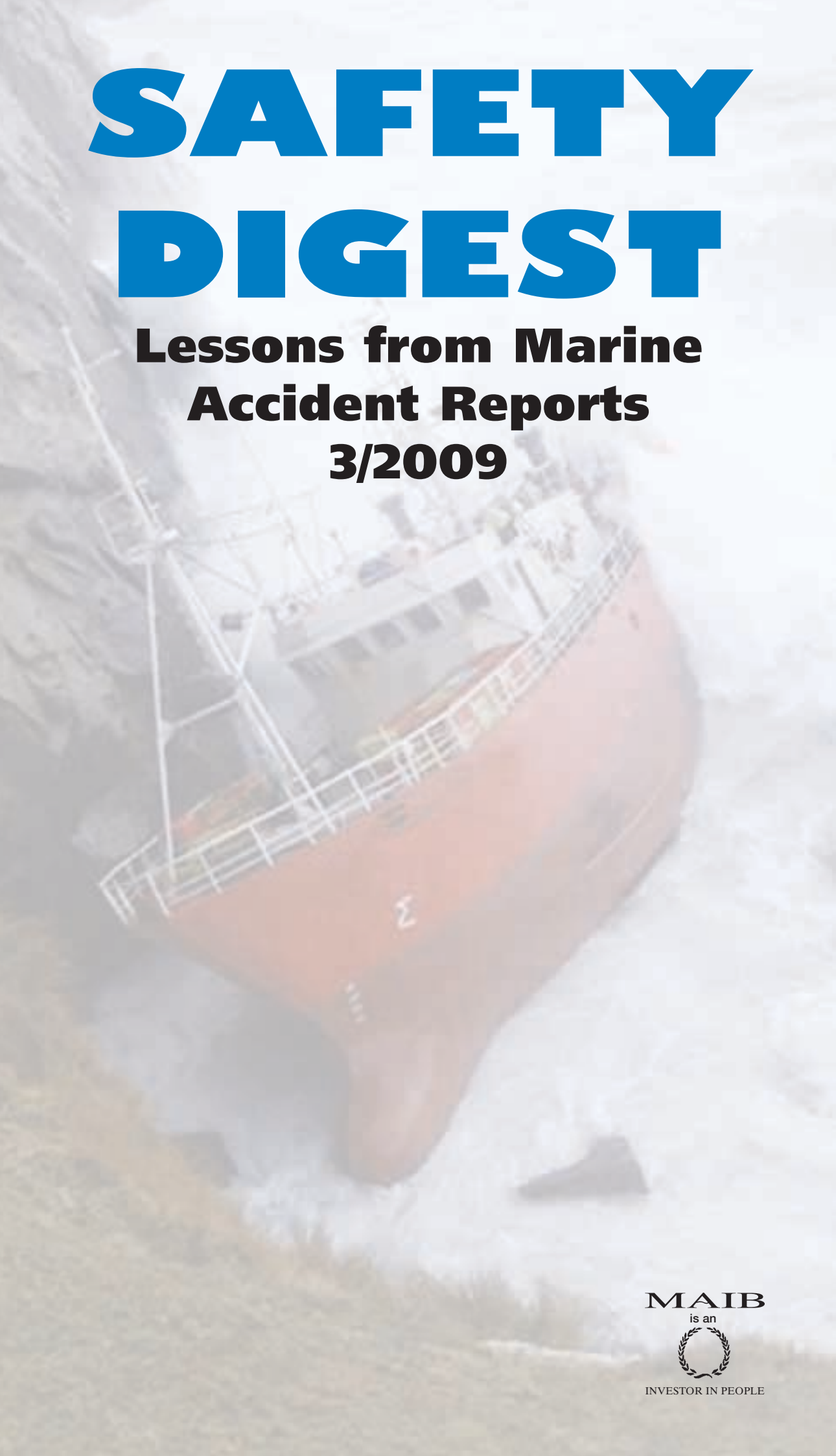


**MAIB**

MARINE ACCIDENT  
INVESTIGATION BRANCH

# **SAFETY DIGEST**

**Lessons from Marine  
Accident Reports  
3/2009**



# SAFETY DIGEST

Lessons from Marine Accident Reports

No 3/2009



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December 2009

# MARINE ACCIDENT INVESTIGATION BRANCH

The Marine Accident Investigation Branch (MAIB) is an independent part of the Department for Transport, the Chief Inspector of Marine Accidents being responsible directly to the Secretary of State for Transport. The offices of the Branch are located at Mountbatten House, Grosvenor Square, Southampton, SO15 2JU.

This Safety Digest draws the attention of the marine community to some of the lessons arising from investigations into recent accidents and incidents. It contains information which has been determined up to the time of issue.

This information is published to inform the shipping and fishing industries, the pleasure craft community and the public of the general circumstances of marine accidents and to draw out the lessons to be learned. The sole purpose of the *Safety Digest* is to prevent similar accidents happening again. The content must necessarily be regarded as tentative and subject to alteration or correction if additional evidence becomes available. The articles do not assign fault or blame nor do they determine liability. The lessons often extend beyond the events of the incidents themselves to ensure the maximum value can be achieved.

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The Editor, Jan Hawes, welcomes any comments or suggestions regarding this issue.

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# MAIB

MARINE ACCIDENT INVESTIGATION BRANCH

The role of the MAIB is to contribute to safety at sea by determining the causes and circumstances of marine accidents, and working with others to reduce the likelihood of such causes and circumstances recurring in the future.

**Extract from  
The Merchant Shipping  
(Accident Reporting and Investigation)  
Regulations 2005 – Regulation 5:**

*“The sole objective of the investigation of an accident under the Merchant Shipping (Accident Reporting and Investigation) Regulations 2005 shall be the prevention of future accidents through the ascertainment of its causes and circumstances. It shall not be the purpose of an investigation to determine liability nor, except so far as is necessary to achieve its objective, to apportion blame.”*

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**Glossary of Terms and Abbreviations**

AB	– Able seaman	m	– metre
ARPA	– Automatic Radar Plotting Aid	“Mayday”	– The international distress signal (spoken)
C	– Celsius		
CCTV	– closed circuit television	MCA	– Maritime and Coastguard Agency
CO <sub>2</sub>	– carbon dioxide	OOW	– Officer of the Watch
CPP	– Controllable Pitch Propellers	PTW	– Permit to Work
ECR	– Engine Control Room	RIB	– Rigid Inflatable Boat
EPIRB	– Emergency Position Indicating Radio Beacon	RNLI	– Royal National Lifeboat Institution
GPS	– Global Positioning System	Ro-Ro	– Roll on, Roll off
HRU	– Hydrostatic Release Unit	SMS	– Safety Management System
IMO	– International Maritime Organization	SWL	– Safe Working Load
kg	– kilogram	TSS	– Traffic Separation Scheme
LPG	– Liquefied Petroleum Gas	UV	– ultraviolet
		VHF	– Very High Frequency
		VTS	– Vessel Traffic Services

# Introduction

It is only a year since I last wrote about the importance of risk assessments. However, in the past 12 months, so many deaths have been reported that could have been avoided by a simple consideration of the risks, that I feel compelled to return to the subject.

Just the phrase “risk assessment” is enough to cause most mariners’ eyes to glaze over. “More paperwork and bureaucracy” I hear you cry. But what I am after is the thought process, not the paperwork. Let me give you a couple of examples.

This morning I was briefed on the death of a fisherman. The owner and the skipper of the vessel had so nearly got it right, but for want of following things through, a man died last week. The fishing boat had one of the best risk assessments I have seen, and the fish deck had been specifically designed to eliminate major hazards. Unfortunately, in the months since the vessel had been built, the method of working had been modified, and the hazards associated with the new system had not been risk assessed. Additionally, neither the skipper nor the owner were monitoring how the crew were operating, and one of the crew had developed his own system of repairing fishing gear. These two minor changes to a well risk assessed system cost one man his life – what a price for 20 minutes or so, to risk assess those changes.

My second example is given in Case 25. Two leisure craft were involved in this case, with two separate risks that had not been considered. In the first, a man fell overboard when doing the simplest of routine daily tasks. Had the risk been thought about, there were several simple ways of reducing it. He was not wearing a lifejacket, and owed his life to the alertness of two men in another yacht, who heard his cries and went to rescue him. Unfortunately, despite there being two men on board, they were unable to get him out of the water. Recovering a person from the water to a yacht or even a small power boat is much more difficult than people imagine. Have you worked out how you would do it – and have you briefed your crew in case it is you in the water? A simple mental run through the risks involved in sailing, and a crew talk at the start of a day’s sailing, would dramatically reduce the likelihood of an accident.

In the aftermath of an accident, we are almost always told what steps people intend to take to stop such an accident happening again. Please read through the accounts of incidents in this Safety Digest, and take appropriate steps now, rather than waiting until you learn the hard way.



Stephen Meyer  
Chief Inspector of Marine Accidents  
December 2009