

ANNUAL REPORT



2025

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 records just over 1,400¹ reports of marine casualties and marine incidents²) each year. The number of reports received exceeds this figure, as not all reports received are recorded in the National Database.

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 National Marine Accident Database. An anonymised subset of data is publicly available via the MAIB Data Portal. In addition, the findings and reports of all published investigations are uploaded to the International Maritime Organization (IMO) Global Integrated Shipping Information System database.

¹ The 5-year average is 1,437.

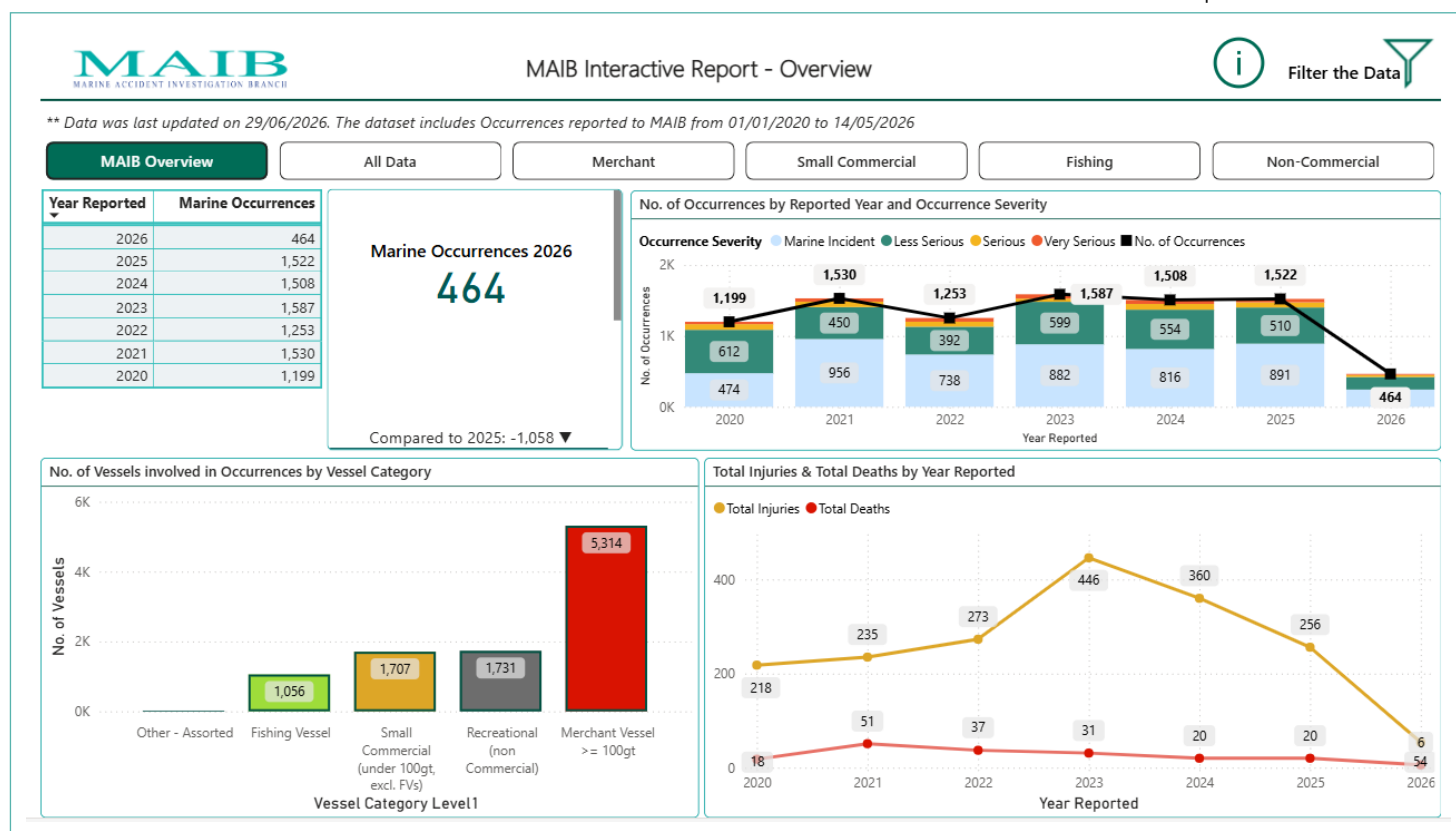
² As defined in Annex A.

MAIB DATA PORTAL

The MAIB Data Portal is designed to provide public access to an anonymised subset of maritime accident data. In development since August 2022, the data portal gives the public and industry open access to download and analyse MAIB's data. Data for occurrences reported to MAIB in 2020, 2021, 2022, 2023, 2024, and 2025 up until 14 May 2026 is available.

- Filter data using MAIB's published dashboard
- Download the most recent datasets
- 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 dataset

Users experienced with reporting data analysis tools can download the MAIB dashboard as a .pbix file. This contains a pre-built Power BI dataset 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.

Access the [MAIB Data Portal](#)

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INTRODUCTION



I am pleased to introduce the MAIB Annual Report for 2025 on behalf of Captain Andrew Moll OBE, who retired as the Chief Inspector of Marine Accidents in February 2026 after nearly 50 years of combined public service in the Royal Navy and at the MAIB. As the new chief inspector, I am honoured to extend gratitude to Andrew for his exemplary contribution to marine safety during his time at the branch.

I will comment on the statistics and safety matters before moving on to the work of the MAIB.

The MAIB started 16 new investigations in 2025 and published 17 accident investigation reports. The streamlining of branch processes has helped to reduce the backlog of completed investigations and has improved the time to deliver reports. This initiative is delivering even better results in 2026.

The reporting of marine casualties and incidents continues to increase year-on-year, although the growth of the reporting rate has slowed. The MAIB is aware that there can be a culture of under-reporting less serious marine incidents and near misses. I wish to issue a rallying call to all in the marine sector to contribute to future marine safety by reporting unsafe occurrences that they have encountered during marine operations. Data on seemingly inconsequential events can inform the bigger picture of risk and can literally provide the opportunity to save lives. A seafarer need not lose their life or a ship be lost to improve marine safety!

The 90% acceptance of the recommendations made by the MAIB during 2025 (representing a 5% increase on the previous year) is heartening and is testament to the positive attitude to improving marine safety adopted by the majority of our stakeholders.

Year	Marine casualties and marine incidents ³	Investigations started	Investigations started involving loss of life
2025	1,585	16	7
2024	1,515	15	7
2023	1,587	19	12
2022	1,252	16	8
2021	1,531	22	14
2020	1,223	19	10
Average ^{4,5}	1,449	17.8	9.7

³ Including those reported to the MAIB under the Red Ensign Group memorandum of understanding (MOU).

⁴ Rounded to the first decimal place.

⁵ MAIB regularly reviews its accident data. On occasion, data from previous years can and will change based on these reviews.

SAFETY ISSUES

Merchant vessels

The standard of watchkeeping, lookout and the application of the collision regulations continue to be a concern on merchant ships. Accidents such as the collision between *Solong* and *Stena Immaculate* in the North Sea in March 2025 show that drift from established seafaring practice can result in loss of life, pollution and the loss of a vessel.

Further, effective use of safety management systems and the application of the International Safety Management Code provide the best opportunity to keep seafarers and vessels safe. Accidents such as the bosun's fatal fall overboard from the bulk carrier *World Prize* in October 2025 demonstrate that the mitigation of hazards recorded in even the most basic risk assessment helps prevent accidents. Deviate at your peril.

A future challenge to marine safety manifested in the collision between the uncrewed surface vessel *X18* and crew transfer vessel *Iceni Legend* in the North Sea in September 2025. Fortunately, there was no loss of life, but the accident is providing the opportunity to understand how a remotely controlled slow-moving vessel operates in the same sea space as a fast-moving vessel helmed by a human. There is a drive to automate, reduce manning and move to larger fully autonomous vessels. The MAIB recognises this is an important investigation that can inform vessel build and operation standards, seafarer training and how a human can understand what the robot might do (and vice versa).

Fishing vessels

Sadly, in 2025 two fishers lost their lives by falling overboard, one from *Sea Eagle* the other *Wilaya*. Although this is a statistical improvement on previous years, one death is too many, especially considering falling overboard is a preventable accident. Safety folders are often present on fishing vessels but it is common to find that the safety procedures that are written are not used and the equipment that they describe, such as safety tethers, are not present. It should be remembered that a safety folder is not merely an exercise in compliance but should describe realistic safety measures that are followed. Although a personal flotation device (PFD) is sometimes worn, PFDs are often presented as a mitigation to preventing falls into water. This is not the whole story: PFDs mitigate the *effect* of falling overboard, helping to keep the airway clear of the water and prevent drowning. The cold waters in the fishing grounds can claim a displaced fisher floating in their PFD – the best policy is to keep the fisher on board their vessel. Separation from fishing gear and fall prevention must also be considered to keep the fisher safe.

Fatigue continues to plague the fishing industry, with two vessels grounded and lost during 2025. The drive to keep fishing is understandable in such a tough economic climate. Long days of fishing and night maintenance can take their toll and the risk of falling asleep on watch is ever present. Do not take a chance by going to sea while exhausted: put the safety of your crew and vessel first – manage your rest periods.

BRANCH ACTIVITY AND DEVELOPMENT

Launched in 2023, the MAIB's [data portal](#) continues to be updated year-on-year. The data now extends back to 2020 and provides dashboards showing statistical overviews for marine occurrence per sector. Since the supporting data is also provided on the website and is available for data analytics using Power BI, the statistical section of the annual report is no longer included.

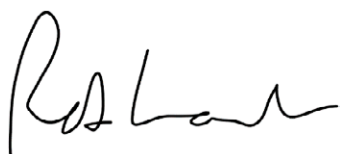
The DfT internal review of the air, marine and rail accident investigation branches reported in April 2025. Recommendations were made that principally focused on improving tri-branch working and synergies in combined corporate functions such as business support. Planning and preparations were started in 2025. The rollout of new initiatives will start in 2026, and will be reported in greater detail in next year's annual report.

The effect of the review combined with the change of senior management is challenging and puts pressure on MAIB's workforce. However, both factors provide great opportunity for the MAIB to grow and reinforce its position as a world leader in the field of marine accident investigation and inform the profile of UK maritime risks.

FINANCE

The annual report deals principally with the 2025 calendar year. However, the expenditure figures below are for the 2025/26 financial year, which ended on 31 March 2026. The MAIB's funding from the DfT is provided on this basis and this complies with the government's business planning programme.

Costs (£)	Budget (£)	Outturn (£)
Pay	2,971,000	3,106,000
Non Pay	1,534,000	1,123,000
Total	4,505,000	4,229,000



Rob Loder
Chief Inspector of Marine Accidents

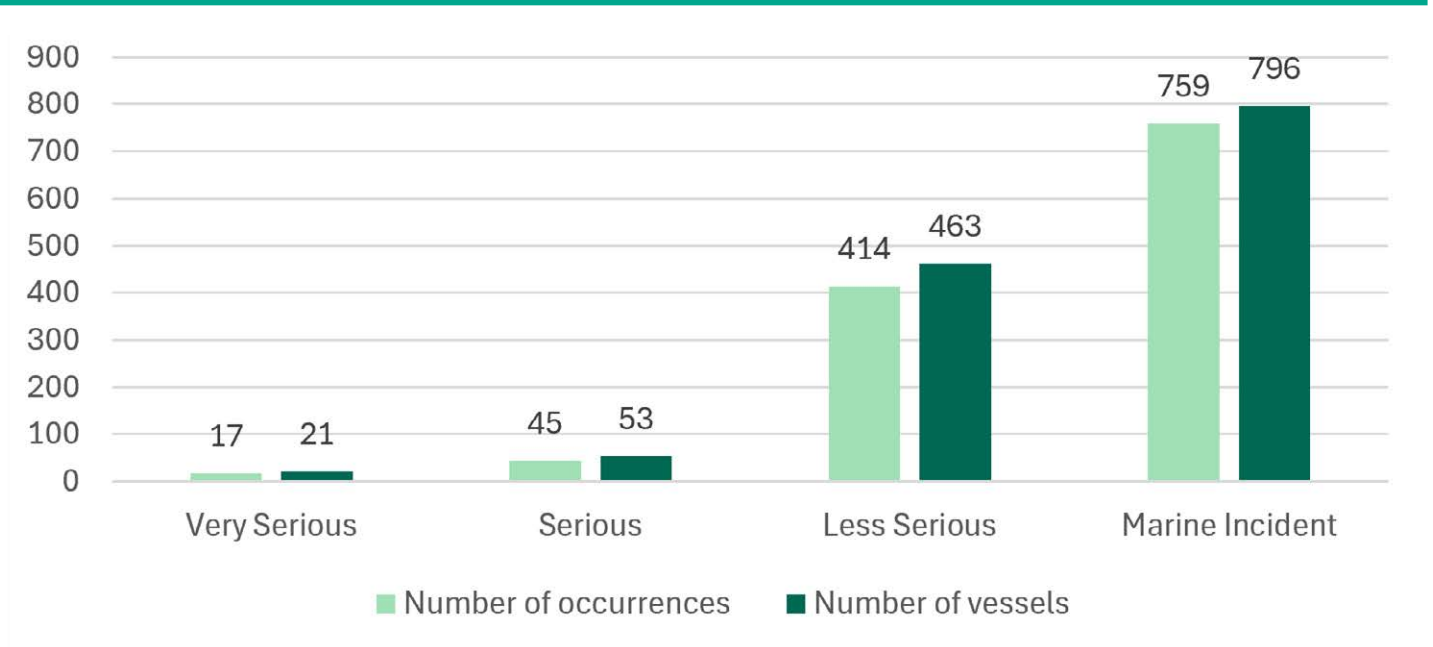
STATISTICAL OVERVIEW

The MAIB recorded 1,585 reports of accidents to UK vessels worldwide or any vessels within UK coastal waters during 2025. A total of 1,737 vessels were involved.

1,506 recorded notifications were within the scope of the Merchant Shipping (Accident Reporting and Investigation) Regulations 2012, as amended⁶ and two fell within the scope of the Red Ensign Group MOU. 77 were not in scope of the Regulations or the MOU and are not included in any of the statistics contained in this annual report.

This statistical overview represents 1,235 occurrences (UK or non-UK vessels in UK waters), involving 1,333 commercial vessels (UK or non-UK vessels in UK waters) that experienced an actual or potential casualty to a vessel.

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



⁶ The Merchant Shipping (Accident Reporting and Investigation) Regulations 2026 came into force on 15 May 2026.

Chart 2: UK merchant vessels of 100gt or more

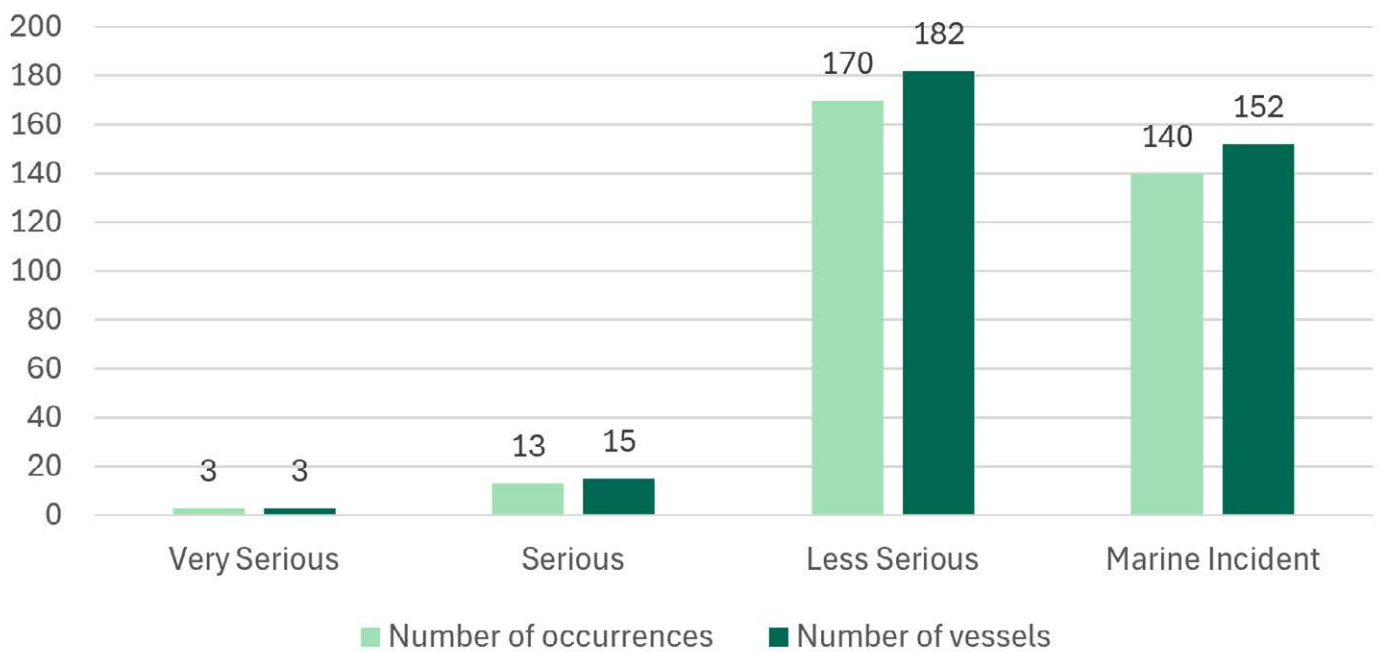


Chart 3: UK merchant vessels of under 100gt

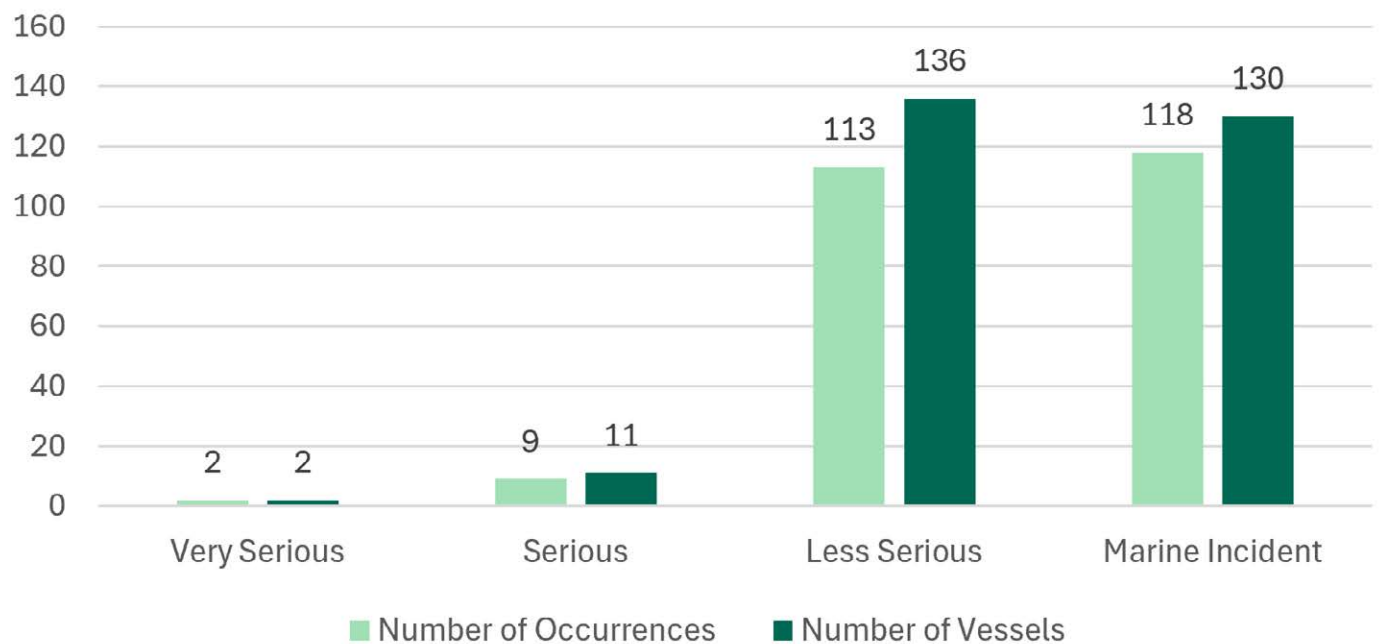


Chart 4: UK fishing vessels

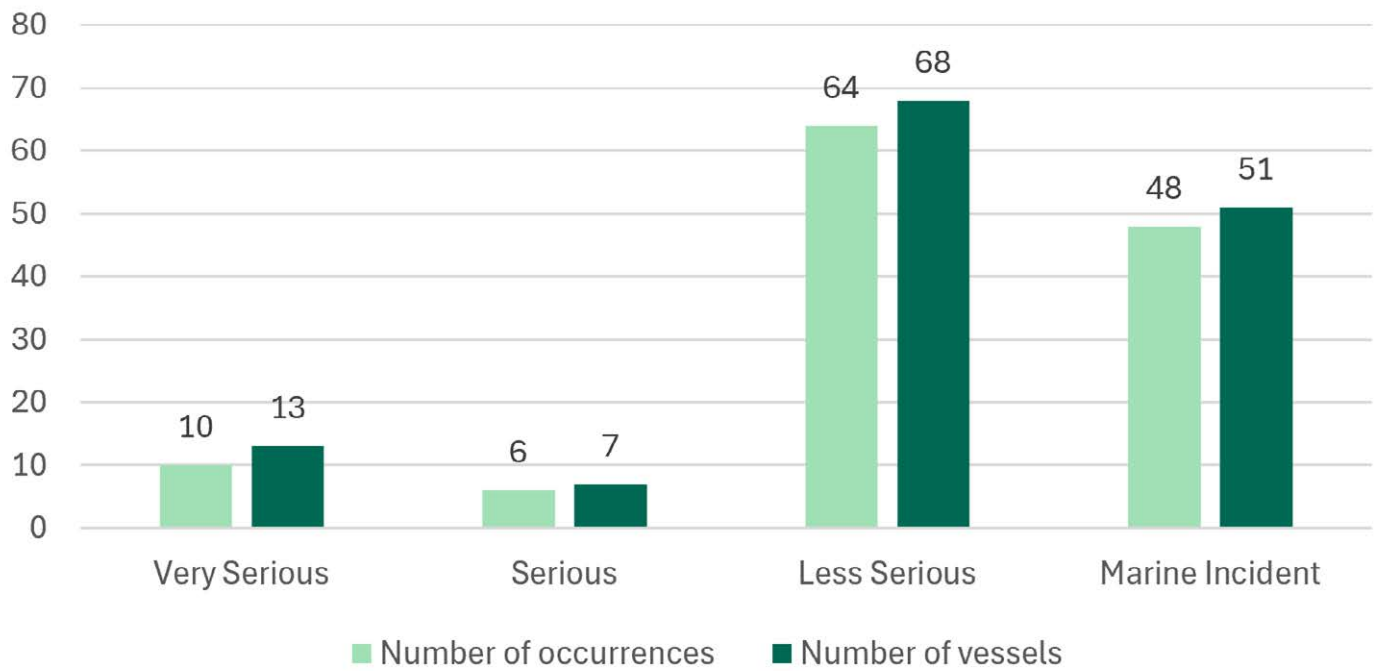
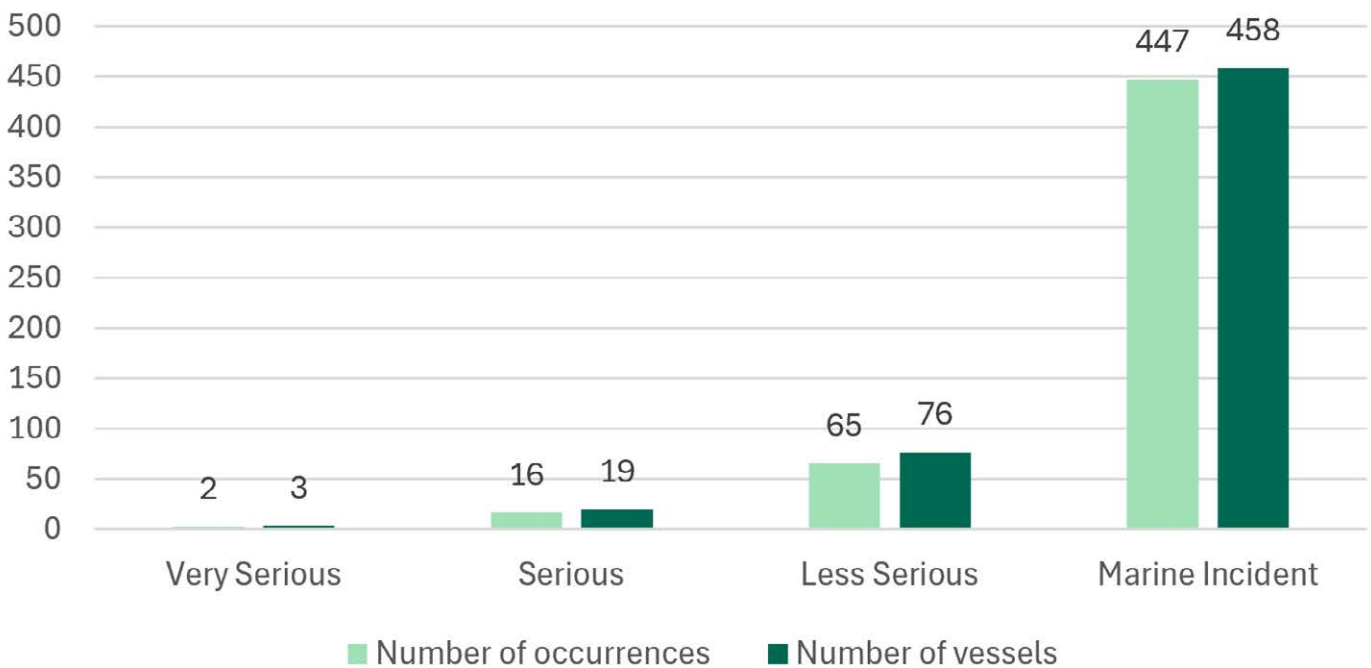


Chart 5: Non-UK merchant vessels in UK 12-mile waters



PART 1: CASUALTY REPORTS TO MAIB IN 2025

INVESTIGATIONS STARTED IN 2025

Occurrence details		Status details
25 Jan	Catastrophic engine failure on board the site investigation vessel Kommandor Susan , resulting in a fire.	Published 6 May 2026 MAIB report 10/2026
4 Feb	Towline failure on board the tug Svitzer Avon while assisting the car carrier Auto Eco , resulting in injuries to two crew members.	Published 12 June 2026 MAIB PA summary 2/2026
10 Mar	Collision between the container ship Solong and the oil/chemical tanker Stena Immaculate , resulting in 1 fatality.	Under investigation Interim report issued April 2025
1 May	Fatal man overboard from the 8.86m fishing vessel Wilaya (M36).	Published 21 May 2026 MAIB report 12/2026
10 May	Serious injury to a crew member on board the 19.7m fishing vessel Jacoba (BM77).	Published 25 June 2026 MAIB report 14/2026
6 Jun	Grounding of the fishing vessel Crystal Stream (LH 147), resulting in the vessel's abandonment.	Published 7 May 2026 MAIB report 11/2026
14 Aug	Allision of the 9m rigid inflatable boat Peaky Blinder with a navigation marker, resulting in the loss of 2 lives.	Published 15 July 2026 MAIB report 15/2026
9 Sep	Flooding and partial sinking of an inflatable boat carrying migrants in the Dover Strait, resulting in the loss of 1 life.	Consultation stage
19 Sep	Collision between the crew transfer vessel Iceni Legend and the uncrewed surface vessel X18 in the Greater Gabbard Offshore Wind Farm in the North Sea.	Under investigation Interim report issued September 2026
14 Oct	Fatal man overboard from the bulk carrier World Prize while rigging the pilot disembarkation arrangement.	Published 28 July 2026 MAIB report 16/2026
14 Oct	Grounding of the 15m fishing vessel Silver Cloud II (WK 80).	Published 13 August 2026 MAIB report 17/2026
17 Oct	Amputation of a crew member's limb on board the fishing vessel Reliance III (BF 800).	Published 22 January 2026 MAIB PA summary 1/2026
26 Oct	Accident in a lift shaft on the Bermuda registered passenger vessel Arvia (9849693) while on passage from Southampton, England, to Tenerife, Canary Islands, resulting in the loss of 1 life.	Consultation stage Interim report issued January 2026
6 Dec	Loss overboard of 16 containers from the Liberia registered refrigerated cargo ship Baltic Klipper (9454759) near the Nab Anchorage off the Isle of Wight, England.	Under investigation
11 Dec	Grounding of the UK registered 25m guard vessel GV Resolute (7008025) in Fishguard Bay, Wales.	Under investigation
20 Dec	Man overboard, presumed deceased, from the 9.95m fishing vessel Sea Eagle (AH18).	Published 20 August 2026 MAIB report 18/2026

INTRODUCTION

Status as of 7 September 2026

The following pages list the accident investigation reports and safety bulletins published by the MAIB during 2025. 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 47.

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 of Marine Accidents 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 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 of Marine Accidents 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 of Marine Accidents 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 2025

50 recommendations were issued to 26 distinct addressees in 2025. The percentage of all recommendations that are either **accepted and implemented** or **accepted, yet to be implemented** is 90%, which is an improvement on last year's figure of 85%.

Year	Total*	Accepted action		Partially accepted	Withdrawn	Rejected	No response received	Inappropriate action implemented or planned
		Implemented	Yet to be implemented					
2025	50	25	20	2	0	1	1	1

* Total number of recommendations issued

PUBLICATIONS AND RECOMMENDATIONS ISSUED IN 2025

Vessel name(s)	Severity	Publication	Recommendations	Page
Baton Rouge	Very Serious Marine Casualty	Published 23 January MAIB report 1/2025	No	11
Red Sea dive boats	Very Serious Marine Casualty	Published 6 February MAIB safety bulletin 1/2025	No	11
Njord	Very Serious Marine Casualty	Published 13 February ⁷ MAIB report 2/2025	No	12
Waverley	Serious Marine Casualty	Published 26 February MAIB report 3/2025	No	12
Lexi Rose	Very Serious Marine Casualty	Published 27 February MAIB report 4/2025	No	12
Berge Mawson	Very Serious Marine Casualty	Published 20 March MAIB report 5/2025	Yes	14
Calypso 2	Very Serious Marine Casualty	Published 10 April MAIB report 6/2025	Yes	14
Limbitless	Very Serious Marine Casualty	Published 24 April MAIB report 7/2025	Yes	15
Cornishman	Very Serious Marine Casualty	Published 19 June MAIB report 8/2025	Yes	16
Sustain	Very Serious Marine Casualty	Published 3 July MAIB report 9/2025	No	17
Nista	Very Serious Marine Casualty	Published 10 July MAIB report 10/2025	No	18
Argos Georgia⁸ recommendation letter	Very Serious Marine Casualty	Not applicable	Yes	18
Lundy Explorer	Serious Marine Casualty	Published 21 August MAIB report 11/2025	Yes	19
Kingfisher	Very Serious Marine Casualty	Published 11 September MAIB report 12/2025	Yes	20
Finnmaster	Serious Marine Casualty	Published 18 September MAIB report 13/2025	Yes	21
Isabell Princess of the Sea/RIB Vega	Very Serious Marine Casualty	Published 25 September MAIB report 14/2025	No	23
Jean Elaine	Very Serious Marine Casualty	Published 2 October MAIB report 15/2025	No	23
Karin	Very Serious Marine Casualty	Published 16 October MAIB report 16/2025	Yes	23
Odyssey	Very Serious Marine Casualty	Published 17 December MAIB report 17/2025	Yes	24

⁷ On 18 July 2025, we published an updated report. The changes corrected a minor factual error and amended the corresponding analysis.

⁸ [MAIB report 19/2026: Argos Georgia](#) was published on 25 September 2026.

PRELIMINARY ASSESSMENT SUMMARIES PUBLISHED IN 2025

Vessel name(s)	Severity	Publication	Description
<i>Lord of the Isles</i>	Less Serious Marine Casualty	Published 20 November MAIB PA summary 1/2025	Uncontrolled launch of a fast rescue craft during a training exercise at Lochboisdale, Scotland on 23 August 2025.
<i>Altay</i>	Serious Marine Casualty	Published 27 November MAIB PA summary 2/2025	Cargo hold fire on board a bulk carrier while loading scrap metal in Hull, England on 27 June 2025.
<i>Vos Tracker</i>	Less Serious Marine Casualty	Published 27 November MAIB PA summary 3/2025	Two persons overboard from a standby safety vessel during maintenance of the fast rescue craft in the North Sea on 25 August 2025.
<i>Mollie</i>	Very Serious Marine Casualty	Published 27 November MAIB PA summary 4/2025	Fatal accident on board a recreational sailing vessel in the Solent, England on 5 August 2025.

Baton Rouge

Report number: 1/2025

Fatality of the chief engineer on board the motor yacht *Baton Rouge* at Falmouth Harbour, Antigua on 23 February 2024

Safety Issues

- ▶ Working on live electrical equipment without safety mitigation measures in place
- ▶ No permits to work issued for the tasks to be completed
- ▶ Enclosed space entry/work procedures not followed
- ▶ No plan to rescue a person from an enclosed space

No.	Recommendation(s) to:
	Not applicable

No recommendations have been made in this report.

Red Sea dive boats

Safety bulletin number: SB1/2025

Safety issues on Egyptian liveaboard dive boats operating in the Red Sea

Safety Issues

- ▶ Inadequate stability
- ▶ Poor construction standards
- ▶ Defective lifesaving equipment
- ▶ Poor safety management

No.	Recommendation(s) to:
	Not applicable

No recommendations have been made in this report.

Njord

Report number: 2/2025

Capsize and foundering of the fishing vessel *Njord* (SH 90) resulting in one fatality 150 miles north-east of Peterhead, Scotland on 6 March 2022

Safety Issues

- ▶ Unapproved modifications
- ▶ Loss of stability
- ▶ Ineffective emergency preparedness
- ▶ Downflooding leading to capsize

No. Recommendation(s) to: Not applicable

No recommendations have been made in this report.

Waverley

Report number 3/2025

Contact made by the paddle steamer *Waverley* with Brodick pier, Isle of Arran, Scotland on 3 September 2020

Safety Issues

- ▶ Ineffective maintenance system
- ▶ Lack of formal engineering training
- ▶ Ineffective appraisal of berthing risks

No. Recommendation(s) to: Not applicable

No recommendations have been made in this report.

Lexi Rose

Report number 4/2025

Grounding and capsize of the creel fishing vessel *Lexi Rose* (BF 370) on Melrose Point, north-east Scotland resulting in one fatality on 21 September 2023

Safety Issues

- ▶ Lone fishing
- ▶ Uncontrolled emergency
- ▶ PFD not worn
- ▶ Fishing close to shore

No. Recommendation(s) to: Not applicable

No recommendations have been made in this report.

Berge Mawson

Report number: 5/2025

Deaths of three stevedores in a cargo hold access space on board the bulk carrier *Berge Mawson* at Bunyu Island anchorage, Indonesia on 27 June 2022

Safety Issues

- ▶ Unauthorised entry into cargo spaces
- ▶ Ineffective monitoring of stevedores
- ▶ Pre-entry requirements not completed
- ▶ Oxygen depleted atmospheres are not obvious
- ▶ Risk assessments must include all hazards

No.	Recommendation(s) to: Maritime and Coastguard Agency to:
2025/101	Review and revise the Code of Safe Working Practices for Merchant Seafarers to ensure that emergency drill scenarios for enclosed space rescues include the possible presence of shoreside staff or third parties.
Appropriate action implemented 	

No.	Recommendation(s) to: Bunyu Port Organizing Unit, PT Bintang Kartika Segara and PT Tanjung Mas to:
2025/102	Follow the guidelines set out in the International Maritime Solid Bulk Cargoes Code, BLU Code and BLU Manual to provide stevedores with training and personal protective equipment to enable them to work safely on board bulk carriers.
Appropriate action implemented 	

No.	Recommendation(s) to: Berge Bulk Maritime Pte. Ltd to:
2025/103	Maintain clear and precise guidance for masters and ships' crews on cargo operations and ensure that: • specific duties for cargo-related and emergency scenarios for ship and shore personnel are considered • the control of access to the vessel, deck and all spaces during cargo operations is robustly applied.
Appropriate action implemented 	

No.	Recommendation(s) to: Intercargo, InterManager and RightShip to:
2025/104	Develop a minimum operational safety standard for stevedores conducting cargo operations on board their members' vessels to include: • compilation and distribution of a Ship-Shore Safety Checklist • cargo hold entry procedures • communication with ships' crews • personal protective equipment. Appropriate action planned: 30 April 2027 
2025/105	Encourage their members to introduce the minimum operational safety standard for stevedores as a port and/or terminal requirement and consider its inclusion in the charter party agreement. Appropriate action planned: 30 April 2027 

Calypso 2

Report number: 6/2025

Double fatality and subsequent loss of the small commercial vessel *Calypso 2* near West End, Anguilla on 11 March 2023

Safety Issues

- ▶ Ineffective safety management system
- ▶ Maritime operation not risk assessed
- ▶ No passage plan

No.	Recommendation(s) to: Anguilla Maritime Administration and Shipping Registry to:
2025/106	In collaboration with the Maritime and Coastguard Agency, develop and implement a marine safety management system that encompasses the recommendations made in the Navigation Risk Assessment for Internal Waters, Anguilla completed on 7 July 2023. Appropriate action planned: 31 December 2026 
2025/107	Ensure compliance with the Anguilla Maritime Administration and Shipping Registry requirement for the installation of automatic identification system transponders on board small commercial vessels carrying less than 12 passengers. Appropriate action planned: no date 
2025/108	Ensure that the safety management requirements of Chapter VIII section 4.10 of the Code of Safety for Small Commercial Vessels Operating in the Caribbean Trading Area, 2021 form part of the assessment of small commercial vessels at inspections conducted for their certification. Appropriate action planned: 31 December 2026 

No.	Recommendation(s) to: Royal Anguilla Police Force to:	
2025/109	Review and implement amendments to its operational procedures for the management and allocation of appropriate resources to marine incidents.	Appropriate action implemented 

No.	Recommendation(s) to: Anguilla Fire and Rescue Service to:	
2025/110	Review and modify the arrangements of SAR-1 to ensure that its operational capabilities include the ability to retrieve unconscious people from the water.	Appropriate action implemented 

No.	Recommendation(s) to: Calypso Charters Ltd to:	
2025/111	Develop and implement a safety management system for its domestically operating vessels in compliance with the requirements of Chapter VIII section 4.10 of the Code of Safety for Small Commercial Vessels Operating in the Caribbean Trading Area, 2021.	No response: closed 

Limbitless

Report number: 7/2025

Person overboard from the keelboat *Limbitless* resulting in one fatality off Cowes, Isle of Wight, England on 1 October 2022

Safety Issues

- ▶ Incomplete risk assessments
- ▶ No means of efficient recovery of a person from water
- ▶ Ineffective exercising of recovery method

No.	Recommendation(s) to: Maritime and Coastguard Agency to:	
2025/112	Review the definition of the term 'Pleasure Vessel' to clarify that vessels operated by organisations and charities to take vulnerable adults and children afloat do not fall within the scope of that definition.	Appropriate action planned: no date 

No.	Recommendation(s) to:	Local Government Association Coastal Special Interest Group to:
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2025/113	Bring this report to the attention of local authorities and invite them to consider oversight of waterborne charitable activities within their jurisdictions.
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Appropriate action implemented 

Cornishman

Report number: 8/2025

Fatal accident to a deckhand on board the beam trawler *Cornishman* (PZ 512) 44 nautical miles south-south-west of the Isles of Scilly, England on 6 February 2021

Safety Issues

- ▶ Failure to follow the risk assessment
- ▶ Unsuitable equipment design and material selection
- ▶ Working under suspended loads

No.	Recommendation(s) to:	Maritime and Coastguard Agency to:
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2025/114	Update The Merchant Shipping and Fishing Vessels (Lifting Operations and Lifting Equipment) Regulations 2006 guidance to state the training requirements and accreditation of competent persons carrying out lifting equipment inspections, including: • monthly and yearly company inspections • annual third party inspections • 5-yearly load testing
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Appropriate action implemented 

2025/115	Update its training and guidance to surveyors to improve their ability to check compliance with The Merchant Shipping and Fishing Vessels (Lifting Operations and Lifting Equipment) Regulations 2006 during surveys.
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Appropriate action implemented 

No.	Recommendation(s) to:	W. Stevenson & Sons Limited to:
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2025/116	Ensure the maintenance of lifting equipment, including thorough examinations and inspections by competent and independent personnel, is suitable and sufficient to control the risks of failure and complies with The Merchant Shipping and Fishing Vessels (Lifting Operations and Lifting Equipment) Regulations 2006.
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Appropriate action implemented 

2025/117	Review and update its risk assessments to ensure that all loads are properly secured from falling while work is undertaken on or in proximity to suspended heavy equipment.	Appropriate action implemented 
2025/118	Before purchase, confirm with chain suppliers and/or chain manufacturers that the selected chains are suitable for their intended use.	Appropriate action planned: no date 
2025/119	Ensure that its crews hold complete and up-to-date mandatory training qualifications in compliance with MCA Marine Guidance Note 411 (M+F) Training and Certification Requirements for the Crew of Fishing Vessels and their Applicability to Small Commercial Vessels and Large Yachts.	Appropriate action planned: no date 
2025/120	Implement the Fishing Safety Management Code for its fleet and develop an effective safety management system.	Inappropriate action implemented or planned: closed 

No.	Recommendation(s) to:	Capital Group FASING S.A to:
2025/121	Review and amend as necessary its chain quenching and tempering processes to ensure the resulting hardness levels are consistent throughout the steel and do not make the chain susceptible to embrittlement.	Appropriate action implemented 
2025/122	Offer its customers hardness test certificates for the lifting chains it manufactures to assist them to select the most appropriate chain for the intended purpose.	Appropriate action implemented 

Sustain

Report number: 9/2025

Grounding and subsequent loss of the prawn trawler *Sustain* (UL 45) on Rubha Camas a' Mhaoraich, Loch Broom, Scotland on 16 November 2023

Safety Issues

- ▶ Noncompliance with International Labour Organization hours of rest regulation
- ▶ Failure to implement the risk assessment
- ▶ No passage plan

No.	Recommendation(s) to:	Not applicable
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No recommendations have been made in this report.

Nista

Report number: 10/2025

Fatal man overboard from the lone-operated creel fishing vessel *Nista* (LK121) north of Belnahua, north-west Scotland on 13 December 2023

Safety Issues

- ▶ Lone fishing
- ▶ Proximity to deploying fishing gear
- ▶ Working deck arrangement

No.	Recommendation(s) to:	Not applicable
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No recommendations have been made in this report.

Argos Georgia

Recommendation letter issued by the chief inspector

Foundering of the longline fishing vessel *Argos Georgia* approximately 190 nautical miles east of Port Stanley, Falkland Islands with the loss of 13 lives on 22 July 2024

No.	Recommendation(s) to:	Marin Teknikk to:
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2025/123	Appraise the design of their shell door opening/closing drive mechanism and control system to ensure that the mechanism is not subjected to excessive loads while in operation and modify the design as appropriate.	
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Partially accepted: closed 

2025/124	Notify installers and vessel operators using Marin Teknikk shell doors of any required design changes resulting from recommendation 2025/123.	
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Partially accepted: closed 

No.	Recommendation(s) to:	Argos Froyanes Limited to:
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2025/125	Liaise with the suppliers of the shell doors installed in Argos Froyanes' managed vessels to confirm that the shell door opening/closing drive mechanism and control system is not subjected to excessive loads while in operation and implement any design changes the supplier deems necessary.	
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Appropriate action planned: no date 

2025/126 Inform its fleet's classification society, Det Norske Veritas, of any changes to the shell door opening/closing drive mechanism and control system that have resulted from recommendation 2025/125.

Appropriate action implemented 

Lundy Explorer

Report number: 11/2025

Serious injury to a passenger on the sea safari rigid inflatable boat Lundy Explorer at Ilfracombe, England on 7 June 2023

Safety Issues

- ▶ Inappropriate seating arrangement for passengers
- ▶ Inadequate safety briefing
- ▶ Unpredictable local environmental conditions
- ▶ Regulatory standards do not reference seating in RIBs
- ▶ Ineffective safety management

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

2025/127 Extend the anthropometric assessment recommended in the Seadogz report (recommendation 2023/120) to include vertical impacts resulting from operating high-speed commercial vessels in varied sea conditions and speeds.

Appropriate action implemented 

2025/128 In consideration of MAIB Safety Bulletin SB3/2023, include in the forthcoming The Code of Practice for the Safety of Small Vessels in Commercial Use for Sport or Pleasure (The Sport or Pleasure Vessel Code) a requirement to assess and mitigate the risks of seating people in the front third of a rigid inflatable boat or a high-speed boat.

Appropriate action implemented 

No. Recommendation(s) to: Ilfracombe Sea Safari Limited to:

2025/129 Implement a safety management system as recommended in the Passenger Safety On Small Commercial High Speed Craft & Experience Rides – a Voluntary Code of Practice to include:

- operating procedures detailing pre-departure considerations and what actions to take should the conditions change;
- a pre-departure safety brief;
- risk assessments that accurately reflect potential hazards; and
- use of jockey seats.

Appropriate action planned: no date 

2025/130 In line with Marine Guidance Note 436 (M+F) Amendment 4 – Whole Body Vibration: Guidance on Mitigating Against the Effects of Shocks and Impacts on Small Vessels, install to all company-owned rigid inflatable boats sensors that provide real-time measurement of the forces experienced in the boat's forward section to better enable the person at the helm to protect passengers and crew against the effects of vibrations and shocks.

Rejected: closed 

No. Recommendation(s) to: Royal Yachting Association, British Marine, and the Professional Charter Association to:

2025/131 Promulgate this report to their members.

Appropriate action implemented 

Kingfisher

Report number: 12/2025

Fatal man overboard from the fishing vessel *Kingfisher* (DH 110) approximately 30 nautical miles east-north-east of Wick, Scotland on 12 July 2024

Safety Issues

- ▶ Proximity to fishing gear
- ▶ Damage to a PFD can make it unsuitable for use
- ▶ Poor preparation and lack of updates to risk assessments

No. Recommendation(s) to: Browse Brothers Fisheries Limited to:

2025/132 Review the risk assessment guidance in Marine Guidance Note 588 (F) Amendment 2 to determine and ensure the compatibility of personal flotation devices supplied with the vessel's working areas to mitigate the risk of snagging, or damage to, personal flotation devices so that they remain effective against the risk.

Appropriate action implemented 

2025/133 Review its risk assessment methodology to identify the actual risks on board and implement mitigations to reduce them to as low as reasonably practicable.

Appropriate action implemented 

2025/134 Ensure that its crews have completed all the mandatory training courses.

Appropriate action implemented 

Fire and subsequent loss of power on board the Finland registered roll-on roll-off cargo ship *Finnmaster* at King George Dock, Hull, England on 19 September 2021

Safety Issues

- Inappropriate and unapproved modifications to fuel systems
- Oversight of maintenance
- Maintenance and testing of CO₂ systems
- Testing of emergency sources of power and communication systems
- Ineffective crew training and response

No.	Recommendation(s) to:	Finnish Transport and Communications Agency to:
2025/135	In consultation with the UK's Maritime Administration, draft and submit to the appropriate International Maritime Organization sub-committee a paper proposing the production of a circular providing guidance on the conduct and frequency of routine testing of on board emergency power supplies.	Appropriate action planned: no date 
2025/136	In consultation with the UK's Maritime Administration, draft and submit to the appropriate International Maritime Organization sub-committee a paper proposing functional requirements for systems supporting the operation of the two-way portable radiotelephone apparatus required by SOLAS Chapter II-2 Regulation 10.4.	Appropriate action planned: no date 
2025/137	In consultation with the UK's Maritime Administration, propose an amendment to International Maritime Organization Circular MSC.1/Circ.1318 Revision 1 to include procedural requirements to verify that a fixed fire-extinguishing system is fully operational on completion of the servicing activity required by section 6.2.1 of the circular.	Appropriate action planned: 31 December 2026 
2025/138	Define its requirements for the acceptance of the training of service technicians for CO ₂ fixed fire-extinguishing systems in line with section 6.2 of International Maritime Organization Circular MSC.1/Circ.1318 Revision 1.	Appropriate action planned: no date 
2025/139	Disseminate the contents of International Maritime Organization Circular MSC.1/Circ.1321 to the Finnish maritime industry to raise awareness of guidance on the prevention of fires in machinery spaces.	Appropriate action planned: no date 

No.	Recommendation(s) to:	Finnlines Plc to:
2025/140	Provide guidance to its fleet on the identification and reporting of machinery failure trends in order to recognise and address recurring issues in equipment.	Appropriate action implemented 
2025/141	Update the ship familiarisation and training programmes within its safety management system to encompass all equipment critical to the emergency response procedures and provide a framework for the conduct of realistic drills to ensure crew can react effectively to emergency situations.	Appropriate action implemented 
2025/142	Ensure that the muster lists used on its ships accurately reflect the response procedures in use on board and that all crew members are included.	Appropriate action implemented 

No.	Recommendation(s) to:	RINA S.p.A to:
2025/143	Propose guidance to the International Association of Classification Societies to improve the acceptance, training and guidance for chief engineers authorised to conduct classification-related surveys and inspections.	Appropriate action planned: 31 December 2026 
2025/144	Provide guidance to its surveyors, restating the requirement for the examination of type approval certificates where surveys of safety critical equipment are carried out.	Appropriate action implemented 
2025/145	Disseminate the contents of International Maritime Organization Circular MSC.1/Circ.1321 and related rule requirements to its surveyors to raise awareness of guidance on the prevention of fires in machinery spaces.	Appropriate action implemented 
2025/146	Noting that the response to previous recommendations has been ineffective in improving the performance of service suppliers conducting servicing of CO ₂ systems under the provisions of Unified Requirement Z17 – Procedural requirements for service suppliers. Propose to the International Association of Classification Societies that an urgent review and revision of UR-Z17 is undertaken to deliver the necessary improvements in the services provided by such suppliers.	Appropriate action planned: 31 December 2026 

Isabell Princess of the Sea/ RIB Vega**Report number: 14/2025**

Collision between the tender to *Isabell Princess of the Sea* and the rigid inflatable boat Vega in Göcek, Turkey, resulting in one fatality on 27 July 2024

Safety Issues

- ▶ High-speed unplanned passage at night
- ▶ Alcohol consumption
- ▶ No effective lookout
- ▶ Inadequately defined responsibility and authority

No. Recommendation(s) to: **Not applicable**

No recommendations have been made in this report.

Jean Elaine**Report number: 15/2025**

Grounding and subsequent loss of the dive support vessel *Jean Elaine* in Saint Peter's Pool, Orkney Islands, Scotland on 22 July 2024

Safety Issues

- ▶ Ineffective passage planning
- ▶ Poor communication
- ▶ Hull defects
- ▶ Ineffective document validity checks

No. Recommendation(s) to: **Not applicable**

No recommendations have been made in this report.

Karin**Report number: 16/2025**

Fatal contact between the dive workboat *Karin* and a recreational diver in Scapa Flow, Orkney Islands, Scotland on 28 September 2023

Safety Issues

- ▶ Ineffective watchkeeping
- ▶ Inadequate communication between vessels
- ▶ Ineffective risk mitigation

No.	Recommendation(s) to:	Orkney Islands Council Harbour Authority to:
2025/147	Conduct a further risk-based review of recreational diving operations for dive vessel operators within its areas of responsibility, to include: • The effectiveness of permit arrangements for recreational dive vessels and enforcement of permit conditions. • The control and monitoring of diving support operations by Orkney vessel traffic services, including the number of vessels permitted to operate simultaneously. • Engagement with local stakeholders and consideration of the re-establishment of the local safety committee. • The development of a local code of practice for recreational diving operations that considers the principles outlined in Marine Guidance Note 424 (M) – Safety Responsibilities on board Dive Boats.	Appropriate action implemented 

Odyssey

Report number: 17/2025

Capsize and foundering of the prawn trawler *Odyssey* (FR 70) in the North Sea approximately 133 nautical miles south-east of Peterhead, Scotland on 29 October 2024

Safety Issues

- ▶ Flood risk due to limited drainage
- ▶ Insufficient risk management
- ▶ Obstructed drainage

No.	Recommendation(s) to:	Maritime and Coastguard Agency to:
2025/148	Update Merchant Shipping Notice 1872 (F) Amendment 1 to ensure that existing vessels without the independent pumping capability outlined in 4.3.2.1 (iii) have additional measures in place to adequately address the risk of water accumulation on weathertight shelter decks due to blocked, seized, or shut tonnage valves or other water freeing arrangements.	Appropriate action planned: 31 December 2027 
2025/149	Update its Marine Survey Instructions for the Guidance of Surveyors and relevant aide-memoires to: • Ensure that the additional measures required for vessels without the independent pumping capability outlined in MSN 1872 (F) 4.3.2.1(iii) are adequately assessed during survey and inspection. • Ensure that all vessels without independent pumping capabilities have an adequate shelter deck flooding risk assessment that includes mitigations for wash water build up.	Appropriate action planned: 1 October 2026 

- 2025/150 Provide guidance on the additional measures that can be implemented to adequately address the risk of water accumulation on weathertight shelter decks caused by blocked, seized, or shut tonnage valves or other water freeing arrangements.

Appropriate action planned: 1 October 2026 

ONGOING RECOMMENDATIONS FROM PREVIOUS YEARS

2024 RECOMMENDATIONS – PROGRESS REPORT

Status as of 7 September 2026

Kirkella/Shovette

Report number: 4/2024

Collision between the fishing vessel *Kirkella* (H7) and harbour tug *Shovette* resulting in pollution at King George Dock, Hull, England on 24 June 2022

Safety Issues

- ▶ Loss of propulsion control at transfer from bridge to engine room due to lack of interlocks
- ▶ No procedure for changing propulsion control between stations
- ▶ Approval standards for propulsion control system transfers unclear

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

- 2024/111 Propose to the International Association of Classification Societies that Unified Requirement M43.12 is reviewed to clarify its intent.

Appropriate action implemented 

- 2024/112 Inform its customers that the Rolls-Royce Helicon-X3 system might allow remote control station changeover with mismatched levers and suggest that the manufacturer be contacted for advice.

Appropriate action planned: no date 

No. Recommendation(s) to: Kongsberg Maritime to:

- 2024/113 Issue a service letter to its customers advising that the Rolls-Royce Helicon-X3 system remote control changeover process can allow mismatching of levers resulting in the propelling thrust altering significantly, and advise them of methods of operation and/or rectification should these be requested.

Appropriate action planned: no date 

Ali Ka

Report number 6/2024

Contact of the chemical tanker *Ali Ka* with Oikos Jetty 2 on the River Thames at Canvey Island, England on 25 October 2022**Safety Issues**

- ▶ Likely fatigue affected pilot's decision-making
- ▶ Ineffective master/pilot exchange
- ▶ Failure to learn from previous accidents
- ▶ Ineffective control of risks

No.	Recommendation(s) to:	Port of London Authority to:
2024/118	Review the risks to safe pilotage from pilot fatigue, informed by an independent, specialist review of current working practices and, as necessary, implement a comprehensive fatigue risk management system that encapsulates the requirements and responsibilities outlined in regulatory and maritime industry guidance.	Appropriate action implemented 

Angelena

Report number: 8/2024

Capsize and foundering of the fishing vessel *Angelena* (BM271) south-east of Exmouth, England on 18 June 2021**Safety Issues**

- ▶ Vessel stability was compromised
- ▶ Loss of control while lifting heavy loads
- ▶ Liferaft unable to automatically float free, inflate and break free

No.	Recommendation(s) to:	Maritime and Coastguard Agency to:
2024/125	In its implementation of the new Fishing Training Regulations, require fishing skippers to have completed advanced stability training before any certificate of competency is issued under acquired rights; and to engage with the fishing industry to explore, and then implement, pathways to enhance and improve fishers' practical knowledge of stability, advising fishing vessel skippers to complete small fishing vessel advanced stability training during the intervening period.	Appropriate action planned: 30 June 2027 
2024/126	In collaboration with the fishing industry, develop and then implement a process to ensure that owners and operators of fishing vessels undertake risk assessments to define the safe crewing required for the conduct of fishing operations, and for that definition of safe crewing to be documented in an appropriate manner.	Appropriate action planned: 31 October 2026 

Guiding Light/Guiding Star

Report number: 13/2024

Collision between the pair trawlers *Guiding Light* (H 90) and *Guiding Star* (H 360) resulting in the flooding and sinking of *Guiding Star* 33 nautical miles south-east of Fair Isle, Scotland on 6 October 2022

Safety Issues

- ▶ Poor supervision of fishing operations
- ▶ Fish transfers not risk assessed
- ▶ No flood action plan
- ▶ Inaccessible survival equipment
- ▶ Ineffective communications

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

- 2024/134 On the next review of MGN 165 (F), ensure that the consequences of flooding on fishing vessels are highlighted appropriately and update the guidance to surveyors to ensure that crew preparedness for a flooding emergency is checked and that the crew are aware of the actions to take.

Appropriate action implemented 

No. Recommendation(s) to: Peter & J. Johnstone Limited to:

- 2024/135 Ensure the best practice guidance in MGN 313 (F) is followed, in particular that the wheelhouse is not left unattended and the impact of fishing operations on the navigational watch is evaluated.

Appropriate action implemented 

- 2024/136 Ensure skippers are familiar with their vessel's survivability and understand and practise the actions to take in the event of flooding during regular flooding drills. This should include reviewing the survival equipment's location to ensure it is readily accessible in case of an emergency.

Appropriate action implemented 

Wheelyboat 123

Report number: 14/2024

Capsize of the recreational craft *Wheelyboat 123* with the loss of two lives on Roadford Lake, Devon, England on 8 June 2022**Safety Issues**

- ▶ Inadequate maintenance
- ▶ Inadequate guidance or procedures for the safe conduct of operating the vessel with disabled people on board
- ▶ Inadequate risk assessment
- ▶ The operation and maintenance of the vessel was not monitored

No.	Recommendation(s) to:	South West Lakes Trust to:
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2024/139	Update the planned maintenance system used by its activity centres to include the specific maintenance tasks required by the manufacturers of the watercraft they operate, including boats used by people with disabilities.
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Appropriate action implemented 

2024/142	Ensure instructors at its activity centres are educated in how to evaluate the weight and load distribution for users of craft designed for wheelchair users to ensure compliance with the design loading and manufacturer's instruction.
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Partially accepted 

2024/143	Revise driver assessment requirements for craft designed for wheelchair users to ensure drivers are equipped to recognise developing dangerous situations and take emergency action.
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Partially accepted 

MAIB comment: Recommendation 2024/139 has been implemented with appropriate action for watercraft the trust operates excluding craft designed for wheelchair users. South West Lakes Trust does not currently operate any craft designed for wheelchair users but has undertaken to extend the implementation of 2024/139 and implement 2024/142 and 2024/143 should it be decided to operate craft designed for wheelchair users in the future. All recommendations made to South West Lakes Trust in the Wheelyboat 123 investigation report are now closed.

No.	Recommendation(s) to:	The Wheelyboat Trust to:
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2024/145	Review the wheelyboat owner's manual to ensure that guidance around wheelchair securing and the carriage of heavy, motorised wheelchairs is appropriate.
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Appropriate action planned: no date 

Fatal crush accident to a bosun during cargo operations on board the roll-on/roll-off cargo vessel *Clipper Pennant* at Gladstone Dock, Liverpool, England on 20 July 2021

Safety Issues

- ▶ Routine and widespread divergence from safe working practices
- ▶ No safe system for loading high-risk stowage spaces
- ▶ Ineffective supervision of vehicle deck operations
- ▶ Insufficient organisational learning and improvement

No. Recommendation(s) to: UK Chamber of Shipping and Port Skills and Safety Limited to:

- 2024/148 Develop a jointly agreed and consolidated industry Code of Practice for vehicle deck safety on roll-on/roll-off vessels by consulting with the Maritime and Coastguard Agency, Health and Safety Executive, Interferry, and ro-ro ferry operators, considering existing best practice guidance and the lessons learned from this accident and other previous similar accidents. The guidelines should cover, inter alia:
- The role, responsibilities and positioning of banksman while marshalling on vehicle decks in or near the path of a moving vehicle;
 - The dynamic nature of vehicle deck loading operation that reflects the moving danger zone around a semi-trailer;
 - Identification and risk mitigation of vehicle stowage spaces with limited or obstructed areas for escape;
 - Suitable control measures to reduce the risk to people working in close proximity to moving vehicles, including the development of cargo handling procedures and safe systems of work;
 - Safe access arrangements for crew during and after cargo operations;
 - An agreed industry standard for signalling and communication on vehicle decks; and
 - The use of technology to improve safety on deck.

MAIB comment: Recommendation 2024/148 has been superseded by recommendation 2026/130 published in the *Laureline* investigation report.

- 2024/149 Ensure that the consolidated industry Code of Practice for vehicle deck safety on roll-on/roll-off vessels developed in accordance with recommendation 2024/148 is effectively promulgated to the industry.

Appropriate action planned: no date



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

2024/151 Consider the consolidated industry Code of Practice for vehicle deck safety on roll-on/roll-off vessels developed in accordance with recommendation 2024/148 and ensure that its related guidance documents are reviewed and, as appropriate, updated and aligned to reflect this industry best practice.

Appropriate action planned: 31 March 2027 

No. Recommendation(s) to: The Health and Safety Executive to:

2024/152 Consider the consolidated industry Code of Practice for vehicle deck safety on roll-on/roll-off vessels developed in accordance with recommendation 2024/148 and ensure that its related guidance documents are reviewed and, as appropriate, updated and aligned to reflect this industry best practice.

Appropriate action planned: no date 

No. Recommendation(s) to: CLdN RoRo Limited to:

2024/153 Review the findings of its previous safety climate surveys and, with support from external sources, take further action to develop and implement a plan to encourage a positive organisational culture that supports learning from incidents and accidents and encourages reporting.

Appropriate action implemented 

2024/154 Ensure the effective on board supervision of vehicle deck cargo loading operations on its vessels by considering the roles, responsibilities and allocation of resources and the use of technology to oversee and assure the safety of personnel working on deck at all times.

Appropriate action implemented 

No. Recommendation(s) to: P&O Ferries Limited to:

2024/155 Introduce a program to verify that its ports consistently follow its vehicle deck safety procedures, specifically to ensure that tractor unit drivers understand and implement the company's safe systems of work.

Appropriate action planned: no date 

MAIB comment: P&O Ferries Limited is yet to implement these recommendations. The MAIB is awaiting an update.

- 2024/156 Implement a procedure for the effective engagement and liaison with the operators of vessels that it charters to ensure that:
- the safety management systems are aligned; and
 - there is an agreed safe system of work for chartered vessels with appropriate training in place.

Appropriate action planned: no date 

MAIB comment: P&O Ferries Limited is yet to implement these recommendations. The MAIB is awaiting an update.

Biter/Hebridean Princess

Report number: 17/2024

Capsize and sinking of the tug *Biter*, with the loss of two lives, while assisting the passenger vessel *Hebridean Princess* off Greenock, Scotland on 24 February 2023

Safety Issues

- ▶ Towage plan not understood and agreed by all parties
- ▶ Tug's gob rope was unable to withstand force exerted on it
- ▶ Passenger vessel's speed exceeded port's guidance
- ▶ Open watertight doors prevented tug remaining afloat
- ▶ Inadequate training and experience

No. Recommendation(s) to: Clydeport Operations Limited to:

- 2024/159 Commission an independent review of its tug training for pilots within the port.

Appropriate action implemented 

- 2024/160 Formalise the conduct of pilot/tug information exchanges and ensure that they are routinely carried out within its port.

Appropriate action planned: no date 

- 2024/161 Conduct a risk-based review of the Pilot Grade Limits and the Tug Matrix within its waters.

Appropriate action implemented 

- 2024/162 Consider requiring all tugs and workboats, that routinely operate within its statutory harbour area, to be fitted with and operate AIS transponders.

Appropriate action implemented 

No.	Recommendation(s) to:	The UK Maritime Pilots' Association , in conjunction with the British Ports Association, UK Harbour Masters' Association, British Tugowners Association and The Workboat Association, to:
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2024/163	Develop guidance for inclusion in the Port Marine Safety Code's Guide to Good Practice and other appropriate publications that emphasises the importance of conducting a pilot/tug exchange, in addition to the master/pilot exchange, to ensure that the pilot, bridge team and tug crew have a common understanding of the intended arrival/departure manoeuvre, the potential hazards and their respective roles in managing them.
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Appropriate action implemented 

No.	Recommendation(s) to:	The UK Harbour Masters' Association , in conjunction with the UK Maritime Pilots' Association, British Tugowners Association and The Workboat Association, to:
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2024/164	Develop for inclusion in the Port Marine Safety Code's Guide to Good Practice, best practice guidance on matching the capability of the tug to the intended task to ensure that the most appropriate tugs are assigned.
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Appropriate action planned: no date 

MAIB comment: Following discussion with the UK Harbour Masters' Association and with the agreement of MAIB the British Tugowners Association has agreed to lead on taking this recommendation forward. Accordingly, recommendation 2024/164 has been reassigned to the British Tugowners Association.

2024/165	Develop for inclusion in the Port Marine Safety Code's Guide to Good Practice, guidance that harbourmasters require tugs and workboats that routinely operate within their statutory harbour area to be fitted with and operate Auto Identification System transponders.
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Rejected: closed 

No.	Recommendation(s) to:	The British Tugowners Association and The Workboat Association to:
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2024/166	Develop guidance on the testing of gob ropes and towlines used during harbour towage.
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Appropriate action implemented 

Pioneer

Report number: 19/2024

Fatal man overboard from the potting vessel *Pioneer* (NN200) south of Hastings, England on 29 July 2021**Safety Issues**

- ▶ Not wearing a PFD
- ▶ Poor safety management
- ▶ No effective means to recover an unconscious person
- ▶ Inspection guidance and close-out of deficiencies unclear

No.	Recommendation(s) to:	Maritime and Coastguard Agency to:
2024/169	Revise its instructions for the guidance of surveyors to provide clarity on the conduct and recording of fishing vessel surveys and inspections, and review its guidance on the closing out of deficiencies.	Appropriate action implemented 

Stena Europe

Report number: 20/2024

Engine room fire on board the roll-on/roll-off passenger ferry *Stena Europe* while approaching Fishguard, Wales on 11 February 2023**Safety Issues**

- ▶ Inadequate detection of exposed hot surfaces
- ▶ Long-standing defects in fuel system
- ▶ Lack of defect reporting

Harriet J

Report number: 2/2023

Fatal man overboard from the lone-operated creel fishing vessel *Harriet J* (AH180) west of Fast Castle Head, south-east Scotland on 28 August 2021

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 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: no date

Copious

Report number: 3/2023

Man overboard from the stern trawler *Copious* (LK 985) resulting in one fatality approximately 30 nautical miles south-east of the Shetland Isles, Scotland on 18 February 2021

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

BBC Marmara

Report number: 8/2023

Grounding of the general cargo vessel *BBC Marmara* in the Little Minch, off the west coast of Scotland on 25 July 2021**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:
2023/113	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 implemented 

Seadogz

Report number: 10/2023

Contact between the high-speed passenger craft *Seadogz* and a navigation buoy, resulting in one fatality in Southampton Water, England on 22 August 2020**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

- 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.

- 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

- 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 implemented

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: no date

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: no date

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 <i>Passenger Safety on Small Commercial High Speed Craft & Experience Rides – A Voluntary Code of Practice</i> and, when introduced, The Sport & Pleasure Vessel Code.

Appropriate action implemented 

2022 RECOMMENDATIONS – PROGRESS REPORT

Status as of 7 September 2026

Rib Tickler

Report number: 3/2022

Collision resulting in one fatality in the Menai Strait, Wales on 8 August 2020

Safety Issues

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

No.	Recommendation(s) to: Isle of Anglesey County Council to:
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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.
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Appropriate action planned: no date 

Diamond Emblem 1

Report Number: 5/2022

Fatal person overboard at Great Yarmouth Yacht Station, River Bure, England on 19 August 2020

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: no date

MAIB comment: The MAIB continues to seek an update on the progress of this recommendation from the Association of Inland Navigation Authorities.

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

Nicola Faith

Report number: 8/2022

Foundering in Colwyn Bay, North Wales with the loss of three lives on 27 January 2021

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 to MCA surveyors

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

Paddleboards

Report number: 13/2022

Four fatalities during a commercial river tour at Haverfordwest Town Weir, Wales on 30 October 2021

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 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:
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.	sportscotland Appropriate action implemented ✓ Sport Wales Appropriate action implemented ✓ Sport England Appropriate action implemented ✓ Sport Northern Ireland Appropriate action planned: no date ● MAIB comment: The MAIB continues to seek an update on progress of this recommendation from Sport Northern Ireland.
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.	sportscotland Inappropriate action implemented: no date ● Sport Wales Appropriate action planned: no date ● Sport England Appropriate action planned: no date ● Sport Northern Ireland Appropriate action planned: no date ● MAIB comment: Although actions have been taken by sportscotland in response to this accident they do not address this recommendation. The MAIB continues to seek an update on progress of this recommendation from Sport England, Sport Wales and Sport Northern Ireland.

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

sportscotland | **Inappropriate action implemented: no date** 

Sport Wales | **Appropriate action planned: no date** 

Sport England | **Appropriate action planned: no date** 

Sport Northern Ireland | **Appropriate action planned: no date** 

MAIB comment: Although actions have been taken by sportscotland in response to this accident they do not address this recommendation. The MAIB continues to seek an update on progress of this recommendation from Sport England, Sport Wales and Sport Northern Ireland.

Svitzer Mercurius

Report number: 15/2022

Failure of a towline pennant resulting in injury to the crew in Southampton, England on 22 December 2019

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: 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.

Partially accepted: closed 

2021 RECOMMENDATIONS – PROGRESS REPORT

Status as of 7 September 2026

Stolt Groenland

Report number: 9/2021

Cargo tank explosion and fire at Ulsan, Republic of Korea on 28 September 2019

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: 30 November 2026

2020 RECOMMENDATIONS – PROGRESS REPORT

There are no outstanding recommendations for 2020.

2019 RECOMMENDATIONS – PROGRESS REPORT

Status as of 7 September 2026

Unnamed Rowing Boat

Report number: 2/2019

Failure of a throw bag rescue line during a capsized drill at a rowing club in Widnes, England on 24 March 2018

No.	Recommendation(s) to:	British Standards Institution to:
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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.	
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Appropriate action planned: 31 August 2028

CV30

Report number: 7/2019

Fatal man overboard approximately 1,500nm west of Fremantle, Australia on 18 November 2017

No.	Recommendation(s) to:	British Standards Institute Committee to:
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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.	
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Appropriate action planned: no date

2018 RECOMMENDATIONS – PROGRESS REPORT

There are no outstanding recommendations for 2018.

2017 RECOMMENDATIONS – PROGRESS REPORT

Status as of 7 September 2026

Osprey/Osprey II

Report number: 10/2017

Collision between rigid inflatable boats on Firth of Forth, Scotland resulting in serious injuries to one passenger on 19 July 2016

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 implemented 

2016 RECOMMENDATIONS – PROGRESS REPORT

Status as of 7 September 2026

JMT

Report number: 15/2016

Capsize and foundering of a small fishing vessel 3.8nm off Rame Head, English Channel with loss of two lives on 7 July 2016

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: 30 June 2027 

2015 RECOMMENDATIONS – PROGRESS REPORT

Status as of 7 September 2026

Cheeki Rafiki

Report number: 8/2015

Loss of a yacht and its four crew in the Atlantic Ocean, approximately 720 miles east-south-east of Nova Scotia, Canada on 16 May 2014

No. Recommendation(s) to: British Marine Federation⁹ 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: 30 September 2026 

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

2015/120 Include in the SCV Code a requirement that vessels operating commercially under ISAF¹⁰ OSR should undergo a full inspection to the extent otherwise required for vessels complying with the SCV Code.

Appropriate action implemented 

2014 TO 2010 RECOMMENDATIONS – PROGRESS REPORT

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

2009 RECOMMENDATIONS – PROGRESS REPORT

Status as of 7 September 2026

Celtic Pioneer

Report number: 11/2009

Injury to a passenger during a boat trip in the Bristol Channel, England on 26 August 2008

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 implemented 

⁹ British Marine Federation is now known as British Marine.

¹⁰ International Sailing Federation (ISAF) is now known as World Sailing.

Definitions

Marine casualty

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

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

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).

Vessel categories

Merchant vessels >=100gt

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 <100gt

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.

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).

Abbreviations and acronyms

CO ₂	- carbon dioxide
DfT	- Department for Transport
GRP	- glass-reinforced plastic
gt	- gross tonnage
IBC Code	- International Code for the Construction and Equipment of Ships Carrying Dangerous Chemicals in Bulk
IMO	- International Maritime Organization
ISO	- International Organization for Standardization
LSMC	- less serious marine casualty
MAIB	- Marine Accident Investigation Branch
MCA	- Maritime and Coastguard Agency
MGN	- Marine Guidance Note
MOU	- memorandum of understanding
MSN	- Merchant Shipping Notice
nm	- nautical mile
OSR	- Offshore Special Regulations
PFD	- personal flotation device
RIB	- rigid inflatable boat
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)
VSMC	- very serious marine casualty
VTM	- vessel traffic monitoring

Address

Marine Accident Investigation Branch
First Floor, Spring Place
105 Commercial Road
Southampton
SO15 1GH
United Kingdom

Email

publications@maib.gov.uk

General enquiries

+44 (0)23 8039 5500

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

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