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**NOTE**

This report is not written with litigation in mind and, pursuant to Regulation 14(14) of the Merchant Shipping (Accident Reporting and Investigation) Regulations 2012, shall be inadmissible in any judicial proceedings whose purpose, or one of whose purposes is to attribute or apportion liability or blame.

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## Grounding of **COASTAL ISLE** Island of Bute 2 July 2012

### SUMMARY

At 0443 on 2 July 2012, while on passage from Belfast to Greenock, the 89m feeder container vessel *Coastal Isle* ran aground on the Island of Bute. The grounding resulted in significant damage to the forward section of the vessel, including minor breaches to the forward ballast tanks. At about 0240 the chief officer, who was on watch at the time, had dismissed the ordinary seaman who was on lookout duties; shortly afterwards he left the bridge himself. The bridge was unmanned from that time until the vessel grounded at 0443 (**Figure 1**). The chief officer was subsequently found in his cabin.

The vessel had two independent bridge watch alarms, neither of which was in use at the time. The power to the voyage data recorder had been

switched off nearly 2 weeks before the accident. The chief officer held a ‘Chief Mate (Unlimited)’ certificate of competency (CoC) issued by the Panamanian Maritime Authority (PMA) and obtained through a fraudulent organisation in Turkey purporting to represent the PMA. Subsequently the PMA identified training centres located in the Republic of Panama which were working in collusion with organisations in Turkey and employees of the PMA. The PMA has taken action to stop this activity and prevent similar fraudulent schemes. Recommendations have been made aimed at: ensuring that voyage data recorders are functional, certified, and are used to record data following an accident; and, increasing vigilance when checking seafarers’ certificates for authenticity.



**Figure 1:** *Coastal Isle* aground at the Island of Bute

## FACTUAL INFORMATION

### Background and environmental conditions

*Coastal Isle* and its sister vessel *Coastal Deniz* were owned and managed by PASA International Technical Services Ltd, Turkey (PASA), and registered with the Antigua and Barbuda Department of Marine Services and Merchant Shipping. For the past 10 years, both vessels were chartered to Coastal Container Lines Ltd (CCL), Liverpool, a subsidiary of the Peel Ports Group. The two vessels provided a daily feeder container service between Liverpool, Dublin and Belfast. Each weekend, one of the two vessels called at Greenock to load cargo for Liverpool.

At the time of the accident the wind was easterly force 4-5, the sea condition was moderate and the visibility was good with occasional showers. Low water at Millport, 3.1 nautical miles (nm) east of the Island of Bute, was at 0456 on 2 July 2012.

### Narrative of events leading to the grounding

*Coastal Isle* completed loading at Belfast at 1830 on 1 July and was scheduled to sail for Greenock that evening in order to arrive at 0800 the next day. At 2030, the master went up to the bridge and the vessel departed Belfast at 2100. During departure, the deck cadet assisted the master, the second officer was at the forward mooring station with an ordinary seaman (OS), and there were two other seamen at the aft mooring station.

The sea passage commenced at 2130. The second officer went up to the bridge just after 2130 and replaced the cadet on watch. Shortly afterwards, the master stopped the engine so that the vessel would not arrive at Greenock too early. While the vessel drifted, some of the crew members started fishing; the master and second officer took it in turns to join them.

During the departure, the chief officer watched television in the officers' mess. He retired to his cabin when the television reception began to fade as the vessel cleared the coast. At approximately 2250, he went up to the bridge to take over the watch. The master told him that he was not needed as the vessel was still drifting, and asked him to

come back when he heard the engine start. At 2300, the second officer left the bridge. The chief officer took over the watch from the master at 2330. The master left the bridge at 2355 and went to bed immediately afterwards. Just after midnight, the OS who was on lookout duties from midnight to 0400 joined the chief officer on the bridge.

At 0220, when *Coastal Isle* was to the east of Ailsa Craig (**Figure 2**), the chief officer altered the ship's heading to around 006°. The vessel's speed over the ground at the time was around 12 knots. There was no traffic in the area, and the next course alteration point was 30nm away. At approximately 0240, the chief officer dismissed the lookout, who went to his cabin and slept. The chief officer reported that, at some time before 0300, he had started suffering from stomach cramps, and went to his cabin to use the toilet; his cabin was two decks below the bridge and towards the aft end of the accommodation. The nearest toilet to the bridge was only a short flight of stairs away. The chief officer did not recall the lookout or ask any of the other officers to take the watch for him before he left the bridge.

At 0443, *Coastal Isle* ran aground on the Isle of Bute.

### Events following the grounding

The master woke up at about 0430. While he was dressing and preparing to go up to the bridge he felt the vessel vibrating heavily. He went to the bridge immediately. The second officer also ran from his cabin up to the bridge. There was no one there, and seeing the vessel aground the master stopped the engine and switched the steering to manual. He asked the second officer to find the chief officer. Meanwhile, the chief engineer and the lookout who had been on watch with the chief officer arrived on the bridge. They accompanied the second officer to the chief officer's cabin.

The second officer entered the chief officer's cabin while the others waited outside. There was conflicting evidence about where precisely the chief officer was found. Initial witness accounts stated that he was asleep in his bed, but this was later changed to him being found unconscious in the toilet. Immediately after the chief officer

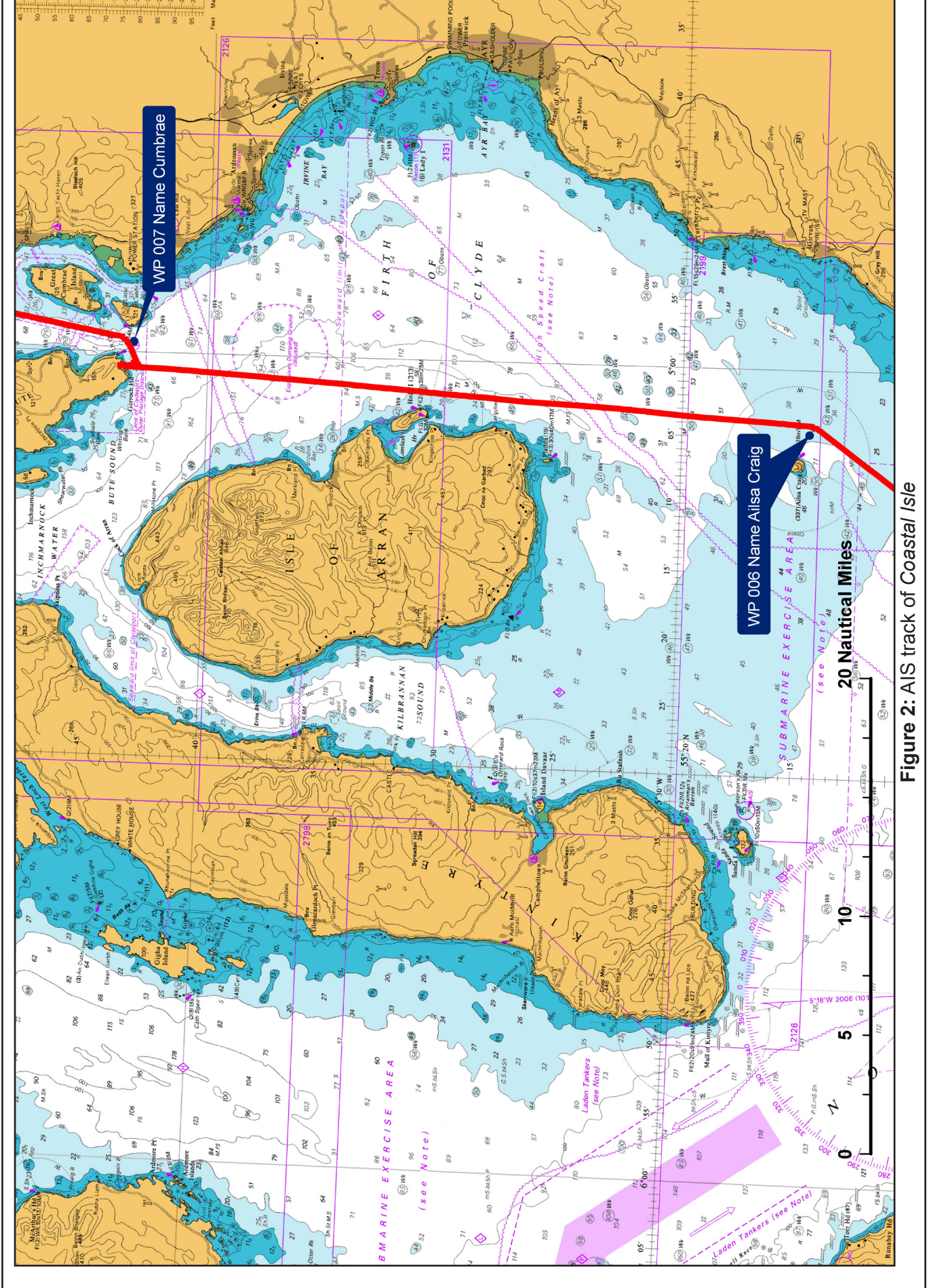


Figure 2: AIS track of Coastal/Isle

emerged from his cabin, the chief engineer accused him of endangering his shipmates' lives by leaving the bridge unattended. The two men then engaged in a heated argument.

At 0510, the master informed the Designated Person Ashore about the accident. He then attempted to refloat the vessel, without success. The master called the Clydeport<sup>1</sup> local port service operator at 0550 and told them that his vessel would be arriving late as it had run aground. After ascertaining that there was no pollution, he informed the coastguard about the grounding at 0600.

Clydeport's deputy harbourmaster arrived on board *Coastal Isle* at 0805 and, with the assistance of a tug, he manoeuvred the vessel from its grounding position. He then piloted the vessel into Greenock, accompanied by the tug, and arrived alongside at 1137. A diving inspection had been requested, but was not completed as the vessel refloated before a diving team could attend. At around noon, the local police carried out a breath alcohol test on the chief officer; the results were negative.

An enforcement officer from the Maritime and Coastguard Agency (MCA) interviewed the chief officer and other crew members. The chief officer told the enforcement officer that he had been unconscious in the toilet for nearly 2 hours. The enforcement officer asked the chief officer if he would like to see a doctor; he declined the offer. On 3 July, Strathclyde Police placed him under arrest on charges of neglecting to keep a safe watch, endangering the lives of his shipmates, and endangering the environment. He was subsequently prosecuted in the Scottish courts. The ship owner demoted him to the rank of ordinary seaman. He continued to work on board and did not suffer any further medical incidents.

## Damage

*Coastal Isle* suffered extensive structural damage and approximately 12 to 13 tonnes of steel had to be renewed. Three ballast tanks, number 1 double bottom tank and the forepeak tank were breached.

Hull damage was extensive along frames 96 to 110 on the port side and from 88 to 115 on the starboard side (the most forward frame of the hull was numbered 130).

## Crew

The master was a German national and the rest of the crew were from Turkey. The deck department comprised the master, chief officer, second officer, a female cadet and two OS. The engine department comprised the chief engineer, a female cadet and an OS. In addition, there was an OS-cook who assisted on deck as required.

The master was 68 years old and had been working in the rank of master from 1983; since 1993 he had been employed only on board *Coastal Isle*. At sea, he kept watch from 0500 to 1200 and from 1800 to 2300. He had a 'Master (Unlimited)' CoC from Germany (STCW<sup>2</sup> II/2) and an endorsement for an equivalent rank from the Antigua & Barbudan administration. He held Pilotage Exemption Certificates (PEC) for Greenock, Liverpool, Belfast and Dublin.

The chief officer was 27 years old, and had started his career at sea in 2008 as a cadet. He was fit and healthy, with no previous medical history of fainting episodes. He joined PASA as a second officer on *Coastal Isle* in January 2012 and was promoted to the rank of chief officer in March 2012. He kept watches from 2300 to 0500 and 1200 to 1800. The chief officer was the vessel's designated safety and security officer. He was due to complete his contract and leave the vessel when *Coastal Isle* next called at Liverpool.

The chief officer's highest certificate of competency, issued by the Turkish administration, was that of a 'Watchkeeping Officer (Restricted)' (STCW II/3) allowing him to keep an independent watch on vessels less than 500 Gross Tonnage (GT). In April 2011, he obtained his Panamanian 'Chief Mate (Unlimited)' CoC (STCW II/2) and a Global Maritime Distress Safety System (GMDSS) operator (Unlimited) by taking an 'on-line'

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<sup>1</sup> The port of Greenock is managed by Clydeport Operations Ltd.

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<sup>2</sup> Standards of Training, Certification and Watchkeeping Convention 1995 (as amended)

computer examination at a test centre in Turkey<sup>3</sup>. By presenting the Panamanian 'Chief Mate' CoC he secured employment in PASA, and gained an endorsement from the Antigua and Barbuda administration to allow him to work in the capacity of chief officer on board *Coastal Isle*. Neither PASA nor the Antigua and Barbuda administration had asked to see an equivalent national CoC on which the Panamanian CoC should have been based.

The replacement for the chief officer who joined *Coastal Isle* after the accident was also a Turkish national. His CoC was also a 'Chief Mate (Unlimited)' issued by the PMA on the basis of an 'on-line' computer examination. This time a test centre, claiming to be the Panamanian Consulate in Istanbul<sup>4</sup>, was used. This man's highest Turkish CoC was that of a 'Watchkeeping Officer (Unlimited)' (STCW II/3).

The second officer was 28 years old and held a Turkish certificate for a rating keeping a navigational watch (STCW II/4). He joined PASA and *Coastal Isle* in June 2012. He did not keep an independent navigational watch, but assisted with the bridge watches from 0800 to 1200 and 2000 to 2400. The two deck seamen kept lookout duties during the hours of darkness. The deck cadet was mostly employed in deck work and gangway watches, and assisted the master on the bridge during departure and arrival.

### **Medical opinion regarding an extended period of unconsciousness**

The MAIB sought the opinion of a practitioner of occupational medicine to examine the likelihood of losing consciousness and remaining in that state for 1 hour and 45 minutes (min). The possible medical reasons for prolonged unconsciousness were stated as being: diabetic coma; epilepsy; head injury; neurological conditions such as meningitis and cephalitis; abuse of alcohol or drugs. The medical opinion was that a simple faint would last only a very short time. The medical report further explained: *an abdominal cramp due to a gastric upset would last seconds or minutes*

*and then go. It would not normally cause any unconsciousness and certainly not cause him to pass out for 1 hour 45 minutes.* It concluded as follows:

*Having reviewed the facts independently I would consider that it is unlikely that a medical illness caused the period of unconsciousness but, on the balance of probability, this would have been a period of sleep albeit at an inappropriate time when he was on watch, particularly as he has denied any relevant medical history, denies taking medication and felt well enough at initial interview to decline a medical examination as he was asymptomatic. [sic]*

### **Safety management system, audits and reporting requirements**

In the event of a grounding accident, *Coastal Isle's* safety management system (SMS) required that a general broadcast be made on channel 16 on very high frequency (VHF) radio. In addition, it required the coastal authorities to be informed along with the company's shore-based emergency team. Clydeport's managers required that any grounding incident should be reported to them without delay.

The SMS made no mention of the requirement to save information on the Voyage Data Recorder (VDR) after an accident. It did, however, require that a grounding accident should be simulated as part of the onboard exercise and drill programme. The last simulated grounding accident performed on board *Coastal Isle* was in June 2012.

A safety audit was conducted by surveyors on behalf of the Antigua and Barbuda administration in February 2012, and immediately after the accident the MCA carried out a Port State Control Inspection on board *Coastal Isle*. Neither of these detected any deficiencies in the crew's certification as the Panamanian CoC was presented as the national certificate for the chief officer.

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<sup>3</sup> Cemre Denizcilik Uncular carsisi, Ahmediye, Üsküdar, Istanbul

<sup>4</sup> Acar Sokak Kubilay Sitesi Mimoza, Tarabya, Istanbul

## Fraudulent certificates

In a study concluded by the International Maritime Organization in 2001, a total of 12635 cases of forgery in certificates of competency and equivalent endorsements was reported. The majority of these cases were either outright forgery of CoCs or the presentation of forged certificates from one administration to obtain endorsements from other administrations. None of the cases involved the collusion of fraudulent organisations working with corrupt officials in training schools or maritime administrations.

The latest amendments ('Manila amendments') to the STCW Convention and its associated code called on maritime administrations to implement improved measures to prevent fraudulent practices associated with certificates of competency.

## Investigation by the Panamanian Maritime Administration

The MAIB asked the PMA to investigate how *Coastal Isle*'s chief officer had managed to obtain a genuine Panamanian CoC with a qualification that was greater than his national CoC, and, a GMDSS (Unlimited) certificate.

The PMA initially stated that the CoC and GMDSS certificate had been issued due to an administrative error. PMA officials subsequently confirmed that there were no centres or consulates in Turkey authorised to issue Panamanian CoCs or conduct examinations. The *bona fide* Panamanian Consulate in Istanbul denied any knowledge of either test centres, and confirmed that both the organisations that helped the two chief officers on board *Coastal Isle* obtain their Panamanian CoCs were fraudulent.

Further investigation carried out by the PMA identified that there were unspecified training centres inside The Republic of Panama which were working in collusion with employees of the PMA and the fraudulent organisations in Turkey, in order to issue genuine Panamanian CoCs and GMDSS certificates.

## Bridge navigational watch alarm

A bridge navigational watch alarm system (BNWAS) is required to be fitted on all new and existing ships built on or after 1 July 2002, in accordance with the amendments made to SOLAS Chapter V Regulation 19 through the IMO's Marine Safety Committee resolution 282(86). On vessels of 3000GT and above, the deadline for fitting such a system was 1 July 2012, or not later than the first annual survey thereafter. The performance standard<sup>5</sup> for the BNWAS requires that it should have three modes of operation: 'manual ON (in operation constantly)', 'manual OFF' (does not operate under any circumstances) and 'automatic' activation based on input from the vessel's heading or track control system. It is also required that access to the system be password protected, with the password available to only the master.

A new system, 'Navgard' from Martek Marine Ltd, which complied with the BNWAS requirement, was installed on board *Coastal Isle* on 14 June 2012. During installation, the terminals for connecting to the autopilot system could not be identified and therefore the BNWAS could not be set up to work in the automatic mode. The master on board at the time of the accident did not know how to switch on or set the system. His predecessor had received instruction from Martek Marine Ltd technicians when the system was commissioned, but these had not been passed on. After successful commissioning, the system was not turned on and the original, default password set by Martek Marine Ltd, was never changed. The MAIB carried out function tests of the system and established that it worked correctly in both the 'manual ON' mode and the 'manual OFF' mode.

*Coastal Isle* was originally fitted with a watch alarm that could be set to give an alarm after 1.5min, 3min or 12min of dormant time. It was a simple on / off system that had no facility to operate automatically. When the system was switched on, the watch alarm sounded on the bridge after the set dormant time; if not cancelled within a certain time, the general alarm would sound. At the time of the accident, this system, although fully functional, was switched off. There were no written instructions on board concerning its use; it was left to the watchkeepers to use it at their discretion.

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<sup>5</sup> Resolution MSC.128 (75)

## Voyage data recorder

*Coastal Isle*'s VDR was supplied by Interschalt GmbH in 2009. In August 2010, the mandatory annual performance test (APT) was carried out and a certificate was issued by Interschalt. Shortly afterwards, following complaints of excessive alarms from the VDR, an Interschalt representative attended the vessel. He found that *Coastal Isle*'s secondary GPS, a FURUNO 30 unit, did not provide the correct signals to the VDR and he asked the owners to have it replaced. In August 2011, an Interschalt representative was once again asked to attend the vessel in order to conduct the APT and issue a certificate. As the problem with the GPS had not been resolved, he refused to issue the APT certificate.

Germanischer Lloyd (GL) issued *Coastal Isle* with a class renewal certificate in October 2011 based on the VDR's service report rather than the APT certificate. During the Antigua and Barbuda safety audit in February 2012, the attending surveyor made a similar mistake, erroneously recording that the vessel's VDR APT certificate was valid. The Antigua and Barbuda administration issued a circular about VDRs (no 02 003-02) in June 2002, drawing the attention of masters and officers to the requirements under the International Convention for the Safety of Life at Sea (SOLAS). It stated that immediately after an accident, the VDR data must be preserved for investigation. The VDR on *Coastal Isle* was found to have been switched off on 16 June and switched on again 45 minutes after the accident. The 'data save' button on the VDR panel was not activated after the accident despite both the master and DPA being instructed to do so by the MAIB.

## Previous accidents

In the period from 1991 to 2011, 16 accidents involving container vessels grounding in UK territorial waters were reported to the MAIB. This is the MAIB's third full investigation into the grounding of an Antigua and Barbuda registered container vessel in the UK. Both the previous two accidents were caused by the bridge watchkeeper falling asleep. This is the first grounding caused by a watchkeeper deliberately leaving the bridge unattended.

## ANALYSIS

### The accident

*Coastal Isle* ran aground because there was no one on the bridge to correct the vessel's heading when it was set off course by the easterly wind. A lookout, in addition to the watchkeeping officer, was available on the bridge during the hours of darkness. However, the chief officer dismissed the lookout assigned to his watch shortly before leaving the bridge himself.

### Use of bridge watch alarm

After the lookout was dismissed, the chief officer was alone on the bridge. He could have then switched on the vessel's original watch alarm as protection against the hazards of single watchkeeping; however, he chose not to use it. In addition, the new BNWAS compliant watch alarm, though functional, was not switched on after it was installed. Both watch alarms were capable of warning the rest of the crew if the bridge watchkeeper was absent or asleep; had either been in use, this accident probably would not have happened. It was not possible to determine exactly why the original watch alarm was not used, but it was considered most likely that it was used so infrequently it had been forgotten.

It was fortunate that *Coastal Isle* grounded head on; had it grounded along its side, there could have been a significant loss of stability with the potential for loss of lives and significant environmental pollution.

### Chief officer's actions

When the chief officer left the bridge at around 0300, he did not recall the lookout; neither did he inform the master or any of the other officers. He chose to use the toilet in his cabin, two decks below the bridge and at the aft end of the accommodation, instead of using the toilet that was only a few metres away.

The expert medical opinion received by the MAIB indicated that it was unlikely that the chief officer had lost consciousness from stomach cramps and remained in an unconscious state for 1 hour and 45 minutes. His claims that he had suffered from a medical disorder were not considered to be credible for the following reasons:

- His ability to engage in a heated argument immediately after he was found in his cabin.
- The absence of any medical history of fainting or unconsciousness.
- His dismissal of the offer of medical attention.
- He was able to continue to work on board as an ordinary seaman after the accident without any further medical incidents.

It was considered most likely that he went to his cabin for some other reason, decided to rest on his bed, and fell asleep.

### **Vigilance in issuing and assessing certificates of competency**

Both the chief officer and the officer who came to relieve him following the grounding had presented themselves for employment with *bona fide* CoCs from the PMA. Neither the ship owner nor the Antigua and Barbuda administration checked their national certificates, and there was no requirement for them to do so because the PMA's practice was to issue new CoCs (which are normally only issued when an equivalent national CoC is presented). Other maritime administrations either require the original national CoC to be surrendered, or they issue an endorsement certificate that is only valid if presented with the original CoC. A consequence of the system used by the PMA was that a sophisticated fraud was allowed to prosper, which was extremely difficult to detect. A port state inspector would be satisfied if a seafarer presents a valid CoC and flag state endorsement; it is impractical to expect them to investigate exactly how each seafarer acquired their CoC.

It is extremely disturbing that inadequately qualified and inexperienced seafarers were able to function in senior roles without this having been identified during initial recruitment, port or flag state inspections, as well as internal and external international safety management system audits. In order to ensure the navigational safety of the large number of non UK flagged vessels operating around the UK coast, it is imperative they are manned by competent crew members. Illegal and fraudulent certificates must be identified and weeded out as a matter of priority. If the limitations of the port state control inspection are accepted, the onus must fall on companies, flag states and certificate issuing authorities to ensure that seafarers are properly qualified. This can only be done by carefully checking the details of how the seafarer obtained their qualification and confirming that it was issued from a legitimate source.

It could not be confirmed if either of the chief officers was aware of the fraudulent nature of the training and assessment centres in Turkey and The Republic of Panama that helped them obtain their Panamanian CoCs. It is, however, alarming that the PMA, responsible for the administration of 21% of the world's tonnage, was not aware that its employees were actively indulging in fraudulent activities related to seafarers' certification. It is hoped that the actions taken by the PMA to comply with the spirit of the 'Manila amendments' following this accident will prevent a recurrence of such activities.

### **Delay in informing shore authorities**

Although the master informed the DPA almost immediately that *Coastal Isle* had grounded, there was a delay of 1 hour before he informed the coastguard or port authorities. During this time, he attempted to free the vessel using the main engine. It is quite possible that, had he succeeded, he might not have informed anyone else, and that he only decided to call Clydeport's authorities when he realised that he would not be able to arrive on time.



Apart from being wholly irresponsible, the master's actions were not in accordance with either the vessel's SMS or Clydeport's requirements, both of which required him to inform the shore authorities immediately after a grounding incident. Experienced shore emergency response teams are normally far better equipped for handling the potential consequences of grounding, including assessing and mitigating any structural damage and environmental pollution. In the interest of the safety of their crew and the environment, it is imperative that masters follow post-accident procedures correctly.

It was concerning that neither GL nor the Antigua and Barbuda surveyors were able to identify that the APT certificate for the VDR on board *Coastal Isle* was not valid. Had either of these organisations recognised this, it would most certainly have resulted in the shipowner taking prompt action to regain the APT certificate. The cause for the spurious alarms might also have been corrected in this process, reducing the chances of the VDR being switched off later.

### **Voyage data recorder**

*Coastal Isle*'s VDR remained switched off for over 2 weeks before the accident. It was possible that the unresolved problem of spurious alarms from the VDR unit was the main reason for keeping it switched off. Some 45 minutes after the accident it was switched on, probably in an attempt to disguise the fact that it had been disabled. In spite of specific instructions from the MAIB to do so, it was possible to determine that the data save function was never activated.

The VDR is a mandatory piece of equipment, and it is the responsibility of the vessel's owner and crew to ensure that it is fully functional at all times. There was no requirement in the vessel's SMS for saving the VDR data in case of an accident and, although the Antigua and Barbuda administration explicitly required it, this shortcoming had never been detected during flag state audits.

The ship owner, by not keeping the VDR in a good functional state, and the crew, by turning it off and not saving the data, were in direct violation of the requirements of the vessel's administration and the SOLAS regulation concerning VDRs. Importantly for this investigation, the absence of VDR data meant that it was not possible to resolve a number of ambiguities in the accounts of events prior to the grounding.

## CONCLUSIONS

- *Coastal Isle* ran aground because there was no one on the bridge to correct the vessel's heading when it was set off course by the easterly wind.
- Had either of the watch alarms on the bridge been switched on, the absence of the bridge watchkeepers would have been detected and this accident could have been avoided.
- It is highly unlikely that the chief officer suffered stomach cramps, passed out in the toilet, or remained unconscious for 1 hour and 45 minutes; it is considered much more likely that he fell asleep on his bed.
- The PMA's investigation revealed that unspecified training centres located inside The Republic of Panama were working in collusion with some employees of the PMA and fraudulent organisations in Turkey, in order to issue genuine Panamanian CoCs and GMDSS certificates.
- There was a delay of 1 hour before the master informed the port about the grounding; this was wholly irresponsible and not in accordance with the vessel's SMS or the requirements of the local port authority.
- The VDR was kept switched off by the crew, possibly due to spurious alarms. Although the VDR APT was not valid, both classification and flag state surveyors failed to identify it.

## ACTION TAKEN

### **PASA International Technical Services** has:

- Resolved the problem with *Coastal Isle*'s VDR and obtained an APT certificate.
- Connected the new BNWAS to the autopilot system and set it up so that the password is available only in the PASA office.
- Amended its SMS to provide detailed and specific instructions about bridge manning requirements.

### The **Panama Maritime Authority** has:

- Revoked the CoC and GMDSS certificate of the chief officer who was on board at the time of the accident.
- Started legal proceedings against the employees of PMA who were involved in fraudulent activities associated with the issuance of seafarers' certificates.
- Revised its auditing process and increased the frequency of the audits of recognised training centres in The Republic of Panama.
- Decided to implement a software system to assist the process of establishing compliance with STCW requirements for issuing seafarers' qualification certificates.

### **Clydeport Operations Limited** has:

- Expressed its displeasure to the master and owner of *Coastal Isle* regarding the master's failure to contact the port and coastguard immediately after the grounding.

### **Coastal Container Lines** has:

- Written to the owners expressing its concerns about the events that led up to the accident and the failure to report it immediately.
- Endorsed the MAIB's recommendations to the owners of *Coastal Isle*.

## RECOMMENDATIONS

The **Antigua & Barbuda Department of Marine Services and Merchant Shipping** and **Germanischer Lloyd classification society** are recommended to:

2013/206 Ensure that during vessel audits and surveys, Voyage Data Recorders are functioning and certificated in accordance with international regulations.

**PASA International Technical Services** is recommended to:

2013/207 Issue specific instructions to its fleet that require data held on vessels' voyage data recorders to be saved in the event of an accident.

2013/208 Develop and adopt additional management controls designed to verify the authenticity of the certificates of competency held by seafarers employed by the company.

## SHIP PARTICULARS

Vessel's name	Coastal Isle
Year of build	1991
Flag	Antigua and Barbuda
Classification society	Germanischer Lloyd
IMO number	930333
Type	Container ship
Registered owner (DOC)	Pasa International Technical Service Ltd (Turkey)
Manager	Pasa International Technical Service Ltd (Turkey)
Construction	Steel
Length overall	89.37m
Gross tonnage	3125
Minimum safe manning	7
Authorised cargo	Containers

## VOYAGE PARTICULARS

Port of departure	Belfast
Port of arrival	Greenock
Type of voyage	Liner container feeder service
Cargo information	Empty containers
Manning	10

## MARINE CASUALTY INFORMATION

Date and time	2 July 2012, 0443
Type of marine casualty or incident	Serious Marine Casualty
Location of incident	55 43.6'N 005 01'W, at Garroch Head (Island of Bute)
Injuries/fatalities	None
Damage/environmental impact	Extensive steel damage, forepeak tank breached
Ship operation	On passage
Voyage segment	Belfast to Greenock
External & internal environment	Morning twilight, poor visibility, sea state: slight, wind: light air to light breeze.
Persons on board	10