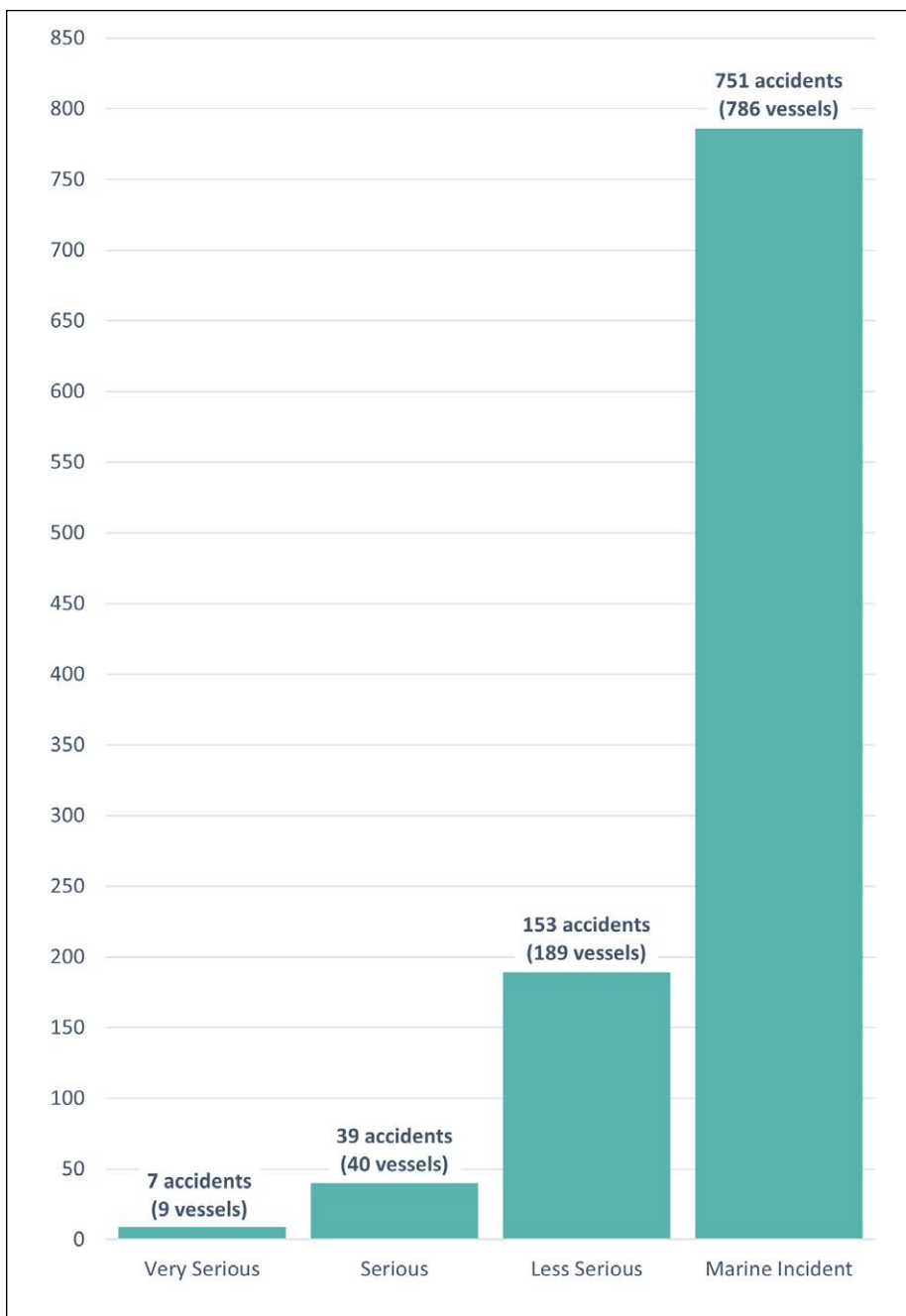


Chart 2: UK merchant vessels of 100gt or more

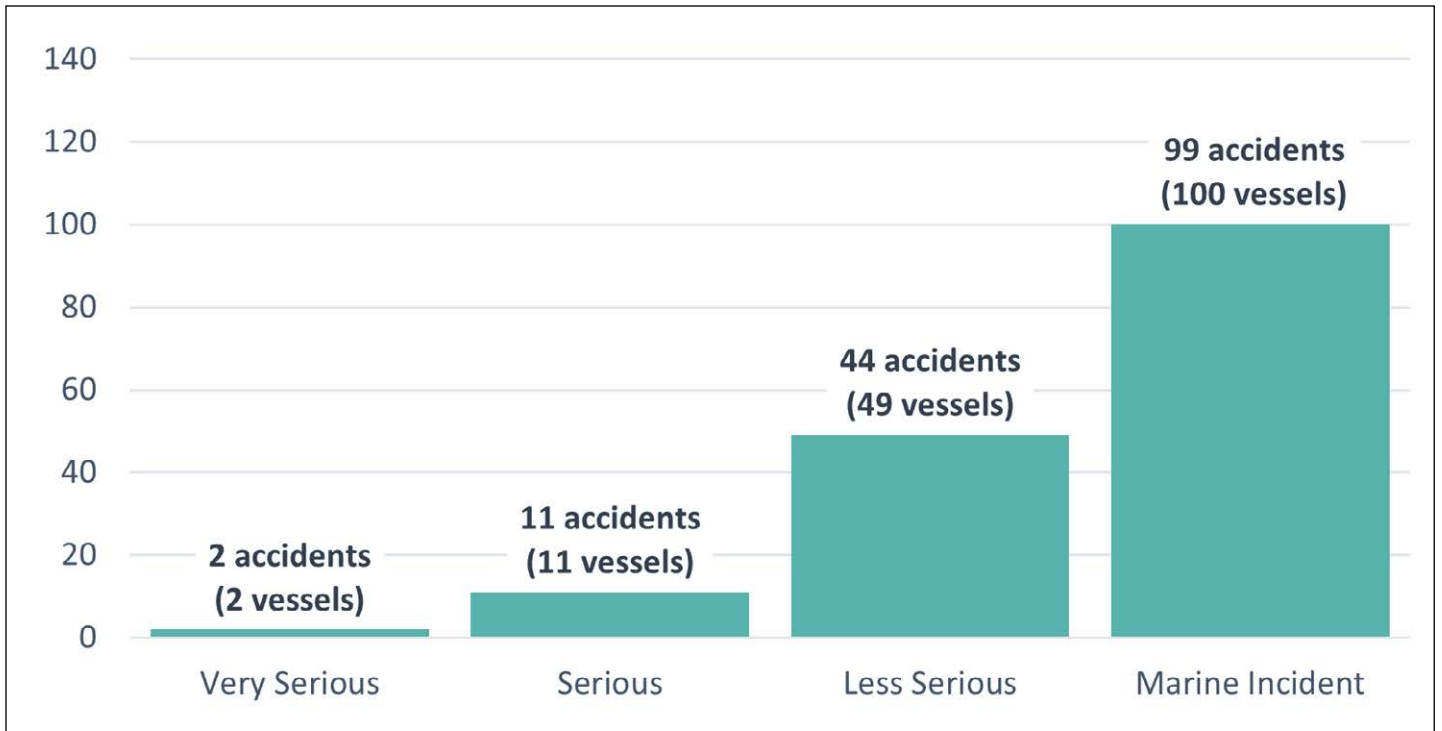


Chart 3: UK merchant vessels of under 100gt

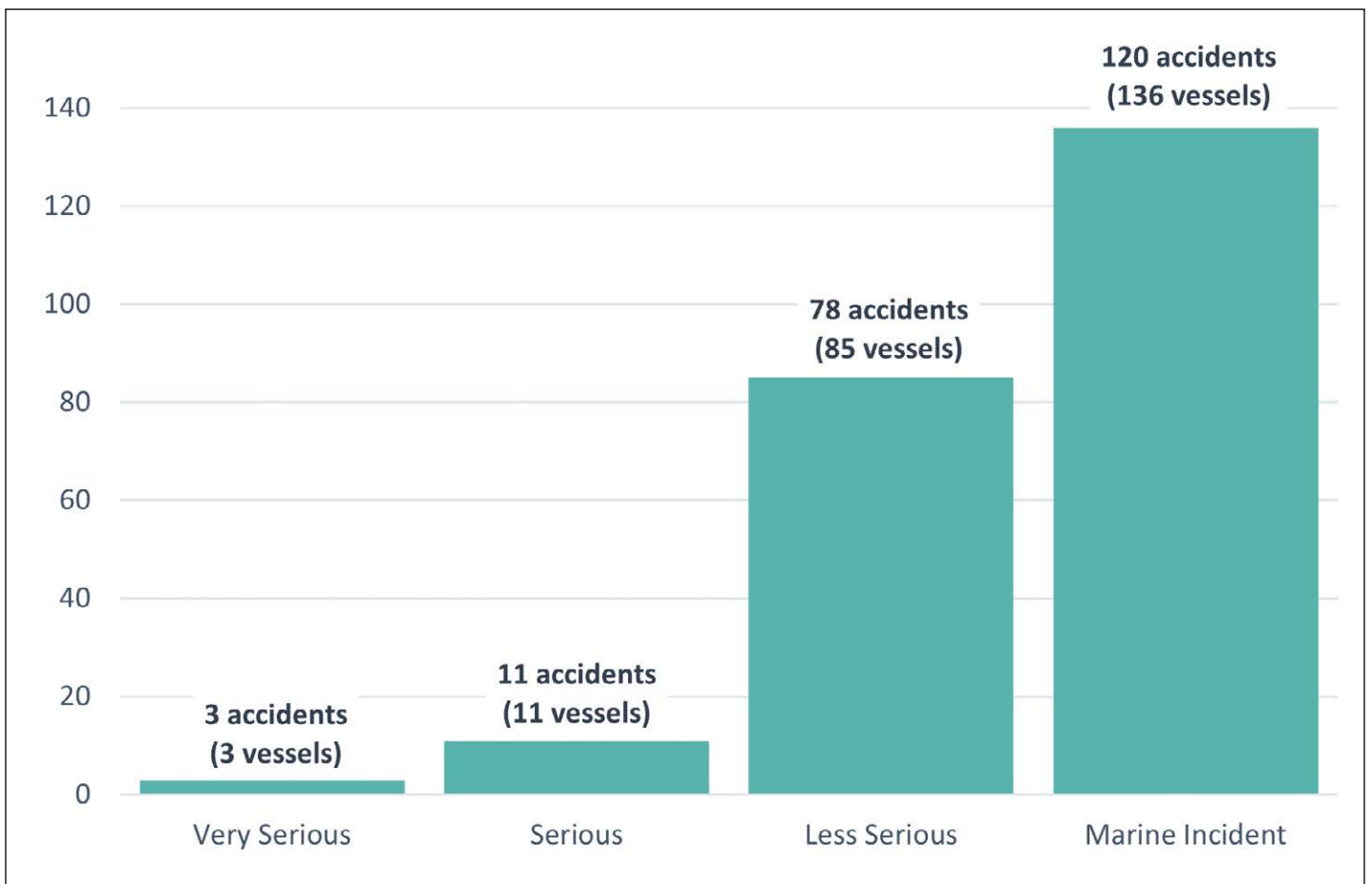


Chart 4: UK fishing vessels

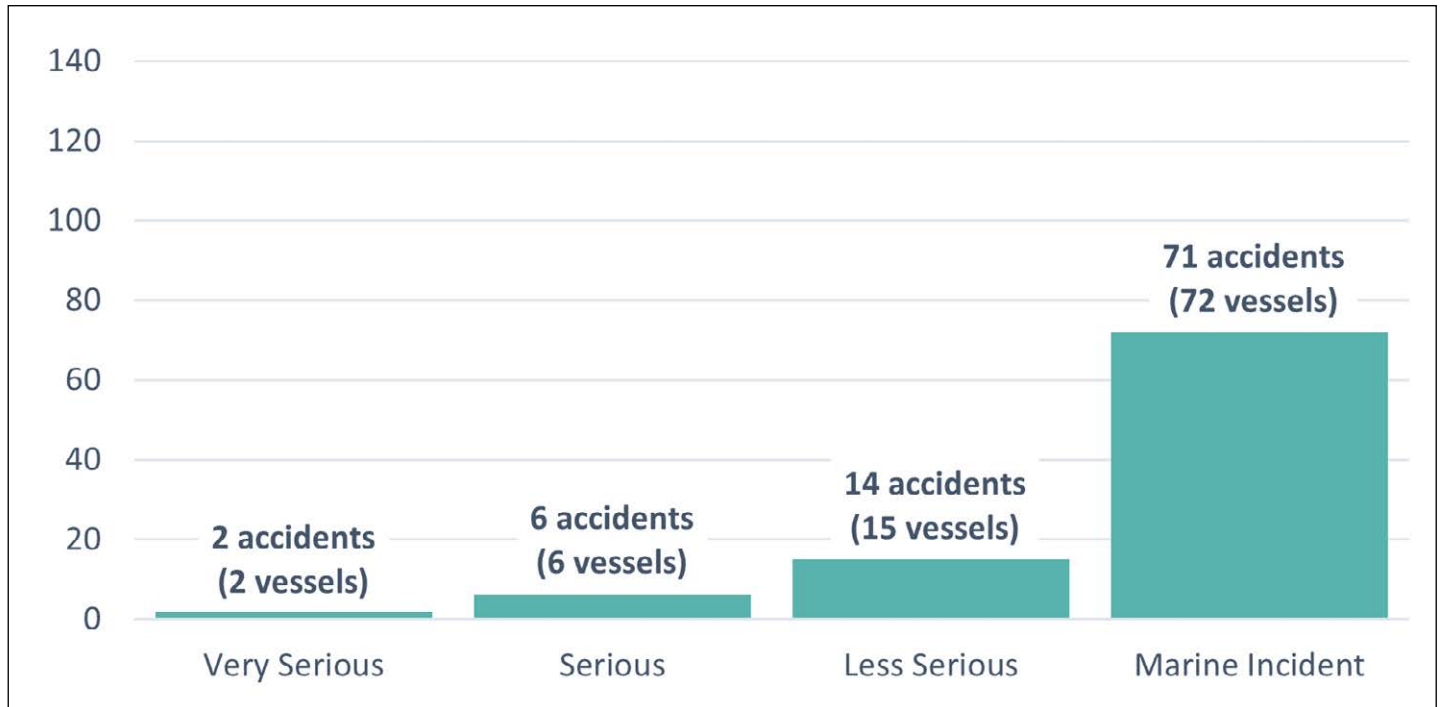
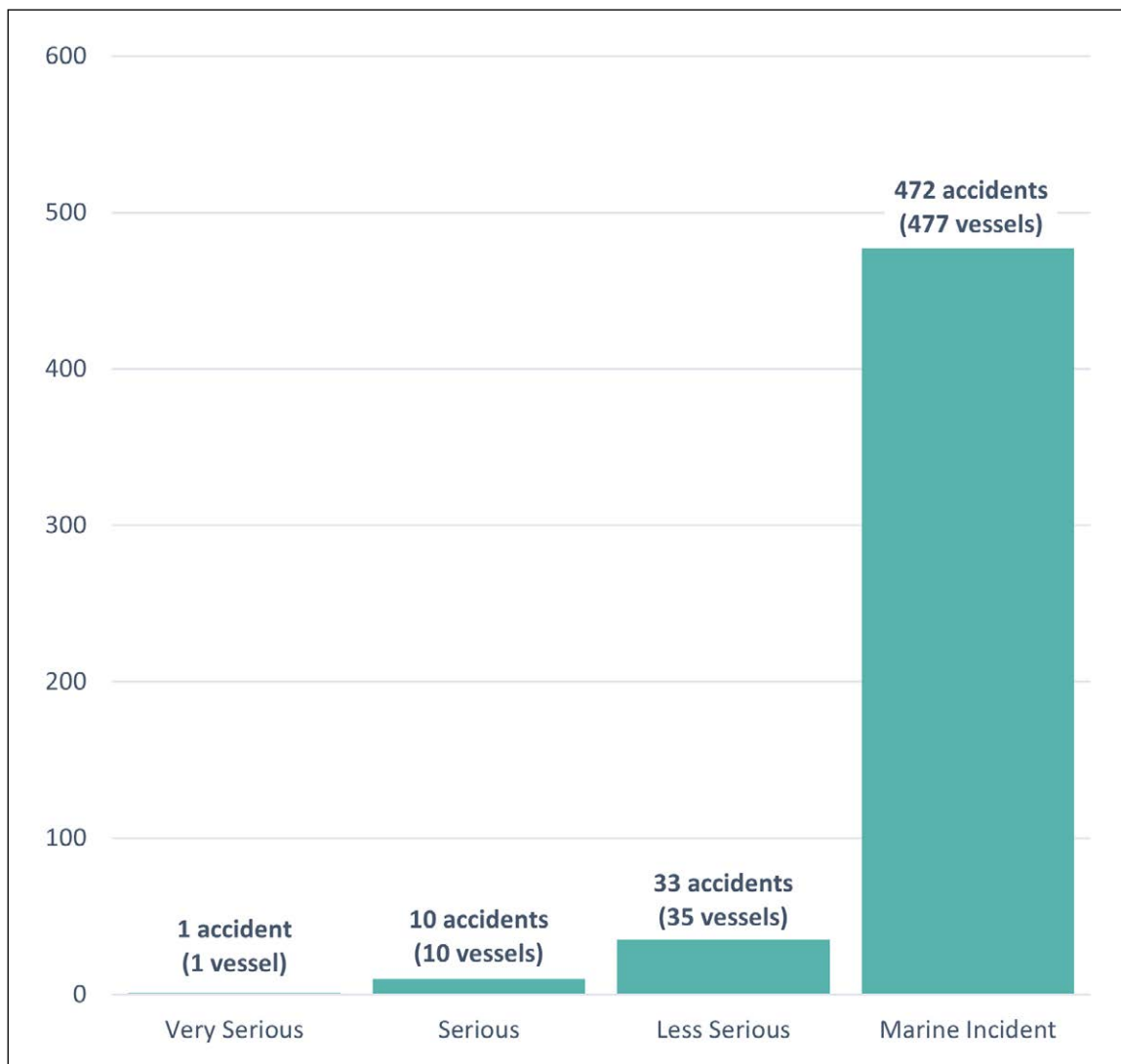


Chart 5: Non-UK commercial vessels in UK 12 mile waters



SUMMARY OF INVESTIGATIONS STARTED IN 2023

Date	Occurrence details
8 Jan	Fall from height on boarding the Finland registered ro-ro cargo ship Finnhawk (9207895) from the UK registered pilot vessel Humber Saturn off the Humber Estuary, England, resulting in the loss of 1 life.
11 Feb	Fire in the engine room and funnel space on board UK registered ro-ro passenger ferry Stena Europe (7901760) while approaching Fishguard Port in Pembrokeshire, Wales.
24 Feb	Capsize and foundering of UK registered tug Biter in the Firth of Clyde off Greenock, Scotland, resulting in the loss of 2 lives.
11 Mar	Grounding of 11m Anguilla registered ³ commercial day excursion boat Calypso 2 on the north-west coast of Anguilla, causing the 2 crew and 4 passengers to be thrown overboard. Several injuries were sustained, and 2 lives were lost.
17 Apr	Fall of an engine room crew member down a ventilation duct on board Cayman Islands registered ⁴ bulk carrier Equinox Seas (9229697) at a shipyard in Ermoupoli, Syros, Greece, resulting in loss of 1 life ⁵ .
23 Apr	Grounding of UK registered bulk carrier Indian Partnership (9521409) near Misool, Indonesia ⁶ .
29 Apr	Machinery failure and subsequent grounding of UK registered ro-ro passenger ferry Pentalina (9437969) at St Margaret's Hope, South Ronaldsay, Scotland.
7 Jun	Sea Safari RIB Lundy Explorer proceeded at slow speed when the wave action caused passengers to be dislodged from their seats resulting in injuries as they departed Ilfracombe, Devon, England ⁷ .
22 Jun	Propulsion failure of UK registered passenger vessel Oceandiva London (9938078) and subsequent contact with a moored barge at Crossness, Halfway Reach, River Thames, London, England.
20 Jul	Grounding of commercial swim event support vessel Channel Queen on a wreck near The Needles, Isle of Wight, England. The damaged vessel was abandoned by crew and passengers in nearby Scratchell's Bay and was later declared as a total constructive loss ⁸ .
21 Sep	Capsize of 7.29m UK registered fishing vessel Lexi Rose (BF370) 2nm east of Macduff, Aberdeenshire, Scotland, resulting in the loss of 1 life.
28 Sep	A passing dive support vessel (Karin) struck a recreational diver making an underwater decompression stop in Scapa Flow, the Orkney Islands, Scotland, resulting in the loss of 1 life ⁹ .

³ Under investigation on behalf of the Governor of Anguilla.

⁴ Under investigation on behalf of the Government of the Cayman Islands/Maritime Authority of the Cayman Islands.

⁵ The accident investigation report was subsequently published on 27 September 2024:
<https://www.gov.uk/maib-reports/fall-from-height-on-bulk-carrier-equinox-seas-with-loss-of-1-life>

⁶ The completed preliminary assessment was subsequently published on 23 August 2024:
<https://www.gov.uk/maib-reports/grounding-of-bulk-carrier-indian-partnership>

⁷ A safety bulletin (<https://www.gov.uk/maib-reports/safety-warning-issued-following-a-serious-passenger-injury-during-a-rigid-inflatable-boat-ride>) was issued on 15 September 2023.

⁸ The accident investigation report was subsequently published on 25 July 2024:
<https://www.gov.uk/maib-reports/grounding-and-subsequent-loss-of-commercial-swim-event-support-vessel-channel-queen>

⁹ A safety bulletin (<https://www.gov.uk/maib-reports/safety-warning-issued-following-contact-between-a-diving-support-boat-and-a-recreational-diver-with-loss-of-1-life>) was issued on 27 June 2024.

Date	Occurrence details
2 Oct	Fall from a gangway on board UK registered sail training vessel Pelican of London (5273339) moored at Sharpness, Gloucester, England, resulting in the loss of 1 life ¹⁰ .
6 Oct	Failure of fishing gear on board UK registered fishing vessel Honeybourne III (PD905) approximately 16nm south-west of Beachy Head, East Sussex, England, resulting in the loss of 1 life ¹¹ .
24 Oct	Collision between the Isle of Man registered ¹² general cargo vessel Verity (9229178) and the Bahamas registered bulk carrier Polesie (9488097) in the German Bight traffic separation scheme, resulting in the sinking of Verity with the loss of 1 life. Two of the remaining 6 crew members were recovered from the water and 4 are missing, presumed deceased.
4 Nov	Loss of propulsion of UK registered passenger vessel Spirit of Discovery (9802683) in the Bay of Biscay, resulting in multiple passenger injuries during heavy weather. One of the passengers suffered spinal injuries and later died.
16 Nov	Grounding and loss of UK registered fishing vessel Sustain (UL45) at the western entrance of Loch Broom, Ullapool, Scotland. The crew were rescued uninjured.
12 Dec	Man overboard, presumed deceased, from UK registered fishing vessel Amadeus (TH7) in the German Bight, approximately 54nm north-west of Heligoland.
13 Dec	Man overboard from UK registered 8.18m fishing vessel Nista (LK121) approximately 1nm west of Luinig, Scotland, resulting in the loss of 1 life.



Pelican of London

¹⁰ The accident investigation report was subsequently published on 12 September 2024: <https://www.gov.uk/maib-reports/fall-overboard-from-sail-training-vessel-pelican-of-london-with-loss-of-1-life>

¹¹ A safety bulletin <https://www.gov.uk/maib-reports/safety-warning-issued-following-a-chain-failure-on-scallop-dredger-honeybourne-iii-with-loss-of-1-life> was issued on 7 February 2024.

¹² Under investigation on behalf of the Isle of Man Ship Registry as the lead marine safety investigation state, and in agreement with the vessel flag states and the coastal state.

PART 2: REPORTS AND RECOMMENDATIONS

INTRODUCTION

The following pages list the accident investigation reports and safety bulletins published by the MAIB during 2023. 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 64.

*Status as of 4 July 2024

Background

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

Following an investigation the MAIB will, normally, make a number of recommendations. These will be contained within the published report but will also be addressed in writing to the individuals or senior executives of organisations concerned. Urgent safety recommendations may also be made in safety bulletins or by letter from the Chief Inspector to the organisations involved, which can be published or issued at any stage of an investigation.

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

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

RECOMMENDATION RESPONSE STATISTICS 2023

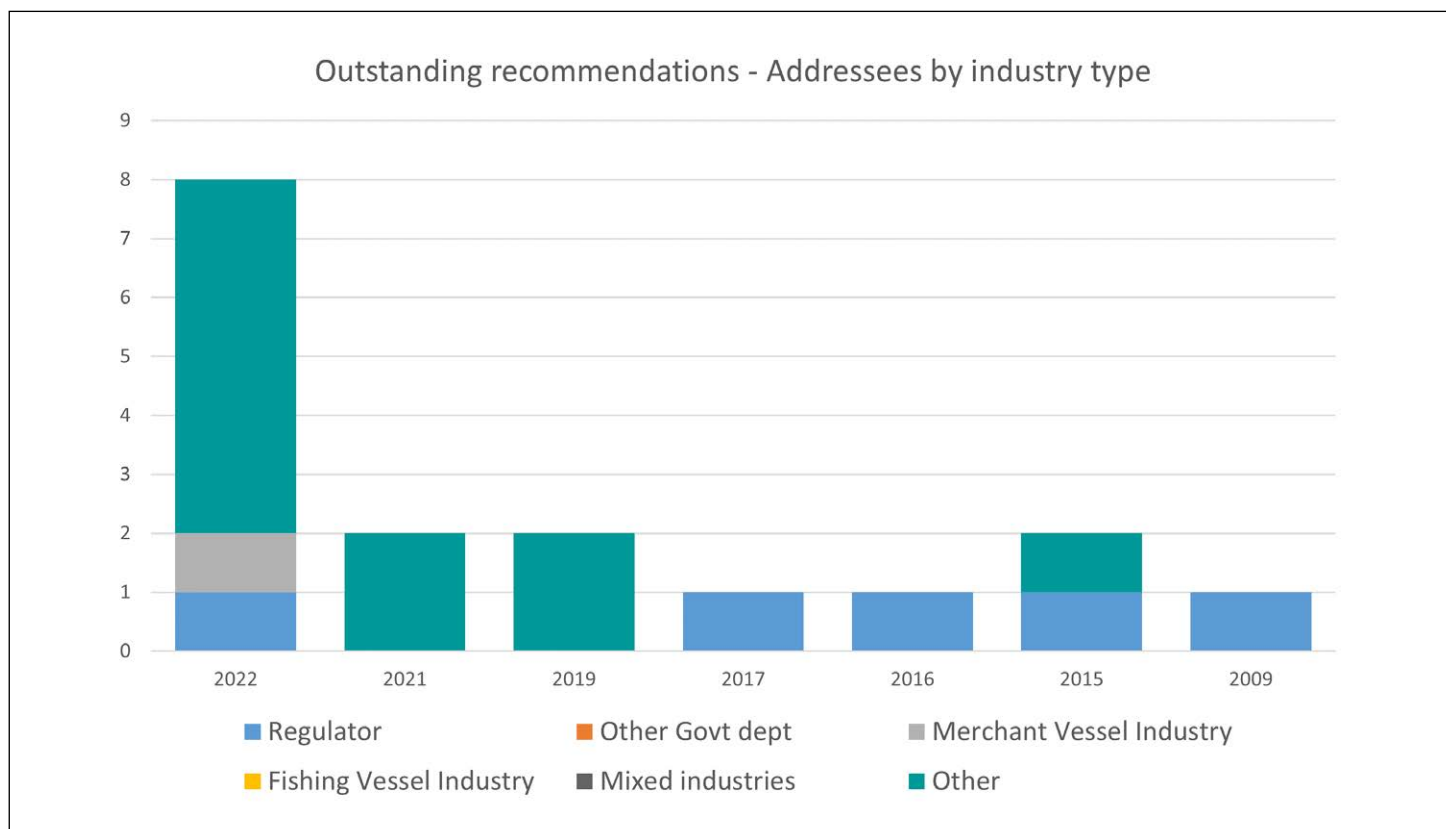
27 recommendations were issued to 16 distinct addressees¹³ in 2023. The percentage of all recommendations that are either **accepted and implemented** or **accepted, yet to be implemented** is **96.3%**.

Year	Total*	Accepted Action		Partially Accepted	Withdrawn	Rejected	No Response Received
		Implemented	Yet to be Implemented				
2023	27	13	13	0	0	1	0

*Total number of recommendations issued








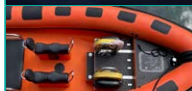





RECOMMENDATION RESPONSE STATISTICS FROM PREVIOUS YEARS

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



¹³ For the purpose of these statistics, recommendation S2023/104M to all vessel owners and operators that have had DSB liferafts certified by the service station Comfer Marin SL during the period of 1 January 2017 to 30 June 2022, page 15 has been classified as 1 distinct addressee.

LIST OF PUBLICATIONS AND RECOMMENDATIONS ISSUED IN 2023

Vessel name(s)	Category	Publication date (2023) and report number	Page
 <i>Finnmaster</i>	Serious Marine Casualty	23 March No SB1/2023	12
 <i>Emma Louise</i>	Very Serious Marine Casualty	27 April No 1/2023	12
 <i>Harriet J</i>	Very Serious Marine Casualty	22 June No 2/2023	13
 <i>Copious</i>	Very Serious Marine Casualty	29 June No 3/2023	14
 <i>Moritz Schulte</i>	Very Serious Marine Casualty	17 August No 4/2023	14
 <i>Piedras</i>	Very Serious Marine Casualty	24 August No SB2/2023	15
 <i>Scot Carrier/Karin Høj</i>	Very Serious Marine Casualty	8 September No 5/2023	16
 <i>Sea Safari RIB</i>	Serious Marine Casualty	15 September No SB3/2023	17
 <i>RRS Sir David Attenborough</i>	Marine Incident	2 November No 6/2023	17
 Inflatable migrant boat	Very Serious Marine Casualty	8 November No 7/2023	18
 <i>BBC Marmara</i>	Serious Marine Casualty	30 November No 8/2023	19
 <i>Resurgam</i>	Very Serious Marine Casualty	7 December No 9/2023	20
 <i>Seadogz</i>	Very Serious Marine Casualty	14 December No 10/2023	21

Preliminary Assessment summaries published on the MAIB's website in 2023

Vessel name(s)	Category	Description	Publication date (2023) and report number
<i>Midsummer</i>	Marine incident	Injury to person during man overboard training on a RIB at St. Andrews Sailing Club, Fife, Scotland on 29 June 2023.	5 October No PA1/2023

2023 RECOMMENDATIONS - PROGRESS REPORT*

*Status as of 4 July 2024

Finnmaster

Safety bulletin number: SB1/2023

Ro-ro cargo ship

Accident date: 19/9/2021

Potential fire hazards from flexible hose installations identified following a fire on board the roll-on/roll-off cargo ship *Finnmaster* in Hull, England

Safety Issues

- ▶ The modification to the alarms system using flexible hoses was not presented to the classification society for approval
- ▶ The engine inspections and surveys carried out during a period of more than 15 years did not identify the use of long flexible hoses routed near to a high temperature exhaust

Although no recommendations were made in this safety bulletin, three recommendations were issued in SB1/2022, relating to the same accident but highlighting serious concerns about potential defects in CO₂ fixed firefighting systems.

Emma Louise

Report number: 1/2023

Sports cruiser

Accident date: 11/1/2022

Carbon monoxide poisoning on board the sports cruiser *Emma Louise* resulting in two fatalities at Port Hamble Marina, River Hamble, England

Safety Issues

- ▶ Exhaust gases funnelled into covered cockpit while engine running alongside
- ▶ No CO alarm fitted
- ▶ Low awareness of CO risk
- ▶ No ventilation to disperse the CO

Given the recommendations issued by the MAIB as a result of its *Love for Lydia* investigation, and the subsequent actions taken during this investigation, no further recommendations were made in this report.



Harriet J

Report number: 2/2023

Fishing vessel (AH180)

Accident date: 28/8/2021

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

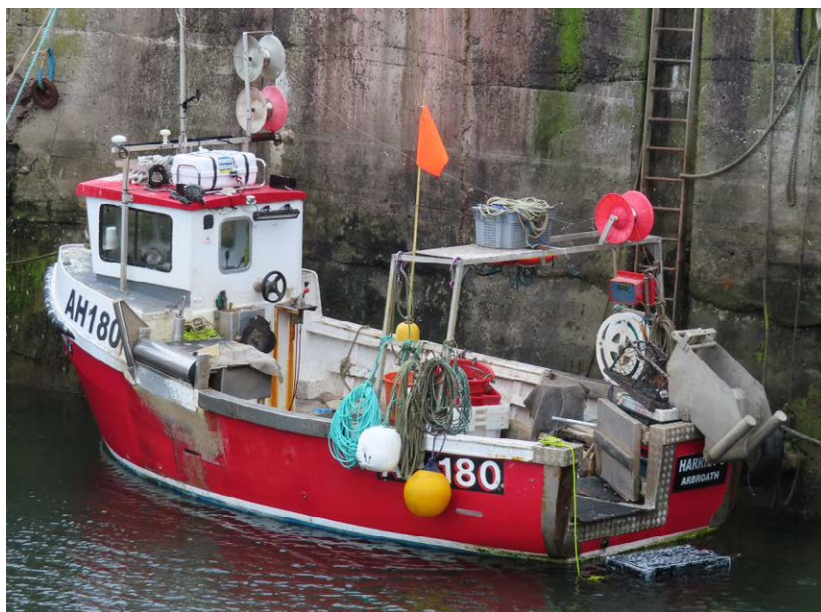
Safety Issues

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

No. Recommendation(s) to: Fishing Industry Safety Group to:

2023/101 Expedite the delivery of the outcomes of its working group on lone-operated fishing vessels, taking into account the work commissioned by the MCA and Seafish.

Appropriate action planned: 30 September 2025



Copious

Report number: 3/2023

Fishing vessel (LK 985)

Accident date: 18/2/2021

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

Safety Issues

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



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

2023/102 Amend commercial fishing vessel regulations to ensure that there is an explicit requirement, in line with that in The Workboat Code Edition 2, for fishing vessels to have an efficient means to recover an unconscious person from the water that is demonstrable during surveys and inspections.

Appropriate action planned: 31 March 2027

Moritz Schulte

Report number: 4/2023

Liquefied petroleum gas/ethylene carrier

Accident dates: 4/8/2020

Engine room fire and subsequent fatality on board the liquefied petroleum gas/ethylene carrier *Moritz Schulte* in Antwerp, Belgium

Safety Issues

- ▶ Ineffective knowledge of fuel systems
- ▶ Poor engineering skills and knowledge
- ▶ Bypassing procedural safety systems
- ▶ Ineffective training system and inappropriate promotion
- ▶ Inadequate fire training affected rescue

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



Piedras

Safety bulletin number: 2/2023

Fishing vessel

Accident date: 1/6/2022

Potential failure of Deutsche Schlauchboot GmbH (DSB) liferafts serviced by Comfer Marin SL, Marin, Spain identified following the foundering of the fishing vessel *Piedras* (FD 528) south-west of Mizen Head, Ireland

Safety Issues

- ▶ Concerns relating to the servicing and certification of liferafts
- ▶ Risk of liferafts not functioning correctly when deployed

No. Recommendation(s) to: Survitec Group Limited to:

S2023/103 Distribute a copy of the safety bulletin to all vessel owners and operators that have had Deutsche Schlauchboot GmbH liferafts certified by the service station Comfer Marin SL during the period 1 January 2017 to 30 June 2022 and continue to take actions to urgently address recommendation 2022/130.

Appropriate action implemented ✓

No. Recommendation(s) to: All vessel owners and operators that have had DSB liferafts certified by the service station Comfer Marin SL during the period 1 January 2017 to 30 June 2022 to:

S2023/104M Immediately contact their nearest approved Survitec liferaft service station to arrange for the liferafts to be urgently reinspected and serviced to ensure they are fully functional and comply with statutory requirements.

Appropriate action implemented ✓



Scot Carrier/Karin Høj

Report number: 5/2023

General cargo vessel/split hopper barge

Accident date: 13/12/2021

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

Safety Issues

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



No. Recommendation(s) to: Intrada Ships Management Ltd to:

2023/105 Review the results of its programme of navigational audits and determine what additional training and instruction is needed for its masters and crews. Any additional development needs identified from this process should be completed within 12 months.

Appropriate action planned: 30 September 2024 ●

No. Recommendation(s) to: Rederiet Høj to:

2023/106 Ensure that it actively monitors crewing levels to ensure its vessels are adequately crewed at all times.

Appropriate action implemented ✔

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

2023/107 Advise the shipping industry that the posting of a lookout in addition to a bridge watchkeeper during the hours of darkness and restricted visibility is an absolute requirement in UK waters and on UK ships, and to clarify this in its publications.

Rejected ✘

MAIB comment: The MCA has referred to the requirements for watchkeeping in The Merchant Shipping (Standards of Training, Certification and Watchkeeping) Regulations 2022 and the guidance previously published in MGN 315 (M) in 2006 in its response to this recommendation. However, it is disappointing that the specific intent of this recommendation has not been addressed with no further advice issued to the shipping industry making explicit the UK's absolute requirement that a lookout is provided during the hours of darkness and restricted visibility.

Rigid inflatable boat

Safety bulletin number: 3/2023

Rigid inflatable boat

Accident date: 7/6/2023

Serious passenger injury on board a sea safari rigid inflatable boat

Safety Issues

- ▶ Spinal injury risk on RIBs
- ▶ Passenger risk exposure on RIBs
- ▶ Passenger knowledge of risk

No recommendations were made; however, the bulletin urged owners and operators of passenger excursions to review operations, risk assessments and pre-departure briefings in line with current guidance to ensure passenger safety.

RRS *Sir David Attenborough*

Report number: 6/2023

Polar research vessel

Accident date: 4/3/2021

Falling of a lifeboat into the sea during a launching exercise on board the polar research vessel RRS *Sir David Attenborough* on Loch Buie, Isle of Mull, Scotland

Safety Issues

- ▶ Initial safety equipment survey failed to identify the incorrect installation of the davit system
- ▶ Maintenance of critical equipment and systems had been suspended by the operator
- ▶ No routine maintenance on the davit had been completed following its installation
- ▶ The crew were unfamiliar with the correct operation of the davit

No.	Recommendation(s) to:	Maritime and Coastguard Agency to:
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2023/108	Review its processes for delegating Safety Equipment Surveys to Recognised Organisations and ensure that feedback mechanisms are in place to provide the necessary assurance that the surveys have been carried out effectively and in compliance with SOLAS regulations.	
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Appropriate action implemented 

No.	Recommendation(s) to:	Maritime and Coastguard Agency to:
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2023/109	Review its policy for delegation to consider whether it is appropriate to delegate initial safety equipment surveys for newbuild vessels or those joining the UK register.	
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Appropriate action implemented 

Inflatable migrant boat

Report number: 7/2023

Inflatable boat

Accident date: 24/11/2021

Flooding and partial sinking of an inflatable migrant boat resulting in the loss of at least 27 lives in the Dover Strait

Safety Issues

- ▶ Unsuitability of small boats attempting to cross the Dover Strait
- ▶ Lack of usable information from small boats including multiple calls from the same boat and high levels of reported peril
- ▶ Lack of contingency plan to provide aerial surveillance
- ▶ Parallel missions had not been reconciled into a coherent maritime response
- ▶ Pressures on working arrangements within HM Coastguard

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

2023/110 Build on existing liaison with French authorities to devise a tracking and identification system that, to the greatest extent possible, removes the possibility of confusion and error when compiling an overview of small boats attempting the crossing.

Appropriate action implemented 

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

2023/111 Develop procedures for achieving, as far as is practicable, an overview picture of migrant boat activity during periods when aerial surveillance is limited to rotary wing aircraft or is unavailable.

Appropriate action implemented 



BBC Marmara

Report number: 8/2023

General cargo vessel

Accident date: 25/7/2021

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



Safety Issues

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

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

2023/112 Ensure that the hazards of distraction to vigilance-based roles such as VTM and the management of vigilance related hazards are captured in appropriate training packages, practices, and the Coastguard Information Portal pages.

Appropriate action planned: 31 March 2025 

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

Appropriate action planned: 31 March 2025 

No. Recommendation(s) to: **Briese Schifffahrts GmbH & Co. KG** to:

2023/114 Determine and implement the crew resource needed to avoid a conflict between safe navigation and operational tasks such as maintenance. This should include a link to safety management requirements to ensure STCW guidance is followed, and a lookout is on the bridge during hours of darkness and in restricted visibility.

Appropriate action implemented 

2023/115 Review and implement the management assurance tools necessary to provide accurate feedback of its SMS navigation practices, including, but not limited to, the presence of a lookout during hours of darkness or in restricted visibility, the use of BNWAS while at sea and standards of passage monitoring.

Appropriate action implemented 

Resurgam

Report number: 9/2023

Fishing vessel (PZ1001)

Accident date: 15/11/2019

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

Safety Issues

- ▶ Ineffective oversight at the system design stage for the vessel and lack of oversight for the installation on board by either Ocean Engineering¹⁴ or the Maritime & Coastguard Agency
- ▶ The hazards to human health associated with the activation of the condensed aerosol generators were not identified in FirePro's safety-related documentation
- ▶ The owner/operator of the fishing vessel did not have a robust system for the control and safe management of contractors work on its fishing vessels
- ▶ There was no nationally developed standard for the training of designers and installers of fire-extinguishing systems on UK registered vessels

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

- 2023/116 Take steps to improve the standard of installation of safety critical fire-extinguishing systems in vessels operating under codes of practice (i.e. non-SOLAS vessels) to ensure that, specifically:
- Vessel owners are aware of the obligation to notify the Maritime and Coastguard Agency in advance of the installation in order to obtain pre-installation approval.
 - Equipment installation is undertaken in accordance with manufacturers' instructions and the relevant statutory requirements.
 - In collaboration with industry stakeholders, introduce a competency standard for the installers of systems on vessels.
 - The information provided in the Marine Survey Instructions for the Guidance of Surveyors for Fire Protection Arrangements (MSIS 12) and the Certificate of Inspections and Tests is consistent.

Appropriate action implemented 

No. Recommendation(s) to: **FirePro** to:

- 2023/117 Undertake a specific risk assessment for the installation and operation of each of its fire-extinguishing systems to identify and mitigate all of the associated hazards, including those identified as part of this investigation, to a level that is considered as low as reasonably practicable.

Appropriate action planned 

- 2023/118 Review its safety-related documentation for its fire-extinguishing systems (including, but not limited to, the installation and operational guidance and material safety data sheet) to:

- Incorporate the hazards identified as part of this investigation, specifically those associated with carbon monoxide generation and risk of inhalation injury, and the required control measures.

Appropriate action planned 

¹⁴ Ocean Engineering went into liquidation in 2022. As a result of the liquidation no MAIB recommendations were made.

No. **Recommendation(s) to:** **W. Stevenson & Sons Limited** to:

2023/119 Update its safety management system for vessels alongside, specifically to include the control and safe management of contractors, including the provision of rescue plans for people working on board.

Appropriate action implemented 

Seadogz

Report number: 10/2023

High-speed passenger craft

Accident date: 22/8/2020

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

Safety Issues

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

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

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

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

Appropriate action planned: 30 June 2027 

MAIB comment: **The extended implementation date for this recommendation reflects the envisaged long timescale for procuring and completing this significant anthropometric assessment.**

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

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

Appropriate action planned: 31 December 2029 

MAIB comment: The extended implementation date for this recommendation reflects: the envisaged long timescale for completing and reviewing the outcome of the anthropometric assessment to address recommendation 2023/120; and the opportunity to update The Sport & Pleasure Vessel Code when the post-implementation review for the new Code is conducted 5 years after it was issued.

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

- the operators of such craft to implement a safety management system that includes, but is not limited to:
 - operational procedures for the craft's full range of intended operations, including navigational and emergency response procedures.
 - accident reporting and investigation procedures;
- appropriate deck manning levels for the craft's intended operations;
- forward visibility from the helm position aligned with the requirements in BS EN ISO 11591;
- the installation and use of automatic identification systems;
- the recording of information relating to the permitted crewing level and function of the craft on the certificate issued to show the craft's compliance with The Sport & Pleasure Vessel Code.

Appropriate action planned: 31 December 2024

MAIB comment: It is hoped that this important recommendation will be addressed by the long-awaited publication of The Sport & Pleasure Vessel Code by the end of 2024.

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

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

Appropriate action planned: December 2028

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

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

Appropriate action planned: 30 September 2024

No. Recommendation(s) to: Associated British Ports Southampton to:

2023/125 Ensure that its risk assessments consider the operation of high-speed small commercial passenger craft within the port limits.

Appropriate action implemented ✓

2023/126 Establish an agreement with any operator of high-speed small commercial passenger craft, where ABP Southampton is not able to issue a licence to the operator, to assure the proper use of the craft within the port limits.

Appropriate action implemented ✓

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

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

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









Appropriate action planned: 31 December 2024 ●



ONGOING RECOMMENDATIONS FROM PREVIOUS YEARS

Vessel name	Publication date/report number	Page
2022 recommendations - progress report		26
 <i>Rib Tickler</i>	17 February 2022 No 3/2022	26
 <i>Finnmaster</i>	10 March 2022 SB1/2022	27
 <i>Paddleboards</i>	not applicable, recommendation(s) issued pre-publication by letter	27
 <i>Wight Sky</i>	28 April 2022 No 4/2022	28
 <i>Diamond Emblem 1</i>	5 May 2022 No 5/2022	28
 <i>Joanna C</i>	22 June 2022 No 7/2022	29
 <i>Nicola Faith</i>	23 June 2022 No 8/2022	30
 <i>Piedras</i>	not applicable, recommendation(s) issued pre-publication by letter	30
 <i>Bella</i>	2 September 2022 No 10/2022	31
 <i>Paddleboards</i>	8 December 2022 No 13/2022	31
 <i>Svitzer Mercurius</i>	22 December 2022 No 15/2022	32
2021 recommendations - progress report		33
 <i>Stolt Groenland</i> ¹⁵	20 July 2021 No 9/2021	33
2020 recommendations - none outstanding		34

¹⁵ Investigated on behalf of Cayman Islands Government in accordance with the Memorandum of Understanding: <https://www.gov.uk/government/publications/mou-between-maib-and-reg-category-1-registries>

Vessel name	Publication date/report number	Page
2019 recommendations - progress report		34
	Unnamed rowing boat 31 January 2019 No 2/2019	34
	CV30 20 June 2019 No 7/2019	34
2018 recommendations - none outstanding		34
2017 recommendations - progress report		35
	CV21 12 April 2017 No 7/2017	35
	Osprey/Osprey II 18 May 2017 No 10/2017	35
	Nortrader 7 December 2017 No 26/2017	36
2016 recommendations - progress report		36
	JMT 7 July 2016 No 15/2016	36
2015 recommendations - progress report		37
	Cheeki Rafiki 29 April 2015 No 8/2015	37
2014 to 2010 recommendations - none outstanding		37
2009 recommendations - progress report		38
	Celtic Pioneer 21 May 2009 No 11/2009	38

2022 RECOMMENDATIONS - PROGRESS REPORT*

*Status as of 4 July 2024

Rib Ticker

Report number: 3/2022

Rigid inflatable boat/ Personal watercraft

Accident date: 8/8/2020

Collision resulting in one fatality in the Menai Strait, Wales

Safety Issues

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



No. Recommendation(s) to: Isle of Anglesey County Council to:

2022/102 Reviewing the current legislation governing the waters at Menai Bridge and, if appropriate, seeking to amend and improve its powers via a Harbour Revision Order.

Appropriate action planned: no date

No. Recommendation(s) to: Royal Yachting Association and Personal Watercraft Partnership to:

2022/104 Collaborate to formalise the creation of a cross-industry forum, focused on the safe and consistent management of personal watercraft in the UK's coastal and inland waters. Items for consideration by the forum should include, among other things:

- Membership of the forum, which it is anticipated will include; the Maritime and Coastguard Agency, British Marine, the UK Harbour Masters Association, the British Ports Association, and the Local Government Association's Coastal Special Interest Group, plus other organisations and stakeholders as appropriate;
- The effective dissemination to all relevant authorities of the Personal Watercraft Partnership's publication, Managing Personal Watercraft, A guide for local and harbour authorities;
- The adoption of nationally consistent launch site signage relevant to personal watercraft;
- The adoption of a nationwide voluntary registration scheme for all personal watercraft.

Withdrawn

MAIB comment: It is disappointing that the PWP was unable to collaborate with the RYA and other stakeholders to create a cross-industry forum focused on the safe and consistent management of personal watercraft in the UK's coastal and inland waters. In the absence of an industry-led approach to improving safety it is likely that regulation of this sector will need to increase.

Finnmaster

Safety bulletin number: SB1/2022

Ro-ro cargo vessel

Accident date: 19/9/2021

Blockage of fixed CO₂ fire extinguishing system pilot hoses identified following an auxiliary engine room fire while departing Hull, England

Safety Issues

- ▶ Ineffective quality assurance process during the manufacture of safety critical hose assemblies
- ▶ Ineffective on board installation and service testing procedures for safety critical firefighting systems
- ▶ Unapproved components used in the manufacture of safety critical hose assemblies



No. **Recommendation(s) to:** **Geeve Hydraulics B.V. to:**

S2022/106 Amend its purchasing and quality control procedures to ensure that hose assembly components are procured in accordance with the relevant type approval requirements.

Appropriate action implemented ✓

Paddleboards

Recommendation letter issued by the Chief Inspector

Stand up paddleboards

Accident date: 30/10/2021

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

Safety Issues

- ▶ Lack of weir risk assessment to establish the hazard it posed to public safety
- ▶ Inadequate signage to alert river users to the extreme hazard posed by the weir



No. **Recommendation(s) to:** **Dŵr Cymru Welsh Water to:**

2022/108 In conjunction with Pembrokeshire County Council, Milford Haven Port Authority and other stakeholders as appropriate, is recommended to conduct an immediate risk assessment of the hazard posed to river users by Haverfordwest Town Weir, and to implement control measures as appropriate to mitigate that risk. Such measures could include, inter alia, riverside signage, warning marker buoys and, if deemed necessary, physical barriers.

Appropriate action implemented ✓

Wight Sky

Report number: 4/2022

Ro-ro passenger ferry

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

Two catastrophic engine failures, first at the entrance to Lymington River resulting in a fire and the second while berthing at Lymington Pier, near Southampton, England

Safety Issues

- ▶ Insufficient technical oversight of main engine maintenance and operating parameters
- ▶ Problems with main engine auxiliary system design and configuration
- ▶ Lack of clear ownership for engine maintenance and engine condition monitoring
- ▶ Errors during factory and workshop assembly



No. Recommendation(s) to: Lloyd's Register to:

2022/111 Assess the need to introduce within its rules and regulations the time taken to declutch a main propulsion engine from the drive shaft in the event of an emergency shutdown, to prevent the engine from being driven and increasing the risk of serious injury and damage.

Appropriate action implemented ✓

Diamond Emblem 1

Report Number: 5/2022

Motor cruiser

Accident date: 19/8/2020

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

Safety Issues

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



No. Recommendation(s) to: Association of Inland Navigation Authorities, in consultation with its members to:

2022/113 Provide its members with comprehensive best practice guidance on processes for the administration and oversight of compliance with The Code for the Design, Construction and Operation of Hire Boats, commonly referred to as the Hire Boat Code, in order to support their adoption of the code as mandatory in 2022.

Appropriate action planned: 31 July 2024 ●

No. **Recommendation(s) to:** **A J & J Cator t/a Ferry Marina to:**

2022/121 Incorporate interlocks on any boats they operate with multiple helm control positions to prevent inadvertent engine operation from an inactive helm control position.

Appropriate action implemented 

No. **Recommendation(s) to:** **Boat Safety Scheme to:**

2022/123 Conduct a review of the Boat Safety Scheme requirements for hire boats with multiple helm control positions or systems with the intention of:

- Aligning the requirements with the technical standards outlined in ISO 25197:2020 to require positive visual indication of the active helm control position and that the transfer of command between helm control positions can only be completed at the intended active helm control position; and
- Including a requirement to incorporate system interlocks in order to prevent inadvertent engine operation from an inactive helm control position.

Appropriate action planned: no date 

Joanna C

Report number: 7/2022

Scallop dredger (BM 265)

Accident date: 21/11/2020

Capsize and sinking off Newhaven, England with the loss of two of the three crew

Safety Issues

- ▶ Low margin of stability left the vessel vulnerable to capsize
- ▶ Eroded margins of stability due to extensive through-life modifications
- ▶ Incomplete stability analysis led to missed opportunities to detect deficiencies
- ▶ Unrestricted operation permitted by flag state despite the vessel's unknown stability condition
- ▶ Insufficient uninflated liferaft buoyancy due to no existing standard for non-SOLAS liferafts

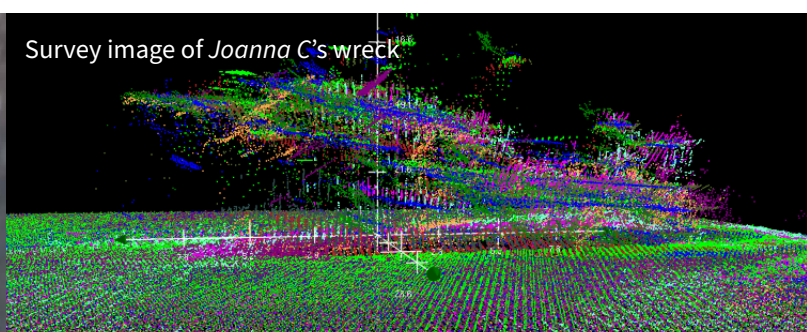
No. **Recommendation(s) to:** **Maritime and Coastguard Agency to:**

2022/124 Ensure that fishing vessel stability compliance activity is effectively monitored such that stability requirements for small fishing vessels are applied as intended. Where stability checks are required, fishing operations should be suspended until a vessel's stability has been satisfactorily assured.

Appropriate action implemented 



Joanna C's uninflated liferaft floating mid-water



Survey image of Joanna C's wreck

Nicola Faith

Report number: 8/2022

Whelk potter (BS 58)

Accident date: 27/1/2021

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

Safety Issues

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

Recovery of Nicola Faith's whelk pots and gear



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

2022/125 Revise the wording in MSN 1871 Amendment No. 2 (F) *The Code of Practice for the Safety of Small Fishing Vessels of Less than 15m Length Overall* to refer to a load limit rather than a catch limit.

Appropriate action planned: 30 June 2028 ●

Piedras

Recommendation letter issued by the Chief Inspector

Fishing vessel (FD 528)

Accident date: 1/6/2022

Foundering approximately 77 nautical miles off the south-west coast of Ireland

Safety Issues

- ▶ Incorrect routine servicing led to liferaft failing to function as designed
- ▶ Insufficient actions by the authorised service station repeatedly failed to ensure liferaft checks complied with certification regulations
- ▶ Ineffective oversight of the actions of the authorised service station to identify liferaft servicing issues
- ▶ Concerns that other non-deployed liferafts may not operate correctly if needed in an emergency

No. Recommendation(s) to: **Survitec Group Limited** to:

2022/130 Take urgent action, as appropriate, to provide robust assurance that all liferafts serviced by the authorised service station 375 within the past 5 years are fully functional and comply with statutory requirements. This should include informing all affected customers of the potential risks that their liferafts may not be compliant and of any immediate actions required to ensure their effectiveness.

Appropriate action implemented ●

Bella

Report number: 10/2022

Survey workboat

Accident date: 6/7/2021

Flooding and sinking in the approaches to Lynmouth, England

Safety Issues

- ▶ Insufficient reserves of buoyancy as a result of vessel modification
- ▶ Incorrect certification for commercial operation due to overreliance on Recreational Craft Directive information
- ▶ Inexperienced and unqualified crew led to underestimated risk of operating in open sea
- ▶ Crew familiarity with lifesaving appliances and wearing of PFDs increased chances of survival – and ensured a successful rescue in this instance



No.	Recommendation(s) to:	Maritime and Coastguard Agency to:
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2022/131	Provide guidance to Certifying Authorities regarding the application of the Recreational Craft Directive when certifying vessels for commercial operation.	
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Appropriate action implemented

Paddleboards

Report number: 13/2022

Stand up paddleboards

Accident date: 30/10/2021

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

Safety Issues

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

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

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

Appropriate action planned: no date ●

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

Appropriate action planned: no date ●

Svitzer Mercurius

Report number: 15/2022

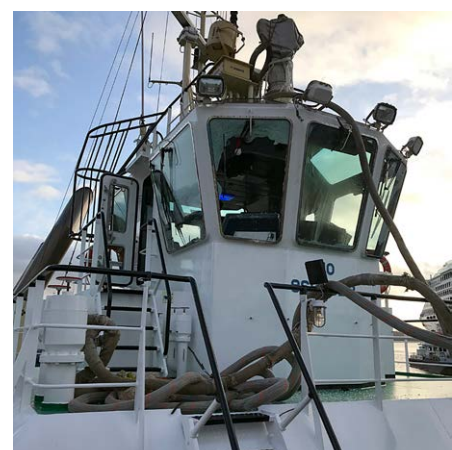
Tug

Accident date: 22/12/2019

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

Safety Issues

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



No. Recommendation(s) to: Det Norske Veritas to:

2022/137 Take the findings of this investigation to IACS, with respect to the failure of the wheelhouse window glazing, and propose the development of a unified requirement to minimise the risk of injury to personnel within the tug wheelhouse from broken window glazing and/or broken skylight glazing, in the event of impact from a recoiling towline.

Appropriate actions implemented ✓

No. Recommendation(s) to: Svitzer Marine Limited to:

2022/138 Undertake a fleetwide risk assessment to determine the level of risk associated with towline failure and snapback and the potential for impact by a line recoiling into wheelhouse windows, and, where appropriate, employ appropriate laminated glass or other defences to mitigate against the risk of flying glass injuring its tug crews.

Appropriate action planned: 30 September 2024 ●

2021 RECOMMENDATIONS - PROGRESS REPORT*

*Status as of 4 July 2024

Stolt Groenland

Report number: 9/2021

Chemical tanker

Accident date: 28/9/2019

Cargo tank explosion and fire at Ulsan, Republic of Korea

No. **Recommendation(s) to:** **Cayman Islands Shipping Registry, through the UK as the Member Government for the Red Ensign Group to the International Maritime Organization to:**

2021/117 Propose to the IMO a revision to Section 15.13 of the IBC Code to:

- Include in the certificate of protection the actions to be taken in the event of a cargo falling outside of the manufacturer's specified oxygen and temperature limits, and that
- Any actions should be realistic, taking account of the limitations on board ships regarding the monitoring, adding, and mixing of inhibitor during the voyage.

Appropriate action planned: no date ●

No. **Recommendation(s) to:** **Chemical Distribution Institute to:**

2021/120 Amend its publication '*Chemical Tanker Operations for the STCW Advanced Training Course – A Practical Guide to Chemical Tanker Operations*' to make it clear that:

- The stowage of heated and inhibited cargoes can result in a dynamic situation in which the degree of heat transfer may be complex and difficult to predict.
- One tank separation between heated and heat sensitive cargoes might not be sufficient.
- Promulgate this report to its members.

Appropriate action planned: no date ●



2020 RECOMMENDATIONS - PROGRESS REPORT*

There are no outstanding recommendations for 2020.

2019 RECOMMENDATIONS - PROGRESS REPORT*

*Status as of 4 July 2024

Unnamed Rowing Boat

Report number: 2/2019

Rowing boat

Accident date: 24/3/2018

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



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

2019/105 Develop an appropriate standard for public rescue equipment ensuring that the topic of throw bags and their rescue lines is addressed as a priority.

Appropriate action planned: 31 December 2025

CV30

Report number: 7/2019

Commercial racing yacht

Accident date: 18/11/2017

Fatal man overboard approximately 1500nm west of Fremantle, Australia

No. Recommendation(s) to: British Standards Institute Committee to:

2019/110 Review and amend ISO 12401 and ISO 15085 at the earliest opportunity in light of lessons learned from this accident to:

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

Appropriate action planned: 31 December 2025

2018 RECOMMENDATIONS - PROGRESS REPORT

There are no outstanding recommendations for 2018.

2017 RECOMMENDATIONS - PROGRESS REPORT*

*Status as of 4 July 2024

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 Sailing¹⁶/British Marine to:

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.

Appropriate actions implemented 

Osprey/Osprey II

Report number: 10/2017

RIBs

Accident date: 19/7/2016

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

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

2017/115 Include in its forthcoming Recreational Craft Code with respect to commercially operated passenger carrying RIBs:

- A requirement for the certificated maximum number of passengers to be limited to the number of suitable seats designated for passengers.
- Guidance on its interpretation of "suitable" with respect to passenger seating.
- A requirement for passengers not to be seated on a RIB's inflatable tubes unless otherwise authorised by the Certifying Authority and endorsed on the RIB's compliance certificate with specified conditions to be met for a particular activity.

Appropriate action planned: 31 December 2024 

MAIB comment: Further to the many previous updates provided by the MCA regarding this long-standing recommendation, it is hoped that it will finally be addressed, along with recommendations 2009/126 and 2015/120, with the publication of The Sport & Pleasure Vessel Code before the end of 2024.

¹⁶ Actions taken by the Royal Yachting Association and World Sailing have previously been accepted by MAIB.

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, England

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

2017/154 Update The Merchant Shipping (Carriage of Cargoes) Regulations 1999 with appropriate references to the IMSBC Code.

Appropriate action implemented ✓



2016 RECOMMENDATIONS - PROGRESS REPORT*

*Status as of 4 July 2024

JMT

Report number: 15/2016

Fishing vessel (M99)

Accident date: 9/7/2015

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

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

2016/131 Require skippers of under 16.5m fishing vessels to complete stability awareness training.

Appropriate action planned: 31 October 2025 ●



2015 RECOMMENDATIONS - PROGRESS REPORT*

*Status as of 4 July 2024

Cheeki Rafiki

Report number: 8/2015

Sailing yacht

Accident date: 16/5/2014

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

No. Recommendation(s) to: British Marine Federation¹⁷ to:

2015/117 Co-operate with certifying authorities, manufacturers and repairers with the aim of developing best practice industry-wide guidance on the inspection and repair of yachts where a GRP matrix and hull have been bonded together.

Appropriate action planned: 31 December 2024

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

2015/120 Include in the SCV Code a requirement that vessels operating commercially under ISAF¹⁸ OSR should undergo a full inspection to the extent otherwise required for vessels complying with the SCV Code.

Appropriate action planned: 31 December 2024

MAIB comment: Further to the many previous updates provided by the MCA regarding this long-standing recommendation, it is hoped that it will finally be addressed, along with recommendations 2009/126 and 2017/115, with the publication of The Sport & Pleasure Vessel Code before the end of 2024.



2014 TO 2010 RECOMMENDATIONS - PROGRESS REPORT

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

¹⁷ British Marine Federation is now known as British Marine.

¹⁸ International Sailing Federation (ISAF) is now known as World Sailing.

2009 RECOMMENDATIONS - PROGRESS REPORT*

*Status as of 4 July 2024

Celtic Pioneer

Report number: 11/2009

RIB

Accident date: 26/8/2008

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

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

2009/126 Review and revise the deck manning and qualification requirements of the harmonised SCV Code taking into account the speed of craft and the type of activity intended in addition to the distance from shore and environmental conditions.

Appropriate action planned: 31 December 2024

MAIB comment: Further to the many previous updates provided by the MCA regarding this long-standing recommendation, it is hoped that it will finally be addressed, along with recommendations 2015/120 and 2017/115, with the publication of The Sport & Pleasure Vessel Code before the end of 2024.



PART 3: STATISTICS

For details of reporting requirements and terms used in this section please see Annex A: Statistics Coverage on page 61 and glossary on page 64.

Table 1: Loss of life reported to the MAIB in 2023

Date	Name of vessel	Type of vessel	Location	Accident description
Merchant vessels 100gt and over				
2 Oct	<i>Pelican of London</i>	Sailboat (aux. motor)	Sharpness, Gloucestershire, England	Crew member fall from the gangway while boarding a sail training vessel, resulting in one fatality.
25 Oct	<i>Arvia</i>	Cruise	Off the west coast of Vigo, Spain	Passenger fall down stairs, resulting in fatal neck and head injuries.
4 Nov	<i>Spirit of Discovery</i>	Cruise	Bay of Biscay, France	Propulsion failure and subsequent listing in heavy weather resulting in multiple passenger injuries. One passenger suffered spinal injuries and later died.
Merchant vessels under 100gt (including commercial recreational)				
24 Feb	<i>Biter</i>	Tug	Firth of Clyde, Scotland	Capsize and sinking of a stern tug while assisting a cruise ship, resulting in two fatalities.
Fishing vessels				
21 Sep	<i>Lexi Rose</i>	Potter	Melrose Point, Scotland	Grounding on rocks and capsize of a lone-operated fishing vessel. The crew member was later recovered deceased from the water.
6 Oct	<i>Honeybourne III</i> ¹⁹	Scallop dredger	English Channel	Crew member struck by falling fishing gear, resulting in one fatality.
12 Dec	<i>Amadeus</i>	Potter	North Sea	Crew member overboard while recovering pots, resulting in one fatality.
13 Dec	<i>Nista</i>	Potter	Firth of Lorn, Isle of Mull, Scotland	Grounding after the lone crew member became entangled in fishing gear and was dragged overboard, resulting in one fatality.
Pleasure craft (excluding commercial recreational)				
6 Feb	-	Motor craft	Culver Down, Isle of Wight, England	A RIB was found drifting. The lone occupant was found in the water shortly afterwards and declared deceased.
24 Feb	-	Kayak	Gulf of Corryvreckan, Scotland	Capsized inflatable kayak with two people on board, resulting in both persons in the water and one loss of life.

¹⁹ A safety bulletin was published on 7 February 2024: <https://www.gov.uk/maib-reports/safety-warning-issued-following-a-chain-failure-on-scallop-dredger-honeybourne-iii-with-loss-of-1-life>

UK VESSELS: ACCIDENTS INVOLVING LOSS OF LIFE

Date	Name of vessel	Type of vessel	Location	Accident description
16 Apr	-	Canoe	Kempston Weir, River Great Ouse, England	Two canoeists were found deceased at the base of a weir.
19 May	-	Kayak	Lochan na Lairige, Scotland	Capsized inflatable kayak with two people on board, resulting in both persons in the water and one loss of life.
26 May	<i>Aelana</i>	Sailboat (aux. motor)	English Channel	Crew member fall overboard from a sailing vessel. They were recovered by a nearby vessel but did not survive.
26 May	<i>Alexa</i>	Sailboat (aux. motor)	Near Le Havre, France	Crew member fall overboard from a sailing vessel, resulting in one fatality.
24 Jun	<i>Minke</i>	Sailboat (aux. motor)	Falmouth Bay, Cornwall, England	Sailing vessel was found empty by a passing vessel. The lone crew member is presumed to have fallen overboard and been lost at sea.
10 Jul	-	Motor craft	The Broads, Lowestoft, England	Capsized tender with five people on board, resulting in one fatality.
12 Jul	<i>Herschell</i>	Sailboat (aux. motor)	Irish Sea	Crew member of a lone-operated sailing vessel found deceased after being washed ashore. The damaged boat was later found and recovered.
20 Jul	<i>Barracuda</i>	Sailboat (aux. motor)	The Solent, England	Missing crew member of a lone-operated sailing vessel found deceased on a sandbank.
5 Oct	<i>Our Boy Samuel</i>	Motor craft	Southend-on-Sea, England	Capsized tender with two people on board, resulting in one fatality.
8 Oct	-	Rowing boat	Morecambe, Lancashire, England	Rowing boat crew member fall overboard. They were washed over a weir, resulting in one fatality.
4 Nov	<i>Jamick</i>	Rowing boat	River Yealm, Devon, England	Capsized rowing boat with one person on board. The occupant was recovered from the water but did not survive.
6 Dec	-	Rowing boat	River Thames, England	Rowing boat lone crew member fall overboard, resulting in one fatality.

Table 2: Merchant vessel total losses in 2023

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

Table 3: Merchant vessel losses – 2014-2023

Year	Number lost	UK fleet size	Gross tonnage lost
2014	-	1,361	-
2015	-	1,385	-
2016	-	1,365	-
2017	-	1,356	-
2018	-	1,332	-
2019	-	929	-
2020	-	1,242	-
2021	-	1,199	-
2022 ²⁰	2	611 ²¹	298
2023	-	1,226	-

²⁰ From 2022 data was supplied by Sea (www.sea.live) while previous years are based on data provided by IHS Maritime & Trade. DfT conducted sensitivity checks between the two data sources and found that deadweight and gross tonnage were comparable; however, comparisons between data from 2022 and previous years should be used with caution.

A detailed overview of data changes is published by DfT: <https://www.gov.uk/government/statistics/shipping-fleet-statistics-2022/shipping-fleet-statistics-2022-notes-and-definitions>

²¹ In 2022 there was an under-reporting of non-trading vessels. This has been rectified in 2023 after liaising with Sea by Maritech.

Table 4: Merchant vessels in casualties by nature of casualty and vessel category in 2023²²

Casualty event	Solid cargo ship	Liquid cargo ship	Inland waterway vessel	Passenger ship	Service ship	Commercial recreational	Total
Capsizing/listing	-	-	-	1	-	-	1
Collision	5	2	11	6	2	-	26
Contact	1	1	-	1	1	-	4
Damage/loss of equipment	1	-	-	1	2	-	4
Fire/explosion	-	-	-	4	-	-	4
Flooding/foundering	-	-	1	-	-	-	1
Grounding	7	-	5	3	4	3	22
Machinery	2	-	4	8	3	-	17
Total	16	3	21	24	12	3	79²³

Table 5: Deaths and injuries to merchant vessel crew — 2014-2023²⁴

Year	Number of crew injured	Of which resulted in death
2014	145	-
2015	153	2
2016	146	2
2017	163	-
2018	124	-
2019	105	3
2020	78	-
2021	76	-
2022	85	-
2023	132	1

²² Vessel groups include vessels operating on inland waterways.

²³ 79 casualties represents a rate of 64 casualties per 1,000 vessels on the UK Fleet sourced from commercially procured world fleet data, or 75 casualties per 1,000 vessels on the UK Ship Register. Sourced via Table FLE0100 published by Department for Transport: <https://www.gov.uk/government/statistical-data-sets/shipping-fleet-statistics#uk-ship-register-statistics>. See also the footnotes to Table 3.

²⁴ MAIB regularly reviews its accident data. On occasion, data from previous years can and will change based on these reviews.

Table 6: Deaths and injuries of merchant vessel crew by rank in 2023

Rank/specialism	Number of crew	Rank/specialism	Number of crew
Hotel service staff	54	Officer, electro-technical	2
Rating, able seafarer, deck	23	Rating	2
Other crew member	22	Second officer, engineer	2
Officer, engineer	7	Chief officer, engineer	1
Assistant/cadet	4	Master	1
Rating, able seafarer, engineer	4	Rating, electro-technical	1
Officer, deck	3	Rating, part of engine room watch	1
Rating, part of navigational watch	3	Total	132
Chief mate	2		

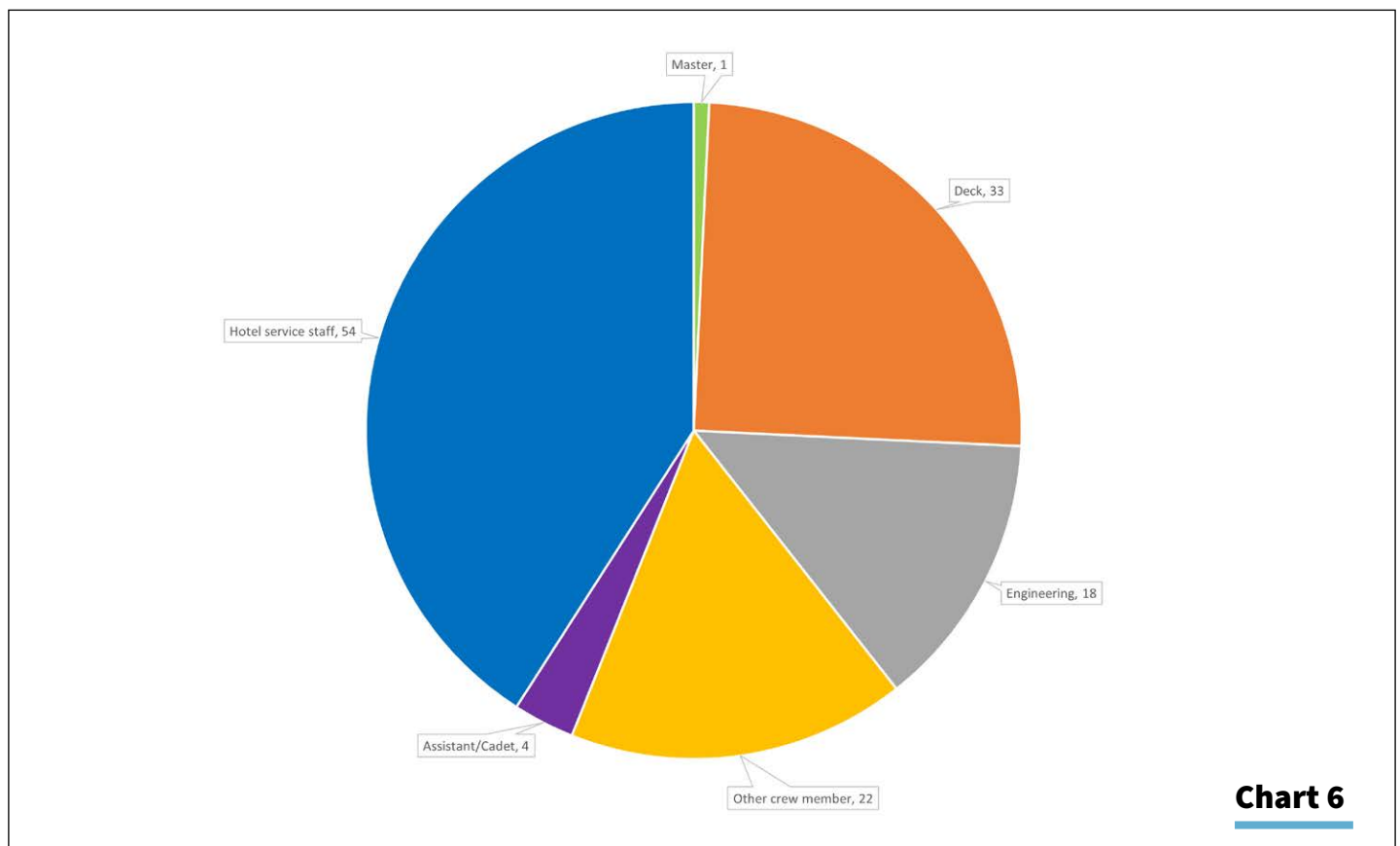


Table 7: Deaths and injuries of merchant vessel crew by place in 2023

Place	Number of crew
Accommodation	
Alleyway	3
Bathroom, shower, toilet	2
Cabin space – crew	15
Cabin space – passengers	4
Galley spaces	14
Laundry	1
Mess room, dayroom	2
Other	2
Restaurant/bar	7
Stairway/ladders	6
Swimming pool	1

Place	Number of crew
Theatre	5
Bridge	
Wheelhouse	1
Cargo & tank areas	
Cofferdam/void space	2
Open deck cargo space	1
Ro-ro vehicle deck ramp	2
Engine department	
Boiler room	1
Control room	1
Engine room	6
Other	2
Workshop / stores	3

Place	Number of crew
Ship	
Bow	2
Deck	33
Forecastle	1
Gangway	1
Other	3
Over side	2
Quarter	3
Stairs/ladders	4
Stern	1
Unknown	1
Total	132

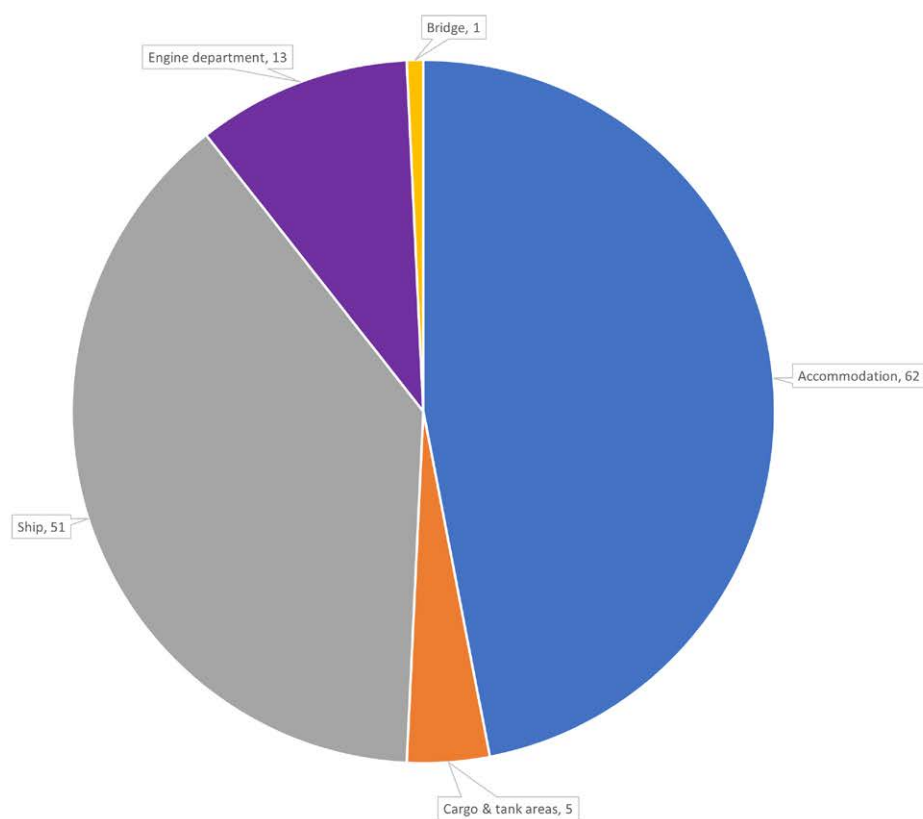


Chart 7

Table 8: Deaths and injuries of merchant vessel crew by part of body injured in 2023

Part of body injured	Number of crew
Whole body and multiple site	
Multiple sites of the body affected	6
Whole body (systemic effects)	1
Head	
Ear(s)	1
Facial area	3
Head (Caput), brain and cranial nerves and vessels	2
Neck, inclusive spine and vertebra in the neck	
Neck, inclusive spine and vertebra in the neck	3
Upper limbs	
Arm, including elbow	9
Finger(s)	27
Hand	7
Shoulder and shoulder joints	9
Upper extremities, multiple sites affected	1
Wrist	8
Back, including spine and vertebra in the back	
Back, including spine and vertebra in the back	8
Back, other parts not mentioned above	1
Torso and organs	
Pelvic and abdominal area including organs	3
Rib cage, ribs including joints and shoulder blade	3

Part of body injured	Number of crew
Lower limbs	
Ankle	10
Foot	9
Leg, including knee	16
Lower extremities, multiple sites affected	1
Lower extremities, other parts not mentioned above	1
Toe(s)	3
Total	132

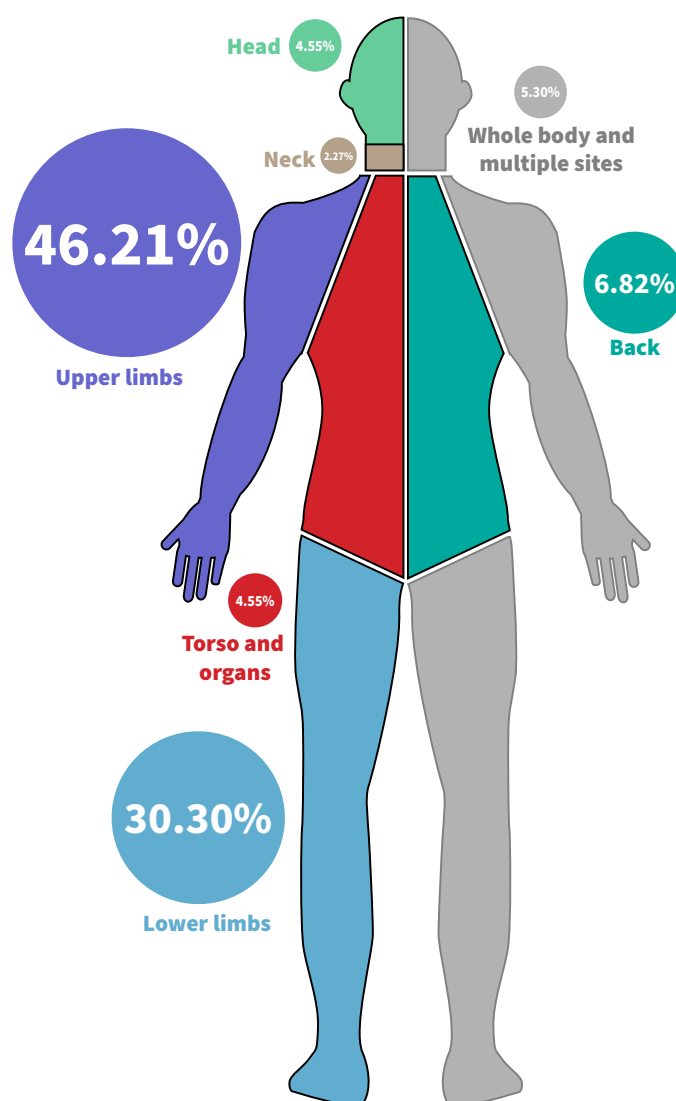


Chart 8

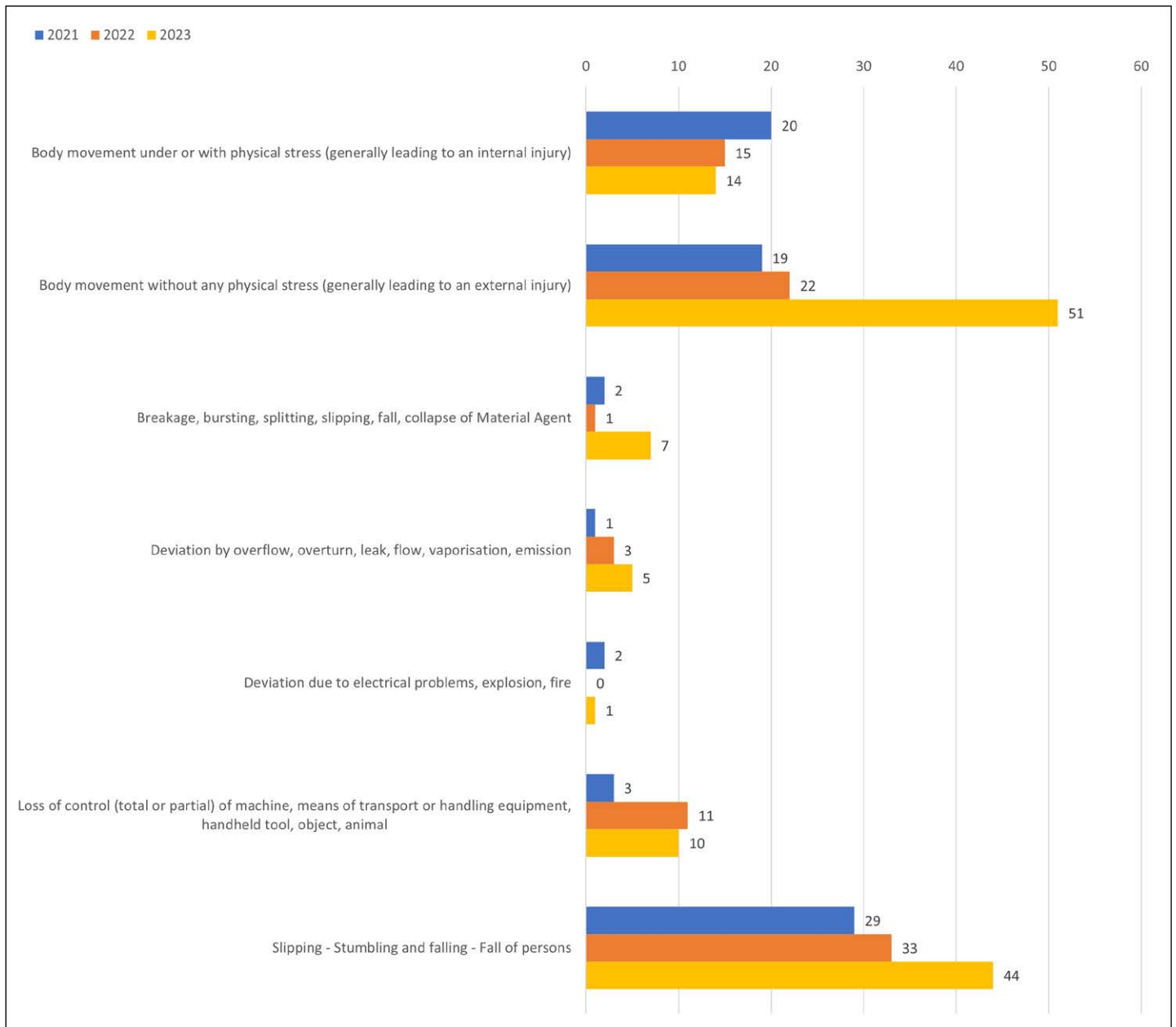
Table 9: Deaths and injuries of merchant vessel crew by deviation* in 2023

Deviation*	Number of crew	
Body movement under or with physical stress (generally leading to an internal injury)	Lifting, carrying, standing up	6
	Pushing, pulling	2
	Putting down, bending down	1
	Treading badly, twisting leg or ankle, slipping without falling	5
	Subtotal	14
Body movement without any physical stress (generally leading to an external injury)	Being caught or carried away, by something or by momentum	17
	Kneeling on, sitting on, leaning against	1
	Uncoordinated movements, spurious or untimely actions	32
	Walking on a sharp object	1
	Subtotal	51
Breakage, bursting, splitting, slipping, fall, collapse of Material Agent	Breakage of material – at joint, at seams	2
	Breakage, bursting – causing splinters (wood, glass, metal, stone, plastic, others)	2
	Slip, fall, collapse of Material Agent – from above (falling on the victim)	3
	Subtotal	7
Deviation by overflow, overturn, leak, flow, vaporisation, emission	Gaseous state – vaporisation, aerosol formation, gas formation	2
	Liquid state – leaking, oozing, flowing, splashing, spraying	3
	Subtotal	5
Deviation due to electrical problems, explosion, fire	Electrical problem – leading to direct contact	1
	Subtotal	1

Deviation*		Number of crew
Loss of control (total or partial) of machine, means of transport or handling equipment, handheld tool, object, animal	Loss of control (total or partial) – of means of transport or handling equipment, (motorised or not)	3
	Loss of control (total or partial) – of object (being carried, moved, handled, etc.)	4
	Loss of control (total or partial) of machine, means of transport or handling equipment, handheld tool, object, animal -> Loss of control (total or partial) – of hand-held tool (motorised or not) or of the material being worked by the tool	2
	Loss of control (total or partial) of machine, means of transport or handling equipment, handheld tool, object, animal -> Loss of control (total or partial) – of machine (including unwanted start-up) or of the material being worked by the machine	1
	Subtotal	10
Slipping – stumbling and falling – fall of persons	Fall of person – to a lower level	22
	Fall overboard of person	1
	Slipping – stumbling and falling – fall of person – on the same level	21
	Subtotal	44
Total		132

*See Terms on page 64

Chart 9: Deaths and injuries of merchant vessel crew by deviation* – 2021 to 2023



*See Terms on page 64

Table 10: Deaths and injuries of merchant vessel crew by type of injury in 2023

Main injury		Number of crew
Bone fractures	Closed fractures	56
	Open fractures	1
Burns, scalds and frostbites	Burns and scalds (thermal)	4
	Chemical burns (corrosions)	1
Concussion and internal injuries	Concussion and intracranial injuries	2
	Internal injuries	1
Dislocations, sprains and strains	Dislocations and subluxations*	7
	Sprains and strains	32
Drowning and asphyxiation	Drowning and non-fatal submersions	1
Effects of sound, vibration and pressure	Acute hearing losses	1
	Effects of pressure (barotrauma)	1
Poisonings and infections	Acute infections	2
	Acute poisonings	1
Wounds and superficial injuries*	Open wounds	7
	Superficial injuries*	7
Traumatic amputations (loss of body parts)		5
Multiple injuries		2
Other specified injuries not included under other headings		1
Total		132

*See Terms on page 64

Table 11: Deaths and injuries to passengers – 2014 to 2023²⁵

Year	Number of injured passengers	Of which resulted in death
2014	61	1
2015	99	2
2016	134	1
2017	129	-
2018	148	-
2019	125	-
2020	26	-
2021	23	-
2022	73	2
2023	178	2

Table 12: Deaths and injuries of passengers by type of injury in 2023

Main injury		Number of passengers
Bone fractures	Closed fractures	148
	Open fractures	2
Burns, scalds and frostbites	Burns and scalds (thermal)	1
Concussions and internal injuries (including crush injuries)	Concussion and intracranial injuries	7
Dislocations, sprains and strains	Dislocations and subluxations*	9
	Sprains and strains	8
Wounds and superficial injuries	Open wounds	1
Multiple injuries		1
Traumatic amputations (loss of body parts)		1
	Total	178

²⁵ From 2014 to 2019 this table excludes injuries/fatalities that were not in connection with the operation of a ship.

Table 13: Merchant vessels < 100gt – total losses in 2023

Date	Name of vessel	Type of vessel	loa	Casualty event
24 Feb	<i>Biter</i>	Tug	15	Capsizing
20 Jul	<i>Channel Queen*</i>	Motorboat	15	Grounding

*Constructive total loss

Table 14: Merchant vessels < 100gt by nature of casualty and vessel category in 2023

Casualty event	Cargo ship solid cargo	Passenger ship	Recreatioant craft power	Recreational craft sail	Recreational craft other	Service ship search and rescue craft	Service ship other	Total
Capsizing/listing	-	-	-	-	-	-	1	1
Collision	-	5	2	6	1	14	11	40
Contact	-	3	2	-	-	5	2	8
Damage/loss of equipment	-	-	-	-	-	1	-	0
Fire/explosion	-	-	-	-	-	-	2	2
Flooding/foundering	-	-	2	-	-	-	-	0
Grounding/stranding	-	3	3	12	-	25	6	49
Loss of control	-	9	10	2	-	6	5	0
Total per vessel type	-	20	19	20	1	51	27	100
Deaths	-	-	-	-	-	-	3	3
Injuries	2	13	9	7	1	0	18	50

There were 4,956 UK registered fishing vessels at the end of 2023. During 2023, 70 casualties to vessels involving these vessels were reported to the MAIB. Figures in the following tables show casualties to vessels and injuries to crew involving UK registered vessels that were reported to the MAIB in 2023.

One fishing vessel was reported lost (0.02% of the total fleet) and there were 4 fatalities to crew.

Table 15: Fishing vessel total losses by vessel length in 2023

Date	Name of vessel	Age	Gross tonnage	Casualty event
Under 15m length overall (loa)				
21 Sep	<i>Lexi Rose</i>	23	2.50	Capsizing
1 Dec	<i>Swift Wing</i>	33	30.86	Grounding
15m length overall - under 24m registered length (reg)				
16 Nov	<i>Sustain</i>	52	65.80	Grounding
Over 24m registered length (reg)				
-	-	-	-	-

Table 16: Fishing vessel losses – 2014 to 2023

Year	Under 15m loa	15m loa to <24m reg	24m reg and over	Total lost	UK registered	% lost
2014	9	3	-	12	5,715	0.21
2015	8	5	-	13	5,746	0.23
2016	5	2	1	8	5,745	0.14
2017	5	1	-	6	5,700	0.11
2018	8	-	-	8	5,603	0.14
2019	2	2	1	5	5,484	0.09
2020	7	1	-	8	5,443	0.15
2021	6	-	-	6	5,378	0.11
2022	3	3	2	8	5,105	0.16
2023	2	1	-	3	4956	0.06

Table 17: Fishing vessels in casualties – by nature of casualty in 2023

Casualty event	Number of vessels involved	Incident rate per 1,000 vessels at risk (to one decimal place)
Capsizing/listing	2	0.4
Collision	11	2.2
Contact	2	0.4
Damage/loss of equipment	3	0.6
Fire/explosion	1	0.2
Flooding/foundering	5	1.0
Grounding/stranding	9	1.8
Loss of control	37	7.5
Total	70	14.1

Table 18: Fishing vessels in casualties – by nature of casualty and by length range in 2023

Casualty event	Number of vessels involved	Incident rate per 1,000 vessels at risk (to one decimal place ²⁶)
Under 15m length overall (loa) – vessels at risk: 4,453		
Capsizing/listing	2	0.4
Collision	6	1.3
Contact	1	0.2
Damage/loss of equipment	2	0.4
Fire/explosion	1	0.2
Flooding/foundering	2	0.4
Grounding/stranding	4	0.9
Machinery	24	5.4
Total under 15m	42	9.4
15m loa - 24m registered length (reg) – vessels at risk: 391		
Collision	4	1.0
Contact	1	0.3
Damage/loss of equipment	1	0.3
Flooding/foundering	3	0.8
Grounding/stranding	5	1.3
Loss of control	9	2.3
Total 15m to 24m	23	5.9
24m reg and over – vessels at risk: 112		
Collision	1	0.9
Loss of control	4	3.6
Total 24m or more	5	4.5
Fleet total²⁷	70	14.1

²⁶ Rates may not add up due to rounding.

²⁷ Total number of UK registered fishing vessels: 4,956.

Table 19: Deaths and injuries to fishing vessel crew by type of injury in 2023

Main injury		Number of crew
Bone fractures	Closed fractures	6
Burns, scalds and frostbites	Burns and scalds (thermal)	1
Concussions and internal injuries (including crush injuries not mentioned above)	Concussion and intracranial injuries	4
Drowning and asphyxiation	Drowning and non-fatal submersions	4
Traumatic amputations (loss of body parts)		4
Wounds and superficial injuries*	Open wounds	7
	Superficial injuries*	1
Total		27

*See Terms on page 64

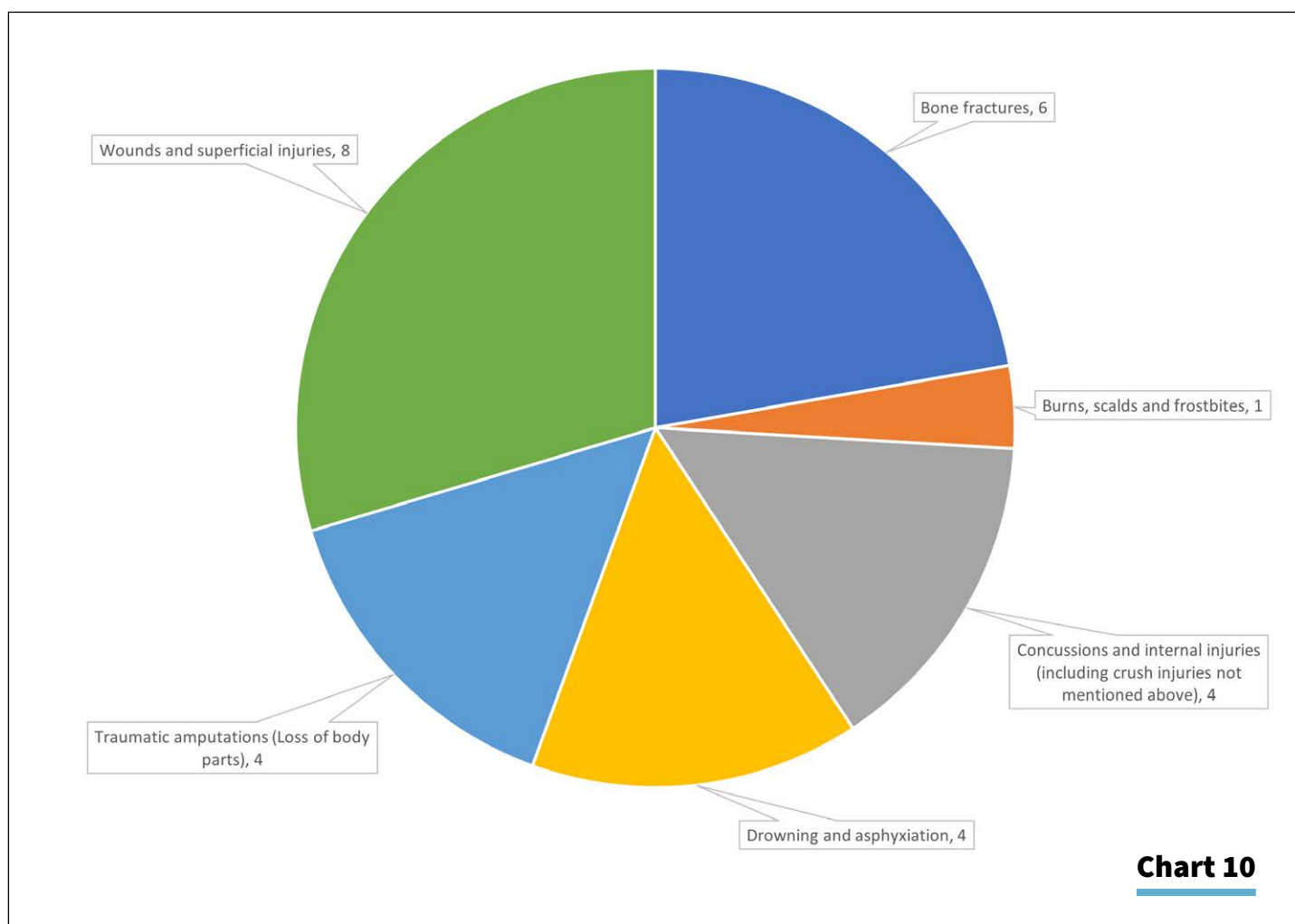


Table 20: Deaths and injuries to fishing vessel crew by part of body injured in 2023

Part of body injured	Number of crew
Whole body and multiple sites	
Whole body (systemic effects)	4
Multiple sites of the body affected	1
Head	
Head (Caput), brain and cranial nerves and vessels	5
Head, other parts not mentioned above	1
Upper limbs	
Finger(s)	7
Hand	4
Shoulder and shoulder joints	1
Torso and organs	
Pelvic and abdominal area including organs	1
Rib cage, ribs including joints and shoulder blade	1
Lower limbs	
Ankle	1
Leg, including knee	1
Total	27

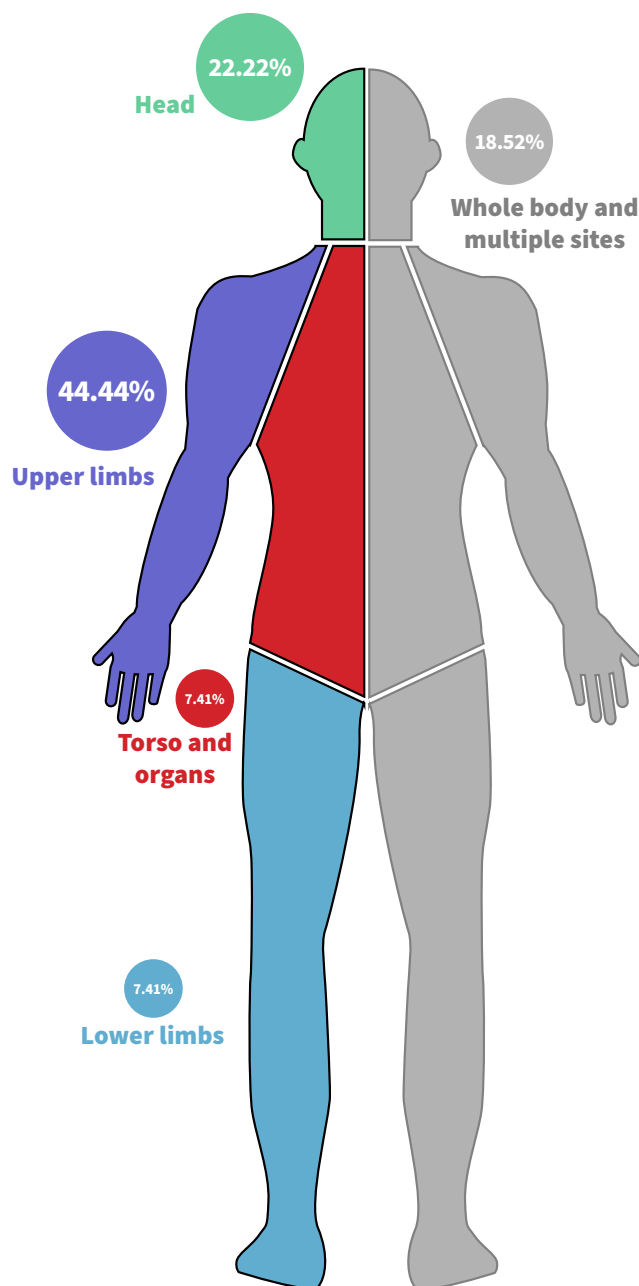


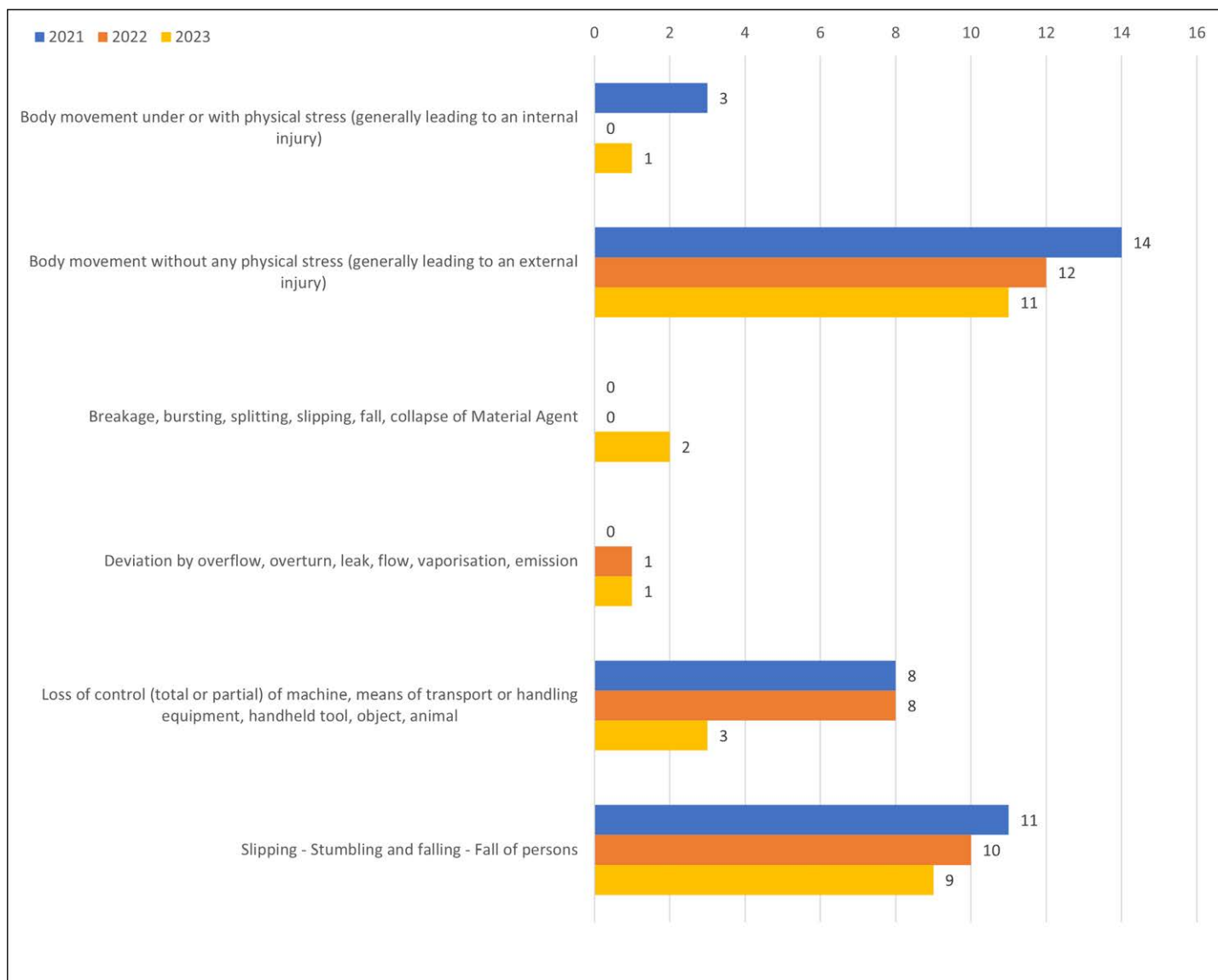
Chart 11

Table 21: Deaths and injuries of fishing vessel crew by deviation* in 2023

Deviation*		Number of crew
Body movement under or with physical stress (generally leading to an internal injury)	Pushing, pulling	1
Body movement without any physical stress (generally leading to an external injury)	Being caught or carried away, by something or by momentum	8
	Uncoordinated movements, spurious or untimely actions	3
	Subtotal	12
Breakage, bursting, splitting, slipping, fall, collapse of Material Agent	Slip, fall, collapse of Material Agent – from above (falling on the victim)	2
	Subtotal	2
Deviation by overflow, overturn, leak, flow, vaporisation, emission	Liquid state – leaking, oozing, flowing, splashing, spraying	1
	Subtotal	1
Loss of control (total or partial) of machine, means of transport or handling equipment, handheld tool, object, animal	Loss of control (total or partial) – of means of transport or handling equipment, (motorised or not)	1
	Loss of control (total or partial) – of object (being carried, moved, handled, etc.)	2
	Subtotal	3
Slipping – stumbling and falling – fall of persons	Fall of person – to a lower level	2
	Fall overboard of person	4
	Slipping – stumbling and falling – fall of person - on the same level	3
	Subtotal	9
Total		27

*See Terms on page 64

Chart 12: Deaths and injuries of fishing vessel crew by deviation* – 2021 to 2023



*See Terms on page 64

Table 22: Deaths and injuries to fishing vessel crew by vessel length (of which, deaths shown in brackets) – 2014 to 2023

	Under 15m loa		15m loa - under 24m reg		24m reg and over		Total	
		()		()		()		()
2014	21	(5)	13	(3)	10	-	44	(8)
2015	10	(4)	19	(2)	6	(1)	35	(7)
2016	17	(7)	19	(2)	6	-	42	(9)
2017	13	(3)	8	(2)	11	-	32	(5)
2018	13	(4)	18	(1)	8	(1)	39	(6)
2019	12	(3)	18	(1)	5	(1)	35	(5)
2020	12	(2)	16	-	10	-	38	(2)
2021	12	(7)	19	(2)	5	(1)	36	(10)
2022	5	-	16	(1)	10	(2)	31	(3)
2023	6	(2)	9	(1)	12	(1)	27	(4)

Chart 13: Deaths and injuries to fishing vessel crew by year – 2014 to 2023

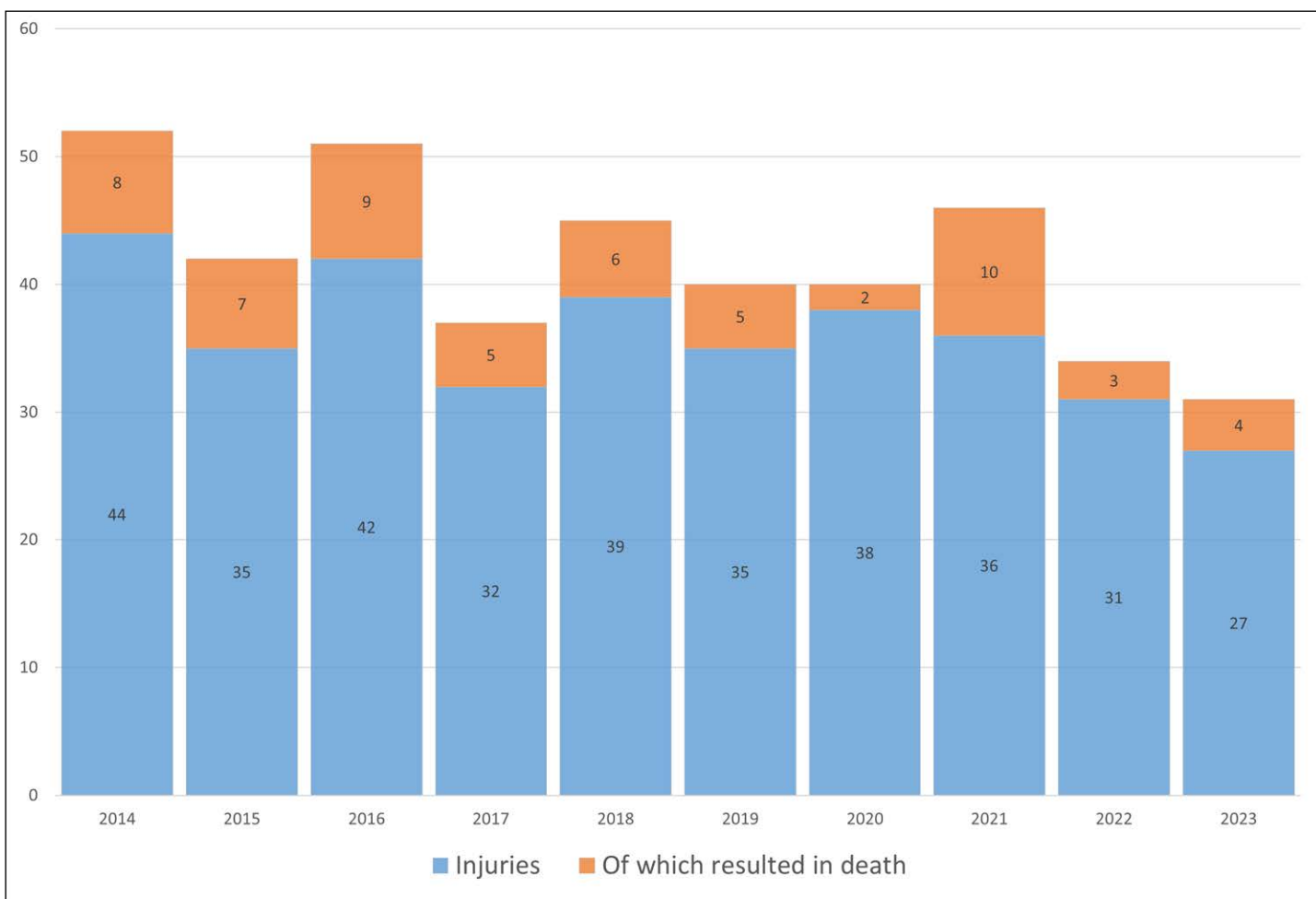


Table 23: All non-UK commercial vessels total losses in UK waters in 2023

Date	Name of vessel	Type of vessel	Flag	loa	Casualty event
14 Feb	<i>Sylvia-Mary</i>	Fishing	Belgium	23.9	Grounding

Table 24: All non-UK commercial vessels in UK waters – by vessel type and by nature of casualty in 2023

Casualty event	Solid cargo ship	Liquid cargo ship	Passenger ship	Service ship	Fishing vessel	Recreational commercial	Total
Collision	8	4	1	4	-	1	18
Contact	5		2	2	1	-	10
Damage/loss of equipment	1	-	-	1	-	-	2
Fire/explosion	-	-	1	-	-	-	1
Flooding/foundering	-	-	1	-	-	-	1
Grounding/stranding	12	2	1	1	-	1	17
Loss of control	11	4	1	1	1	-	18
Total per vessel type	37	10	7	9	2	2	67
Deaths	2	-	1	1	-	-	4
Injuries	10	-	15	7	2	-	34

ANNEX A: 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 2012²⁸ to report accidents to the MAIB.
4. Accidents are defined as being Marine Casualties or Marine Incidents, depending on the type of event(s) and the results of the event(s). See Definitions (Annex B) on page 62 or MAIB's Regulations for more information.
5. Details of vessel types and groups used in this Annual Report are providing as supporting information (Annex B) on page 63.
6. Non-UK flagged vessels are not required to report accidents to the MAIB unless they are within a UK port/harbour or within UK 12 mile territorial waters and carrying passengers to or from a UK port. However, the MAIB will record details of, and may investigate, significant accidents notified to us by bodies such as HM Coastguard.
7. The MCA, harbour authorities and inland waterway authorities have a duty to report accidents to the MAIB.
8. In addition to the above, the MAIB monitors news and other information sources for relevant accidents.

²⁸ <https://www.legislation.gov.uk/uksi/2012/1743>

ANNEX B: SUPPORTING INFORMATION

Definitions

Marine Casualty²⁹

An event or sequence of events that has resulted in any of the following and has occurred directly by or in connection with the operation of a ship:

- the death of, or serious injury to, a person;
- the loss of a person from a ship;
- the loss, presumed loss or abandonment of a ship;
- material damage to a ship;
- the stranding or disabling of a ship, or the involvement of a ship in a collision;
- material damage to marine infrastructure external of a ship, that could seriously endanger the safety of the ship, another ship or any individual;
- pollution, or the potential for such pollution to the environment caused by damage to a ship or ships.

A Marine Casualty does not include a deliberate act or omission, with the intention to cause harm to the safety of a ship, an individual or the environment.

Each Marine Casualty is categorised as ONE of the following:

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

Serious Marine Casualty (SMC) – A Marine Casualty where an event results in one of:

- immobilisation of main engines, extensive accommodation damage, severe structural damage, such as penetration of the hull underwater, etc., rendering the ship unfit to proceed;
- pollution;
- a breakdown necessitating towage or shore assistance.

Less Serious Marine Casualty (LSMC) – This term is used by MAIB to describe any Marine Casualty that does not qualify as a VSMC or a SMC.

Marine Incident (MI)

A Marine Incident is an event or sequence of events other than those listed above which has occurred directly in connection with the operation of a ship that endangered, or if not corrected would endanger, the safety of a ship, its occupants or any other person or the environment (e.g. close quarters situations are Marine Incidents).

Accident

Under current regulations Accident means any Marine Casualty or Marine Incident. In historic data, Accident had a specific meaning, broadly equivalent to (but not identical to) Marine Casualty.

Operation of a ship

To qualify as a Marine Casualty an event/injury etc must be in connection with the operation of the ship on which it occurs. MAIB's interpretation of this includes any 'normal' activities which take place on board the vessel (e.g. a chef who sustains a cut while preparing food is considered in connection with the operation of the ship).

²⁹ <https://www.legislation.gov.uk/ukSI/2012/1743/regulation/3>

Vessel categories

Merchant vessels ≥ 100 gt

Trading and non-trading vessels of 100 gross tonnage (gt) or more (excluding fish processing and catching). Note that this category includes vessel types such as inland waterway vessels and vessels on government service that not all countries consider to be merchant vessels. It excludes Royal Navy vessels and fixed platforms and rigs.

Merchant vessels < 100 gt

Vessels of under 100gt known, or believed to be, operated commercially (excluding fish processing and catching).

Commercial recreational

May be a subset of either of the above two entries. Those over 100gt may, for instance, be a tall ship or luxury yacht. Those under 100gt may be a chartered yacht or a rented dinghy.

UK fishing vessels

Commercial fishing vessels registered with the UK Maritime and Coastguard Agency's Registry of Shipping and Seamen.

Passenger

In addition to seagoing passenger vessels this category also includes inland waterway vessels operating on inland waters.

Service ship

Includes, but not limited to, dredgers, offshore industry related vessels, tugs and search and rescue craft.

Recreational craft

Recreational craft may be commercial or non-commercial. In the statistics section of each Annual Report only 'Table 1: Loss of life...' includes non-commercial recreational craft.

Non-UK vessels in UK waters

Vessels that are not known, or believed to be, UK vessels, and the events took place in UK territorial waters (12 mile limit).

GLOSSARY OF ABBREVIATIONS, ACRONYMS AND TERMS

Abbreviations and Acronyms

CO ₂	-	carbon dioxide
DfT	-	Department for Transport
gt	-	gross tonnage
HM ³⁰	-	Her/His Majesty
HMPE	-	high modulus polyethylene
IBC Code	-	International Code for the Construction and Equipment of Ships Carrying Dangerous Chemicals in Bulk
IMO	-	International Maritime Organization
IMSBC Code	-	International Maritime Solid Bulk Cargoes Code
ISO	-	International Organization for Standardization
loa	-	length overall
LSMC	-	Less Serious Marine Casualty
m	-	metre
MAIB	-	Marine Accident Investigation Branch
MCA	-	Maritime and Coastguard Agency
MI	-	Marine Incident
nm	-	nautical mile
reg	-	registered length
RIB	-	rigid inflatable boat
ro-ro	-	roll-on/roll-off
SCV Code	-	Small Commercial Vessel Code
SMC	-	Serious Marine Casualty
SOLAS	-	International Convention for the Safety of Life at Sea 1974, as amended
STCW	-	International Convention on Standards of Training, Certification and Watchkeeping for Seafarers 1978, as amended (STCW Convention)
UK	-	United Kingdom
VSMC	-	Very Serious Marine Casualty
VTM	-	vessel traffic monitoring

Terms

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

³⁰ HM refers to Her Majesty up to 8 September 2022 and His Majesty from 8 September 2022, inclusive.

CONTACT DETAILS AND ONLINE RESOURCES

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24 hour accident reporting line

+44 (0)23 8023 2527

Press enquiries

+44 (0)1932 440015

Press enquiries (out of office hours)

+44 (0)30 0777 7878

Online resources



www.gov.uk/maib



<https://twitter.com/maibgovuk>



www.facebook.com/maib.gov



www.youtube.com/user/maibgovuk



<https://www.linkedin.com/organization-guest/company/marine-accident-investigation-branch>

