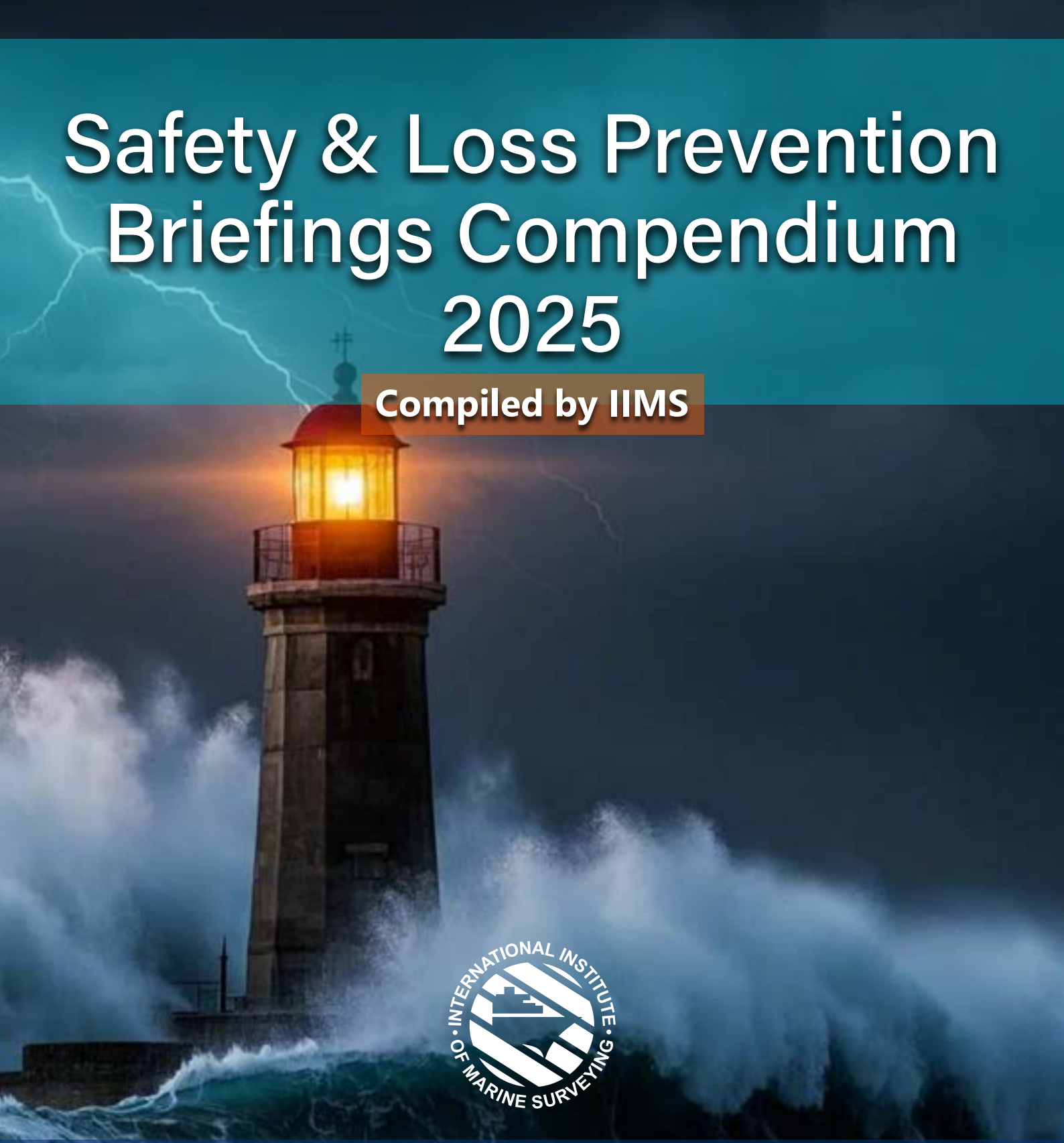
Safety & Loss Prevention Briefings Compendium 2025

Compiled by IIMS



A collection of worldwide marine incident and accident reports, loss prevention briefings and case studies published in 2025

EDITION V

Brookes Bell

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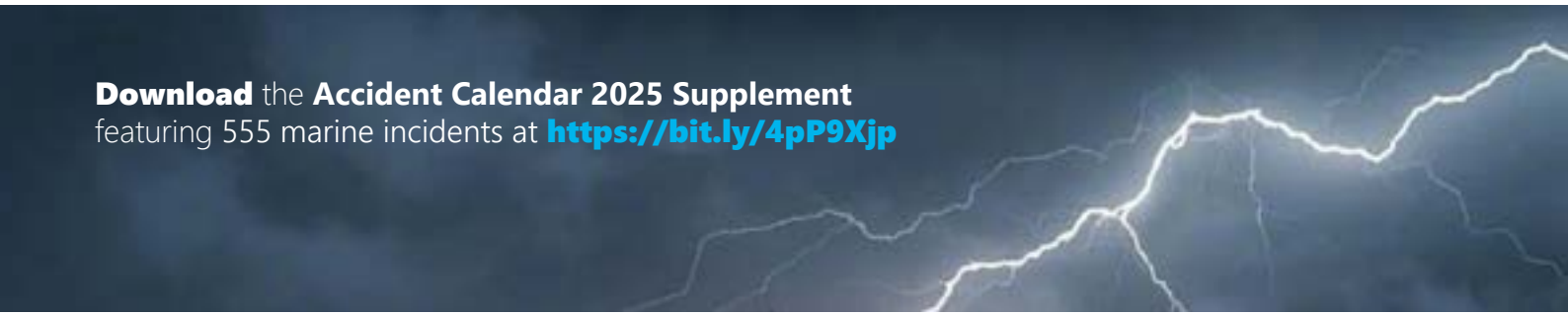
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Editor: *Mike Schwarz* **Sub-editor:** *Frances Birkett* **Design:** *Craig Williams*

www.iims.org.uk | Email: info@iims.org.uk | Tel: +44 (0) 23 9238 5223 | IIMS, Murrills House, 48 East Street, Portchester, Hampshire, PO16 9XS, UK

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Welcome by Mike Schwarz,
Chief Executive Officer,
International Institute of Marine Surveying

Dear colleague

Welcome to edition V of the IIMS Safety & Loss Prevention Briefings Compendium.

We live in uncertain times – a world full of political dysfunctionality, populations at war with each other impacting the marine sector in their own different ways; and a maritime world constantly striving to keep up and make effective new regulations to match and combat the number of incidents and accidents, which continue to blight our industry.

I have read reports from reputable sources that assure me the actual number of vessels lost is lower than in previous years. That may be so, yet the past year has seen a shocking number of deaths at sea and the loss of countless valuable cargoes and assets. As always, when an investigation report finally emerges, (sometimes years after the event), human error will, in many cases, most likely be proven to have been the overwhelming cause. We can ask why this continues to be the case. Not enough training? Bad training? Complacency? Fatigue? Poor risk assessing? In truth, there are no easy answers.

> "...the past year has seen a shocking number of deaths at sea and the loss of countless valuable cargoes and assets."

This state of affairs is reflected in the dark and sometimes harrowing content and nature of this Compendium that my colleagues and I have curated, and which you are about to browse and read. I had hoped this year's edition would be smaller to reflect fewer incidents and accidents, but sadly that is not the case, as already explained.

The reason this publication exists is to educate and inform, and to highlight the ongoing challenges we as an industry face. It also serves as a fitting memorial, dedicated to the human sacrifice that has been made by so many in the pursuit of their career, as an innocent victim caught in the wrong place at the wrong time, or as a result of just wanting to have fun on the water. May those who have lost their lives in 2025 rest in peace.

We routinely read excellent incident and accident reports that are published for our benefit. But do we really take onboard the resulting recommendations and if so, are they effectively implemented? I question that and suspect not always. As we all know, it usually takes a catastrophic disaster for regulatory change to occur. One of the most prominent examples was surely the sinking of the Titanic back in 1912. And look what followed – the development and eventual implementation of SOLAS.



And so it is today, although the challenges are markedly different to the ones faced more than a century ago. Let's consider the evidence. An unacceptable high rate of deaths in enclosed spaces remains a grave concern. Mis-declared cargoes in containers are a serious and ongoing problem. And managing emerging technology, such as lithium-ion batteries, which is causing fires on ships and yachts seemingly with regularity, presents a huge challenge that industry continues to grapple with, and no immediate failsafe solution is at hand. Regulators are behind the curve in many instances as the industry changes around us with alacrity, and it seemingly takes an inordinate amount of time for changes to occur. I encourage them to react faster but also accept that they have no crystal ball to look into the future.

My thanks to Ruchin Dayal, FIIMS and the current IIMS President, for his introduction and words of wisdom. Also, thanks to Karley Smith at Brookes Bell who has contributed so eloquently to this edition. And finally, I am grateful to other organisations including the MAIB, CHIRP and IMCA for allowing me to republish and share their reports and safety advice.

Mike Schwarz, *IIMS Chief Executive Officer*



Introduction by Karley Smith,
Managing Master Mariner, Brookes Bell

In my role as a surveyor and Master Mariner at Brookes Bell, it is a privilege to introduce the International Institute of Marine Surveying Safety & Loss Prevention Briefings Compendium. The IIMS maintains the highest standards in marine surveying and embodies professionalism in all aspects of their work, internationally.

As a full spectrum, multi-disciplinary technical and scientific consultancy, Brookes Bell's team of Master Mariners, Marine Engineers, Cargo Scientists, Naval Architects, Fuel Specialists, Metallurgists and Fire Investigators remain actively engaged in assessing and investigating a broad range of maritime incidents.

As the maritime industry makes moves towards a more sustainable, greener future, throughout the last year, we have seen a rise in incidents and enquiries related to 'modern' cargoes, such as lithium-ion batteries, biomass and future fuels.

Over the past year, significant large ship fires have persisted, with several culminating in a total loss. There has been an ongoing connection between lithium-ion batteries and fire incidents, whether this has involved scrap cargo fires, containerised cargo fires or a fire involving electric vehicles.

Our Scientists and Fire Investigators have experienced a rise in coal cargoes emitting high levels of methane, which at times have led to explosions, as well as incidents involving wood pulp and plywood. The subject of 'future fuels' has been a hot topic of interest for our fuel team.

With modern cargo characteristics introducing new challenges to the maritime industry, the potential dangers that seafarers and surveyors can be exposed to is increasing. The sector must continually adapt and evolve its risk assessment and incident response strategies.



Cargo stowage and securing incidents continue to be prevalent for our mariners, particularly relating to the carriage of steel coils, and our engineers have seen a consistent number of stern tube failures. Additionally, our tanker team continue to attend contamination cases and shortage claims.

The IIMS Safety & Loss Prevention Briefings Compendium focuses on key issues within the maritime industry, offering a comprehensive and current overview of best practices, drawn from actual incidents and informed by the latest regulatory developments. The publication provides marine surveyors and loss prevention professionals with informative insights that can be applied in future surveys and operations.

Brookes Bell's surveyors actively engage with the maritime community through articles we publish and by taking part in webinars, presentations and panel discussions. We issue a monthly newsletter, '***maritimepro***', and publish multiple industry-related articles each week across our social media channels. We are committed to supporting other industry professionals by sharing the lessons we learn through our experiences and attendances.

It was a privilege to support the IIMS earlier in the year, attending the IIMS London Conference to present on the risks related to the carriage of lithium-ion batteries, and to follow up with a feature in the Report magazine.



With the nature of modern cargoes constantly evolving and the volume of cargoes shipped increasing, it is important to share and combine our knowledge so that future incidents become more preventable.

We look forward to continuing supporting and working with the IIMS, as we work towards a safer future together.

Karley Smith, *Managing Master Mariner, Brookes Bell*
BSc (Hons), MNI, WISTA, HCMM



Introduction by Capt Ruchin Dayal FIIMS, IIMS President

Dear Colleagues

It is my privilege, as President of the International Institute of Marine Surveying (IIMS), to introduce the 2025 edition of the ***Safety and Loss Prevention Briefings Compendium***. Each year, this publication stands as one of the most important contributions from our Institute - a consolidation of lessons, analyses, and reflections that help steer our industry toward safer practices. My sincere thanks to Brookes Bell for their thoughtful introduction, and to Mike Schwarz and the IIMS headquarters team for their tireless work in curating this edition.

The past year has once again reminded us that, despite the advances in technology and regulation, shipping remains a sector where risk is ever-present and must be respected. Fires linked to lithium-ion batteries and mis-declared cargoes, structural failures, navigational mishaps, and the continuing tragedy of enclosed space fatalities have all featured prominently in maritime incident reports. These events reinforce an uncomfortable but necessary truth: written procedures alone do not prevent accidents - the culture that surrounds their implementation does.

At the same time, alongside these well-recognised risks, I feel it is important to draw attention once again to an issue that continues to surface in our region - the handling, sampling, and certification of iron ore fines (IOF). Liquefaction may not dominate headlines as dramatically as collisions or fires, but its dangers remain very real, and in some cases, dangerously underestimated.

We often associate liquefaction with catastrophic outcomes such as sudden capsizing, yet the reality is far subtler. A voyage that ends upright does not automatically mean the cargo behaved safely. There are numerous undocumented instances of IOF cargoes beginning to liquefy in mini-bulk carriers, coastal barges, and river-sea vessels along the Indian coastline. These incidents seldom make it into official reporting - not because they do not occur, but because they are less visible and often commercially inconvenient to acknowledge.

Sampling conducted at the last minute, moisture testing carried out by inadequately trained personnel, selective reporting of results, and commercial pressure to "pass" cargoes all undermine the scientific rigor essential for safe carriage. When the integrity of testing is compromised, the safety of seafarers is no longer grounded in procedure or competence, but in chance - and chance has no place in maritime safety.

As IIMS members, we are uniquely placed to lead change in this regard. Our Institute has the credibility, reach, and responsibility to advocate for consistent standards, promote education, and reinforce the importance of scientific accuracy in every stage of the cargo assessment process.

Moving to brighter developments, there is much to be optimistic about as we continue strengthening our professional foundations. This year also marked encouraging progress for the Institute. The launch of the IIMS Learning Portal - our on-demand digital training platform - is a major step forward in making high-quality professional development accessible globally. Additionally, our continued collaborations with the MAIB, CHIRP Maritime, classification societies, and P&I Clubs allow us to bring real-world lessons into the hands of surveyors everywhere, strengthening the safety chain that protects crews, vessels, and the marine environment.

As you explore this Compendium, I encourage you to reflect not only on the incidents formally recorded, but also on the many incidents avoided because someone acted with diligence - and the many more that remain unreported, waiting to teach us something if only we pay attention.



Let us remain steadfast in our commitment to integrity, vigilance, and professional excellence. Together, through shared knowledge and unwavering dedication, we can continue to advance the cause of maritime safety.

Capt Ruchin C Dayal, *IIMS President - Master Mariner (MMI), FIIMS (UK), AMS – SAMS (USA), MAIMS (Australia), AFNI (London)*

THE REPORT

The Magazine of the International Institute of Marine Surveying

MAR 2025 | ISSUE 111

The following Safety Briefings are taken from Issue 111 of The Report magazine



MARCH 2025

EXTRACTS FROM
ACCIDENT REPORTS

The investigation found that, during departure preparations, the crew had forgotten to switch two of the ship's three generators to automatic mode.

Although the ship held valid statutory and classification society certificates, the generators and several other safety-critical systems were found to be in a deteriorated condition.

The vessel was not certified for operation at the time of the accident.

IACS releases new guidelines on safety standards for surveyors

The International Association of Classification Societies (IACS) has introduced new recommendations to enhance safety standards for surveyors.

The new guidelines, Rec. 184, recognise that surveyors continue to face significant occupational health and safety (OHS) risks at work.

There is growing recognition that some of the safety challenges that surveyors' face would benefit from improved collaboration and sharing of experience to establish a more consistent approach.

Designed to creating safer working conditions for surveyors and all personnel engaged in maritime operations, these guidelines outline critical measures to mitigate risks and addresses key areas such as risk assessments and situational awareness, ensuring that they are equipped to handle the hazards they may encounter.

By introducing these guidelines, IACS aims to enhance OHS standards, prioritising the safety and well-being of surveyors and all associated personnel. This initiative supports the development of consistent OHS practices across classification societies and contributes to a safer and more sustainable maritime industry.

Key highlights of the guidelines include:

- Comprehensive Risk Management: The document provides guidance for surveyors to exercise appropriate risk assessment and situational awareness prior to commencing work for prevention of accidents, near-misses, injury or ill health to surveyors, associated personnel and damage to property.
- Increased Focus on Collaboration: IACS encourages surveyors to share experiences and safety challenges to improve the overall safety culture across the maritime industry.
- Fitness for Work: The guidelines emphasize the importance of physical and mental readiness, including undertaking all periodical medical checkups required by their society.
- Fatigue Management: The guidelines stress the importance of ensuring adequate rest to prevent fatigue, which can impair performance and increase the risk of accidents.
- Empowering Surveyors to Use Stop Work Authority: Surveyors are empowered to stop work if they believe safety conditions are at risk, ensuring that corrective measures are taken before continuing with tasks.
- Use of Personal Protective Equipment (PPE): The guidelines mandate the use of appropriate PPE and provide instructions on the maintenance and replacement of worn or damaged gear.
- Standardised Safety Practices: The guidelines reinforce the importance of uniform safety practices, ensuring that surveyors adhere to a consistent set of safety protocols regardless of the work environment.

The guidelines further address activities that pose elevated OHS risks for surveyors, providing tailored recommendations to enhance safety. These include working at height, transfers between boats, and performing surveys in confined spaces or using rafts. The document also covers managing pressure tests, control of stored/electrical energy, and participation in sea trials. Additionally, it highlights precautions for exposure to extreme weather conditions, hazardous materials, and travel-related safety concerns, ensuring surveyors are equipped to navigate the varied risks associated with their roles.

Download the guidelines at **https://bit.ly/42DYYkp**.

AMSA's guidance on upcoming changes to SMS requirements

The Australian Maritime Safety Authority (AMSA) has released information on new safety management system (SMS) requirements for domestic commercial vessels, which comes into effect from 1 June this year.

Key changes

- Simplified SMS: Owners of some vessels under 7.5 metres will be eligible for a simplified SMS. Use our online simplified SMS tool to find out if the simplified SMS applies to you.
- Fatigue management: Vessel owners will need to identify and address the risk of master and crew fatigue in the vessel's risk assessment. This does not apply to Class 4 vessels.
- Drug and alcohol policy: Vessel owners will need to have a drug and alcohol policy in the vessel's SMS to manage the risks associated with drug and alcohol use.
- Cargo and dangerous goods: Vessels undertaking cargo operations, including the carriage of dangerous goods, will need to include a procedure in their SMS outlining how they manage the specific risks.
- Key operational procedures to be covered in every SMS: Class 1, 2 and 3 vessel owners will need to have procedures covering the key vessel operations in their SMS, if relevant.
- Vessel emergency plans: Loss of propulsion and oil or fuel spills will need to be covered in the vessel's emergency plan, if relevant.
- Master and designated person responsibility statement: The master's responsibility and authority statement has been clarified to better outline their authority and there is now a requirement to set out a designated person's responsibility statement. Different rules may apply to vessels eligible to operate under a simplified SMS in certain circumstances.
- Assembly station requirements: Alternative assembly stations will only be required if reasonably practicable based on the vessel's layout, characteristics and risk assessment. Different rules may apply to vessels eligible to operate under a simplified SMS.
- Record of vessel modifications: Vessel owners will need to identify risks to vessel stability in the vessel's risk assessment and maintain a record of vessel modifications impacting stability. This does not apply to Class 4 vessels and different rules may apply to vessels eligible to operate under a simplified SMS.

Find out more: **https://bit.ly/3ZMUzbz**.



Figure 1 – The 41-foot commercial fishing vessel

USCG safety alert: Lifesaving equipment stowage on CFVs

The United States Coast Guard has published issued Safety Alert 01-25 to address hazardous stowage of lifesaving equipment on commercial fishing vessels (CFVs) following two recent marine casualties. Both incidents demonstrated the critical importance of proper storage and accessibility of lifesaving equipment to ensure the safety of crew members during emergencies.

In the first incident, a 41-foot CFV capsized and sank within two minutes after taking on water. The personal flotation devices (PFDs) were not stored in a location that could be easily accessed by the crew. As a result, the crew was unable to retrieve the PFDs before abandoning the vessel. Additionally, the vessel's liferaft and its hydrostatic release unit were improperly attached to an aftermarket fiberglass canopy. This canopy broke away and floated free during the capsizing, preventing the automatic deployment of the liferaft. Fortunately, one crew member managed to swim to the floating canopy and manually deploy the liferaft, averting a worse outcome.

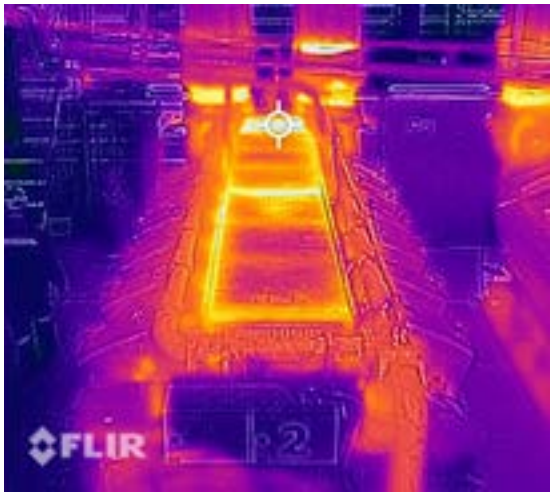
In the second incident, a 60-foot CFV caught fire, forcing the crew to evacuate rapidly. Although the crew retrieved PFDs before abandoning the vessel, these were not stored in a readily accessible location. Instead, the PFDs were stowed in the galley beneath bench seating, far from the crew's normal workstations such as the bridge or aft deck. Additionally, the vessel's throwable liferaft was stored under an internal pilothouse ladder located directly above the engine room, where the fire originated. The intensity of the fire made it impossible for the crew to retrieve the liferaft before abandoning the vessel.

To prevent similar hazardous situations, the Coast Guard strongly recommends that CFV operators take the following actions:

- Ensure that automatically deployable liferafts are securely attached to strong, permanent, and original structures on the vessel, with no overhead or nearby obstructions that could interfere with their float-free deployment.

- Stow manually deployable liferafts in compliance with U.S. Coast Guard requirements under 46 CFR 28.125, which mandate that they be stored in locations that are readily accessible for deployment during emergencies.

- Store PFDs in locations that are easy for all crew members to access, ideally in a manner that would allow them to float free in the event of a capsizing.



Report into fire on board ro-ro ferry

At 2115 on 11 February 2023, a fire broke out in the engine room of the roll-on/roll-off passenger ferry Stena Europe while on passage from Rosslare, Ireland, to Fishguard, Wales.

The fire on board ro-ro ferry caused significant damage to the engine room but nobody was injured and there was no damage to the environment. The fire was extinguished by the crew.

Safety issues

- The fire ignited on a main engine when pressurised fuel from a loose fuel pipe connection sprayed onto a high temperature exhaust pipe. Neither of the designed protections against fuel fires (spray shielding on fuel pipes and insulation of hot surfaces) were effective.
- The original fuel pipe connections had previously been identified as a system weakness, but the manufacturer's recommended modifications had not been fitted to the engine.
- The ship's crew were insufficiently trained to inspect engine fuel systems.
- The temperature measuring equipment used by the crew to monitor the engine exhaust insulation did not effectively identify any hot spots.

Recommendations
A recommendation (2024/170) has been made to the Maritime and Coastguard Agency to submit a paper to the IMO proposing the introduction of a requirement for the use of thermographic equipment to identify exposed high temperature surfaces. Recommendations (2024/171 to 2024/174) have also been made to Stena Line Ltd to: review the existing defect reporting system; provide training to improve equipment inspections; promulgate details of this accident to the ships in its fleet; and introduce the use of thermal imaging cameras for the identification of exposed high temperature surfaces.

Read the report at **https://bit.ly/3ChDBdS**.

New solution aims to address harmful mould infestations on vessels

The potential dangers of mould found on ships and boats is not fully understood by some marine surveyors It can be extremely harmful and is a serios health hazard. VIKAND has developed a solution to address the growing concern of mould infestations on vessels.

Mould, particularly the black variety, poses a serious health risk in the damp, humid environments. It can lead to respiratory problems, allergic reactions, and long-term health complications. Mould often grows in hidden spaces such as air ducts, plumbing systems, and behind walls, making it difficult to detect until it becomes a larger issue.

If left unaddressed, mould infestations can undermine both the health of passengers and crew and the operational safety of the vessel. Timely intervention is key to mitigating these risks.

The air purification technology works by generating hydroxyls, natural molecules that neutralize mould spores, bacteria, viruses, and other airborne contaminants. The system provides continuous purification of both air and surfaces, offering a long-term solution to mould growth.

In practice, it has been shown to eliminate up to 99.9999% of viruses, bacteria, and mould, with significant reductions in mould levels within minutes, VIKAND claims.

"It is crucial to address mould growth promptly to prevent health issues. This includes maintaining low indoor humidity levels, fixing leaks, and ensuring proper ventilation. Overall, while mould is a common environmental issue, its potential health impacts should not be underestimated," stated Mattias Hallberg, Director, Technical Solutions.

Website: **https://vikand.com**

Cashew nutshell marine biofuel warning sent out

Several ships in Singapore and Rotterdam have reported issues after using cashew nutshell marine biofuel. Reported operational problems included fuel sludging, injector failure, filter clogging, system deposits and corrosion of turbocharger nozzle rings. CTI-Maritec carried out extended gas chromatography mass spectrometry testing for very low sulphur fuel oil samples from the vessels. The results showed the fuel was blended with Cashew Nutshell Liquid (CNSL) from undeclared source materials or production processes.

CNSL, a non-FAME biofuel, is a naturally occurring by-product of the cashew nut industry and acts as a low-cost alternative renewable fuel. It has high acid values and is therefore highly corrosive as well. High potassium found in CNSL blend fuels cause serious post-combustion deposits and corrosion of turbocharger nozzle rings.

The latest version of ISO:8217 specifies the accepted biofuels such as FAME-based biofuels, hydrotreated vegetable oil, defined by the specifications of EN 14214, ASTM D6751 and EN 15940 respectively. These fuels are now established and acknowledged by equipment manufacturers, classification societies and flag administrations as 'drop-in' fuels. There is no specification available for CNSL from any authorised body like above.

Proper stowage of mixed cargoes on bulk carriers

The American P&I Club has raised concerns that have arisen regarding the loading of finished and unfinished steel products alongside break-bulk, containerized, and project cargoes in the same cargo hold of bulk carriers.

Examples of break-bulk, containerized, and project cargoes include large, heavy, oversized items, machinery parts, crates, and heavy-duty wheeled items such as trucks, cranes, or pay loaders. Unlike vessels dedicated to carrying break-bulk, containerized, or project cargoes, bulk carriers are not fitted with suitable lashing and securing arrangements.

The irregular sizes, shapes, and weights of such non-pure-bulk cargoes are challenging to safely lash and secure, and typically require makeshift arrangements. Furthermore, such arrangements are challenging for the crew to supervise for safety when a vessel is at sea.

Wheeled cargoes pose a particular risk due to their higher propensity to shift. The stowage and securing of wheeled cargoes are addressed specifically in Annex 4 of the Cargo Stowage and Securing (CSS) Code.

Similarly, break-bulk or project cargoes are often stowed atop steel cargoes. While specified finished and semi-finished steel cargoes are subject to a pre-load survey, as stipulated in the August 19, 2024, Club Circular No. 16/24, Steel Cargo Pre-Load Surveys, operators should also consider employing experienced surveyors familiar with the stowage and securing of break-bulk, containerized, and project cargoes intermixed with or over stowed on top of other cargoes, given the related risk of damage caused by excessive weight or improper securing of such non-pure-bulk cargoes.

The cost of utilizing an experienced surveyor outweighs the potential losses to the cargo, vessel, or injuries to the crew that may arise from a lack of expert assistance during loading.

The essential steps that should be in hand and approved prior to loading cargo are as follows:

- The vessel's stowage plan should be made available well in advance of loading.
- Upon receipt of the stowage plan, the Master should input the relevant data into the loadicator to ensure the vessel's shear force bending moment (SFBM) and stability are within the applicable limits.
- It should be clear how the cargo is to be secured as per the Cargo Securing Manual (CSM), and that relevant stowage and lashing materials and equipment are available aboard the vessel in compliance with the CSS Code.

Shipowners have the responsibility to ensure that the vessel is suitable and fit for purpose to carry break-bulk cargo, containers, and project cargoes with due regard to statutory regulations and classification society standards. The flag State-approved CSM should be on board the vessel as it provides the approved lashing and securing arrangements, in addition to detailing the lashing devices available on board. However, the lashing material for break-bulk cargo, containers, and project cargoes is usually provided by the charterers.

If specified cargoes are not allowed to be loaded as per the vessel's CSM, the owners should notify the charterers and consult their classification society and/or flag State for further guidance. The Master ultimately has the responsibility to ensure that the cargo is safely handled, stowed, and secured as per applicable regulations.



Always review hazardous zone requirements

The US Coast Guard (USCG) has emphasised the critical need for hazard awareness and proper marking of hazardous zones following a recent marine incident involving a tri-fuelled vessel that resulted in severe injuries to crewmembers.

Despite being aware of nearby crankcase and LNG purge vents in their work area, the crew did not know that the vessel was actively using methane as a fuel source. As a result, the work was being conducted in a hazardous zone. Although marked as a hazardous zone on the vessel's plans, the zones were not physically or otherwise marked as hazardous on the deck, providing no visual indication to the crew of the potential hazards present.

While the crew performed assigned work on top of the pilothouse, a failed engine purge valve actuator released LNG vapours through the vents located in the crew's work area. Believing the area was gas-free, a crewmember struck a lighter, igniting the LNG fumes and causing severe injury to both crewmembers in the area. This incident shows the critical importance of hazard awareness, proper marking of hazardous zones, and strict adherence to safety protocols.

The Coast Guard strongly recommends that vessel owners, operators, and other stakeholders:

- Review hazardous zone requirements and ensure crewmembers are fully aware of the circumstances and dangers that define hazardous areas.
- Ensure all hazardous zones are clearly marked and crewmembers are aware of the locations and associated hazards.
- Marine inspectors, investigators, and surveyors should remain vigilant about these issues and take corrective actions as needed.

EXTRACTS FROM
ACCIDENT REPORTS

The master was acutely fatigued, which likely reduced his ability to recognize and respond to the unfolding emergency.

Over time, the practices of the crew drifted, their perception of the risks diminished, and unsafe practices became normalized.

The flexible hose was installed in the fuel system during an unapproved modification and did not meet the required standard.

NTSB report on dinner cruise vessel Spirit of Boston fire

An improperly extinguished chafing fuel heating canister, canned heat used to keep food and beverages warm, led to a fire on the passenger vessel Spirit of Boston last year while moored at the Commonwealth Pier in Boston Harbor.

On March 24, 2023, a fire broke out on the Spirit of Boston's first deck wait station after the scheduled cruise had ended, the vessel had docked and all passengers had departed. NTSB investigators determined the fire started under a plastic glassware rolling cart after an improperly extinguished chafing fuel heating canister was unintentionally dropped by hospitality staff in the area. None of the service workers who were onboard at the time of the fire were injured. The fire resulted in $3.1 million in damages to the vessel.

All of the marine crewmembers had departed the vessel before the fire began. Without a properly trained marine crewmember onboard with the remaining hospitality staff, the emergency response plan for a fire could not be executed as intended. The NTSB found that the fire could have likely been extinguished before it grew had a marine crewmember been on board at the time. The NTSB recommended City Cruises US, operator of the Spirit of Boston, require at least one marine crewmember to remain on board its vessels until all noncrew personnel depart the vessel.

Investigators also found City Cruises US lacked documented procedures on how to handle open-flame devices on its vessels. Hospitality staff were verbally instructed on how to handle the heating canisters. NTSB investigators found in some cases the hospitality staff did not consistently extinguish canisters in accordance with the verbal instructions or manufacturer's guidance. The NTSB recommended City Cruises US develop procedures for crewmembers and hospitality staff on the proper handling of open-flame devices on board its vessels.

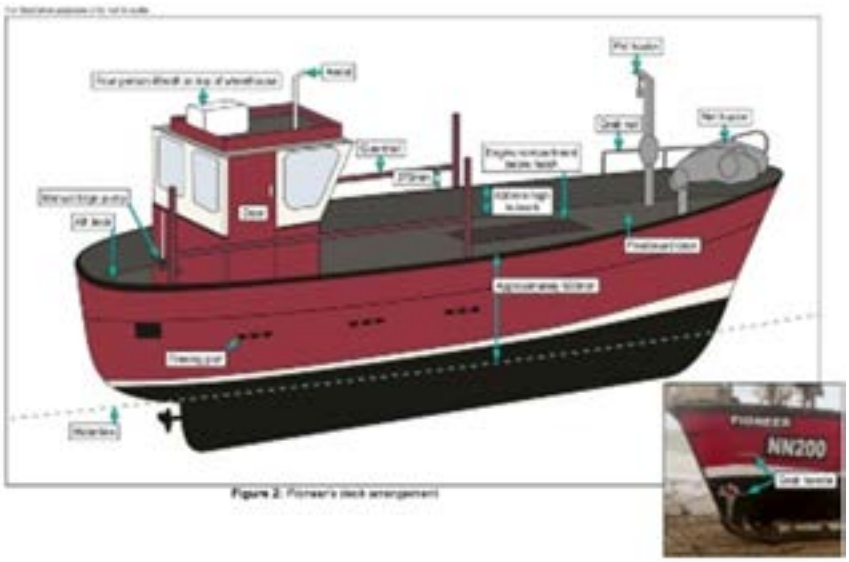
The NTSB also recommended City Cruises US implement a safety management system, or SMS, for its fleet. An SMS is a comprehensive, documented system to enhance safety for a company and its vessels and when implemented is an effective tool for safety oversight. Procedures for handling open-flame devices and requirements for crewmembers to be on board would typically be included in an SMS.

The NTSB also reiterated a safety recommendation to the U.S. Coast Guard to require all operators of U.S.-flag passenger vessels to implement SMS. The NTSB has advocated for SMS for passenger vessels since 2005, and in 2010, Congress explicitly granted the Coast Guard the authority to require such systems. Progress has been stalled since January 2021 when the Coast Guard took initial steps to address the NTSB's recommendation.

Read the report at **https://bit.ly/4a8JSoD**.



MAIB report: Man overboard from potting vessel Pioneer with loss of 1 life



On the morning of 29 July 2021, the skipper of the UK registered potting vessel Pioneer (NN200) accidently entered the water as the vessel was heading back to its beach standing in Hastings, England. Pioneer's sole deckhand was unable to pull him back on board and the skipper was later recovered from the water with the help of a rescue helicopter's winchman and airlifted to hospital, but he could not be revived.

The MAIB investigation found that Pioneer had a low bulwark at its aft deck, which did not prevent the skipper's fall into the water. At the time of the accident neither the skipper nor deckhand were wearing a personal flotation device, although two were available on board.

Critical safety equipment was either missing, incorrectly fitted or out of date. There were no risk assessments held on board, emergency drills had not been practised and the skipper had not undertaken mandatory risk awareness training. Collectively, these deficiencies indicated that Pioneer was being operated with a low standard of safety management at the time of the accident.

Conclusions

Safety issues directly contributing to the accident that have been addressed or resulted in recommendations

1. The low bulwark around the aft deck offered little protection from falling overboard, and the skipper was not wearing a tethered safety harness to mitigate the risk of falling overboard.
2. The lack of an effective means of recovering an unconscious person and the absence of MOB drills impeded the deckhand's ability to recover the skipper from the water.

Other safety issues directly contributing to the accident

1. The skipper's fall into the water was not observed but could have been the result of the vessel's movement, a slip or trip, or a non-fatal heart attack.
2. The skipper died because of immersion in the water leading to a heart attack and dry drowning.
3. The skipper was not wearing a PFD and it would have taken considerable effort to remain afloat in the developing swell.
4. The skipper had a pre-existing heart condition, which combined with the effect of cold-water shock may have affected his ability to respond to this accident.
5. The skipper had not completed the Safety Awareness and Risk Assessment course and so may not have had a full appreciation of the risks associated with his vessel's operation.



U.S.C.G. releases Lithium Battery Guide for shippers

The United States Coast Guard has published a helpful compliance resource, Lithium Battery Guide for shippers. The publication aims to assist shippers to safely package lithium cells and batteries for transport by all modes, including vessel shipments, with new regulatory requirements based on cell or battery configuration as well as Watt-hour (Wh) rating.

As described in the guide, the transport of lithium cells and batteries via vessel can be subject to both the domestic regulations and the International Code for the International Maritime Dangerous Goods (IMDG) that may require additional actions. Both publications should be consulted based on shipment route.

Download the PDF at **https://bit.ly/423e7el**.

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The retaining clamps on the fuel injection lines were not in place, increasing the fuel lines' exposure to the effects of engine vibration.

Unknown to the crew, an isolation valve in the fire main piping was corroded, and it obstructed the flow of water to the fire.

The heater was left unpowered, leaving the measuring head vulnerable to false alarms caused by water vapour.

Proactive measures to mitigate fire hazards including thermal imaging

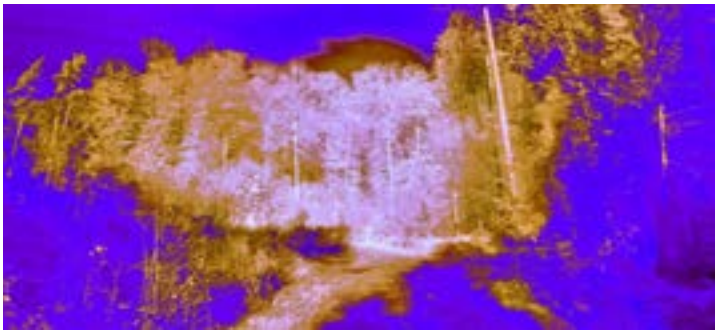


The American P&I Club urges operators to implement proactive measures such as maintenance and thermal imaging to mitigate fire hazards. Thermal imaging inspections are highlighted as an effective tool by the American Club in identifying early heat signatures caused by electrical faults, which could escalate into a fire if left unchecked. Fires of this nature often stem from one or a combination of three primary causes: electrical system failures, machinery malfunctions, and human error.

Although the likelihood of a fire may be low, specific conditions, such as defective thermal insulation on hot surfaces combined with localized fuel or oil leaks, can create a serious fire risk. Additionally, the complexity and number of electrical connections onboard vessels amplify the challenge of monitoring these systems during routine inspections, further underscoring the importance of rigorous preventive measures.

Thus, proactive maintenance and regular inspections of relevant components on board their vessels is an integral part of each vessel's planned maintenance system. Specifically, this should include:

- Implementation of a detailed shipboard maintenance plan based on the manufacturer's recommendations, operation, and maintenance specifications.
- Availability of specialized instruments, testing equipment, guidance, and the upkeep of adequate spare parts.
- Crew training to ensure the proper use of equipment and implementation of the shipboard maintenance plan.
- Ship management's commitment to supporting and following up on the maintenance plan and arranging timely shore-based service.
- Regular inspections of critical components, logging results using traditional testing tools and visual inspections, or preferably by using thermal imaging instruments.





Marshall Islands publishes Blue Cecil report after enclosed space entry deaths

The Republic of the Marshall Islands Maritime Administrator has released its report into the deaths of three crewmembers on bulk carrier Blue Cecil in 2023. The vessel's C/E, ETO and Fitter died after they were found unconscious inside of Cargo Hold No. 1. Despite a rescue attempt, with all three being recovered from the hold, they were unresponsive and did not respond to CPR. A post-mortem examination by the Philippine authorities determined their deaths was "asphyxia by suffocation."

The following lessons learned were identified:

a) Entering a loaded cargo hold without authorization and without following established shipboard enclosed space entry and rescue procedures is extremely hazardous and should not be attempted.
b) Physical boundaries are critical for preventing unauthorized access into an enclosed space.
c) Enclosed space rescue procedures must be properly practiced and drills conducted as if they were a real emergency.
d) Stop-work authority can prevent marine casualties. For stop-work authority to be effective, crewmembers must not only be aware that they have this authority, but they must also have confidence that the authority is non-negotiable and can be exercised without fear of repercussion. They must also be as familiar with how to issue and respond to a stop-work action or instruction as they are with their other shipboard duties.

The Republic of the Marshall Islands Maritime Administrator's marine safety investigation determined that the C/E, ETO, and Fitter had entered Cargo Hold No. 1 to recover the welding cable and other tools 9 without complying with the Company's enclosed space entry procedures despite the Bosun's prior warning to the C/E that it was dangerous and required permission from the Master.

Read the Blue Cecil report in full at **https://bit.ly/4jl2HJr**.



Marshall Islands issues fatal falls from height warning

The Republic of the Marshall Islands Maritime Administrator has published Yacht Safety Advisory 13-24 on fatalities due to falls from height.

Since 2019, falls from height on RMI-flagged commercial vessels have been the leading very serious marine casualty (VSMC) by incident type. It accounts for 31% of VSMCs and has resulted in 22 deaths. In the last two years, 11 seafarers have died falling from height. The maritime authority has stressed the importance of wearing fall protection equipment when a risk of falling from height exists.

Recommendations:

- The Administrator strongly recommends that the owner or the owner's representative review and amend, as necessary, onboard safe working practices to ensure they comply with the requirements outlined in the RMI Yacht Code (MI-103). The review should take into account task and location specific safety assessments addressing the risk of falling.
- Masters should hold a special safety meeting to review and discuss the information provided in this Yacht Safety Advisory and attached Safety Flyer on Falls to ensure that risks of falling from height are adequately understood.
- It is also recommended to display the accompanying Safety Flyer on Falls on board in areas where yacht crew are likely to interact with it daily.

Download the advisory and flyer at **https://bit.ly/4jrSqv9**.



Carriage of plastic pellets by sea in freight containers

The Liberia Maritime Authority has sent out recommendations for the carriage of plastic pellets by sea in freight containers. These recommendations are the first step in a two-stage approach aimed at reducing the environmental risks associated with the carriage of plastic pellets in packaged form by sea, pending IMO's consideration of future mandatory measures for their carriage.

Summary of the Recommendations

1. Plastic pellets should be packed in good quality packaging which should be strong enough to withstand the shocks and loading normally encountered during transport. Packaging should be constructed and closed to prevent any loss of content which may be caused under transport normal conditions.

2. Transport information should clearly identify those freight containers containing plastic pellets. Additionally, the shipper should supplement the cargo information with a special stowage request requiring stowage as outlined in item 3 below.

3. Freight containers containing plastic pellets should be properly stowed and secured so as to minimize the hazards to the marine environment without impairing the safety of the ship and persons on board, either under deck wherever reasonably practicable, or inboard in sheltered areas of exposed decks.





Improper use and installation of hoses may result in fire

The Norwegian Maritime Authority (NMA) issued an alert urging all shipping companies to ensure that hoses installed or intended to be installed in connection with the engine and in the engine-room of their vessels are type-approved and installed according to the supplier's installation instructions.

The Norwegian Maritime Authority highlighted that this is particularly important for hoses and fittings where damage or rupture could result in oil or other flammable liquids splashing onto hot surfaces, increasing the risk of fire.

A thorough mapping and risk assessment must be carried out for all hot surfaces that may pose a fire hazard. Additionally, the NMA recommends the protection and insulation of hot surfaces, hoses, pipes, connectors and related components.

MSC.1/Circ.1321 – 11 June 2009 – Guidelines for measures to prevent fires in engine-rooms and cargo-pump rooms.

- Hoses should be constructed to a recognized standard and be approved as suitable for the intended service, taking into account fire resistance, pressure, temperature, fluid compatibility and mechanical loading including impulse where applicable.

- Hoses should be installed in accordance with the manufacturers' instructions, having regard to: minimum bend radius, twist angle and orientation, and support where necessary. In locations where hoses could possibly suffer external damage, adequate protection should be provided. After installation, the system should be operated at maximum pressure and checked for possible malfunctions and leakages.

Following a fire in the engine room of a vessel, the NMA has been informed that the fire was caused by a ruptured hose, which resulted in oil splashing onto hot surfaces.

The hose used on board was not intended for use on board vessels (it was designed for industrial applications) and was not installed in accordance with the supplier's instructions.

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The main engine exhaust pipe (including the silencer) was covered with a type of lagging that could not be removed without damaging the lagging.

A 41-foot CFV capsized and sank within two minutes after taking on water.

The ship's safety management system did not explicitly require a risk assessment before entering the free-fall lifeboat to conduct a safety check.

Sjøfartsdirektoratet
Norwegian Maritime Authority

Fire damper location importance highlighted in circular

Companies should review the placement and labelling of fuel quick-closing valves and assess the operation of fire dampers, advises the Norwegian Maritime Authority. The recommendation comes following a fire on a Norwegian vessel.

During the incident, quick-closing valves were used to shut off the diesel supply to the auxiliary and main machinery. However, the control handles for the quick-closing valves for the emergency generator were located in the same cabinet, leading to the unintended shut-down of the emergency generator.

On the same vessel, handles for closing fire dampers were located within a partially enclosed area. As a result, crew members tasked with closing the dampers had to enter a smoke-filled area, exposing themselves to smoke and requiring medical attention.

The Authority now recommends companies assess and improve the location and labelling of quick-closing valves. More specifically, quick-closing valves for the emergency generator should be positioned separately from those controlling the auxiliary and main machinery. Additionally, it is crucial that the crew members are familiar with the location and operation of these systems during inspections and drills.

Alarm instructions should align with the procedures practised during on-board drills.

It added it advises companies and ship designers to position fire damper controls in a way that minimises the risk of smoke exposure. For existing vessels, it recommends identifying potential risk areas and implementing corrective measures as necessary. During on-board fire drills, particular attention should be given to any areas that may lead to smoke exposure for the crew members.





Counterfeit pilot ladders lead to USCG warning



The United States Coast Guard (USCG) has issued a safety alert after discovering counterfeit pilot ladders during a Port State Control examination at the Port of Baltimore. The identification plate on the ladder contained several errors, including referencing ISO 779-1 instead of the correct standard, ISO 799-1, and lacking the ISO 799-1 designation type.

Additionally, while the serial number on the ladder matched the accompanying certificate, the number of steps and the length of the ladder did not align with the specifications listed on the certificate. The plate and certificate indicated that the ladder was produced by "QINGDAO GOOD BROTHER MARINE LIFE SAVING APPLIANCE Co. LTD.," a company that manufactures SOLAS-approved pilot ladders. However, in March 2019, the Australian Maritime Safety Authority (AMSA) identified counterfeit pilot ladders falsely bearing this company's name and SOLAS certification.

The Coast Guard strongly recommends that ship owners and operators:

- Thoroughly inspect pilot ladders to ensure vessels are outfitted with genuine SOLAS-approved equipment.
- Verify certification details. Check for proper ISO approval numbers and ensure the specifications on the certificate match the actual ladder.

Download the marine safety alert at **https://bit.ly/3DZBSKt**.

Transport Malta investigation into boiler explosion death

Transport Malta has released an investigation report into the boiler explosion on board oil/chemical tanker Torc, resulting in the death of a crewmember.

The incident took place on 8 January 2024 as the Maltese-registered ship was traveling between Agioi Theodorai and Genoa.

On 03 January 2024, Torc departed Agioi Theodoroi, Greece, after discharging part of its cargo of Paraffin. The vessel was bound for Genoa, Italy with an expected date of arrival of 10 January 2024. Shortly after departing from Agioi Theodoroi, the engineers changed over the boiler fuel consumption to very low sulphur fuel oil (VLSFO) for both boilers. However, the starboard boiler failed repeatedly to start. Eventually, both boilers were restarted on low sulphur marine gas oil (LSMGO). On the morning of 08 January 2024, the engineers, in consultation with the master and chief officer, decided to change over the fuel consumption of the boilers from LSMGO to VLSFO.

Just before 1400, the boiler fuel consumption was changed to very low sulphur fuel oil. Both boilers failed to fire because of low fuel oil temperature. Subsequently, the port boiler started working normally, but the starboard boiler failed to fire. Eventually, another attempt was made to restart it. While it was on the purge cycle, the second engineer went up to the burner platform to inspect it. At 1406, a loud explosion was heard and a fire started at the top of the starboard boiler. The fire alarm sounded within a few seconds.

The engineers went up to the boiler platform, to find the second engineer lying unconscious on top of the starboard boiler. The water mist system installed above the port boiler activated and the crew extinguished the fire with the help of portable extinguishers. The second engineer was carried outside onto the poop deck and placed in the dry provision room. The master sought medical advice from the company doctor and broadcast an emergency signal on the Digital Selective Calling system. Although the crew members attempted cardiopulmonary resuscitation, the second engineer passed away at around 1450.

Chemical analysis results made available to the safety investigation revealed that at the time of the explosion, the boiler was burning LSMGO and in the process of changing to VLSFO. The safety investigation believes that the cause of the explosion on boiler no. 1 was excessive vaporised LSMGO inside the unit and the likely presence of unburnt LSMGO inside the boiler.

Read the report in full at **https://bit.ly/4au23FI**.

THE REPORT

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The following Safety Briefings are taken from Issue 112 of The Report magazine



JUNE 2025

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No consideration was given to the compound's thermal sensitivity, seasonal temperature extremes, or the heat retention properties of an unplugged reefer.

The fixed carbon dioxide fire-extinguishing system failed to fully operate due to defects in the system.

The master and cargo crew of the cargo vessel were not aware of the barge's loading limits, and consequently, the barge was loaded beyond its capacity.



Understanding the explosion hazards of shipping coal

A bulk carrier shipping a type of coal called "Bailey High Vol Coking Coal" experienced consecutive explosions in the two forward cargo holds. While still under investigation, the explosions are likely a result of the accumulation of methane gas that created an explosive atmosphere and resulted in significant damage to the two associated cargo holds. It was soon discovered that the other five cargo holds also had highly elevated levels of methane that were approaching the Lower Explosive Limit, presenting an immediate threat to the safety of the mariners and the ship.

Shipment of coal by sea presents a wide range of hazards, including but not limited to methane emission (creating a potentially explosive atmosphere), self-heating, and liquefaction. To mitigate these hazards, coal must be shipped per the standard precautions set out in the International Maritime Solid Bulk Cargo (IMSBC) Code. In addition to these general standards for shipping coal, the IMSBC Code specifies that the ship must also be provided with a cargo-specific shipping declaration that identifies particular hazards and details any supplementary conditions required for safe transport for the specific type of coal.

In this case, the U.S. Coast Guard noted that the cargo-specific shipping declaration did not meet the IMSBC standard to disclose that this type of coal was liable to produce methane. Investigators also noted that the ventilation of the cargo holds, the atmospheric sampling within the cargo holds, and the cargo's trimming after loading did not comply with IMSBC standards.

In light of this recent incident and to mitigate the inherent risks associated with the shipment of coal by sea, the U.S. Coast Guard strongly recommends that vessel owners, operators, mariners, and other maritime personnel:

- Validate that the cargo-specific shipping declaration is complete by thoroughly addressing the properties and potential hazards of the specific type of coal being shipped as well as detailing stipulations for mitigation of these hazards.
- Review and ensure full implementation of conditions of carriage required for shipment of coal by sea as stipulated by IMSBC, the cargo-specific shipping declaration, the vessel's Safety Management System, and industry best practices.
- Communicate openly with the shipper if the cargo's behaviour differs from that specified in the cargo declaration at any time during shipboard transit, at the loading facility, or during transit to the facility.
- Review contingency procedures detailing the detection of and appropriate responses to cargo-related emergencies, both onboard ships and at the loading facility.
- Exercise increased vigilance whenever interacting with coal in any capacity, both onboard ships and at the loading facility, understanding that this is a hazardous cargo that may pose an immediate danger. This includes taking strict precautions to remove or mitigate sources of ignition, including, but not limited to, electrical continuity, hot work protocols, and strict no-smoking zones.

Upcoming deadline for new EU regulation on firefighting suits

Shipowners and operators of EU vessels must take steps to ensure that all new firefighting suits on board comply with changes to European regulations which enter into force from June 2025, according to urgent advice from VIKING Life-Saving Equipment.

The life-saving equipment solutions provider recommends fleet managers undertake a full risk assessment of their firefighting suits to verify compliance with requirements applying under MED regulations (EU) 2024/1975. These are in addition to provisions in effect since August 2024 – that all new firefighting suits must be tested to EN469:2020 standards.

From June, all new firefighting suits bought for EU vessels must feature all three of the enhanced protection capabilities included in 'Level 2' classifications within MED regulations. While 'Level 1' fire suits in-service will remain compliant until they wear out, they must be replaced by Level 2 PPE once they are no longer fit for purpose or worn out.

Developed in response to high-risk firefighting, Level 2 notation covers radiant and convective heat resistance (X2), enhanced water penetration protection (Y2) and breathability (Z2). The inclusion of Y2 responds to growing risks of electrical fires on ships and greater seafarer exposure to close-quarters firefighting in enclosed spaces where water is used in high volumes. Y2 suits feature an extra moisture barrier to protect firefighters against steam burns and chemicals.

NTSB reveals cargo on President Eisenhower lost due incorrect cargo weight data

The U.S. National Transportation Safety Board has published a report after cargo was lost and damaged off containership President Eisenhower.

The input of incorrect container cargo weight data when developing the cargo loading plan led to the shipping containers falling off a cargo ship and others becoming damaged while the vessel was drifting off the coast of California.



Photo credit: Bar Pilot

On 6 February 2024, the U.S. flagged containership President Eisenhower lost 23 shipping containers overboard and another 10 were damaged as the vessel was drifting about 94 miles south of Oakland, California, while awaiting a berthing assignment. None of the lost containers contained hazardous materials. The value of the lost cargo and damage to the containership was estimated at over $735,000.

Longshoreman at the Port of Los Angeles began loading the vessel on January 31 in accordance with a cargo loading plan. The cargo loading plan was developed by the ship planners using the verified gross mass, or VGM, of each container, which was provided by the booking agent. The VGM was determined by combining the empty weight of the container plus the weight of the cargo loaded into it. Before the plan was developed, the booking agent had to manually enter the cargo weight of 40 containers due to an error in the booking system.

During the manual entry, 39 container cargo weights were entered incorrectly and the VGM for those containers was significantly underreported. The actual VGMs for the 39 containers was 18.3 to 22.2 metric tons greater than the VGMs used to develop the cargo loading plan. Because the cargo loading plan included inaccurate VGMs, the container stack weights exceeded the maximum weight limit and the containers were loaded in reverse-stratified stacks, which caused the cargo-securing equipment to fail while the vessel drifted south of Oakland. The booking agent has since modified their procedures and booking system to prevent this type of input error from occurring again.

Download the full report at **https://bit.ly/4ifcyil**.

Liberian Registry issues notice on recall of rocket parachute flares



The Liberia Maritime Authority has published marine advisory 04/2025 on the Voluntary replacement and recall of rocket parachute flares Kokusai Kakoh Co., Ltd / Type: KP-16. Kokusai Kakoh Co., Ltd recalled the flare due to concerns regarding the specified altitude and burning time when fired. The item in question:

Product name/type: Kokusai Kakoh Co., Ltd. Rocket parachute flares Type: KP-16

Date of manufacture: From February 2021 to July 2024. The Liberian Maritime Authority recommends replacing these flares in accordance with information provided by the manufacturer, "Instructions (for outside of Japan)". The instructions also contain steps on how to identify the rocket parachute flares and where to find the nearest Comet distributors for WesCom Signal & Rescue.

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The investigation revealed that the operator failed to perform a thorough safety assessment.

Deliveries of scrap cargo were visually checked on arrival. There was no additional sorting and screening facility to ensure that contaminants were not present.

Contributing to the collision was the delayed response from the ship's crew to implement the emergency steering procedure from the bridge.

Incorrect valve starts fatal fire



The U.S. National Transportation Safety Board have released the results of a report after the installation of an incorrect valve in a pipe to a diesel oil tank led to a fatal fire aboard a cargo vessel docked in LaPorte, Texas.

On 8 January 2024, a fire broke out in the engine room aboard the cargo vessel Stride during bunkering, or fueling, operations while docked at the Barbours Cut Marine Terminal. The fire self-extinguished after crewmembers shut down all ventilation to the engine room. Two crewmembers died as a result of the fire, and one was seriously injured.

The vessel was declared a total loss valued at $12 million. Six weeks before the fire, a replacement valve was ordered for the ship's port double bottom diesel oil, or DBDO, tank. After the fire, investigators discovered the installed valve was not the same type of valve specified by the vessel's fuel oil system drawing. Rather than an angle stop valve, a similar looking angle stop check valve, which allows diesel oil to flow in only one direction, even when open, was ordered and installed instead.

As a result of the incorrect valve installation, once diesel oil filled another tank to capacity during bunkering, the diesel oil was directed up the common vent line, rather than the port (or intended) DBDO tank, where it flowed from a small cut out section of the vent pipe that had been sealed at an unknown time. The flexible sealing and tape covering the cut out failed, and diesel oil poured down into the engine room and onto operating machinery, causing a fire.

"Vessel drawings contain piping symbols for equipment such as valve types, sizes, and functions," the report said. "Owners, operators, and crews should carefully note all components of a vessel's drawings and diagrams to ensure that proper spare or replacement parts are ordered to maintain functionality." Contributing to the overfilling of the diesel oil tank was engine crewmembers not monitoring the levels of the tanks being filled aboard the vessel, as required by the bunkering procedure in the operating company's safety management system.

The company's bunkering procedures required a minimum of two engineering officers and two engine ratings to be on duty during bunkering operations. However, at the time of the fire, only three engineering crewmembers (two engineering officers and one engine rating) were involved with bunkering operations. "During bunkering operations, vessel owners, operators, and crews should ensure adequate personnel are available to take frequent soundings, establish fuel tank filling rates, and communicate to the person in charge, so tanks are monitored and do not overflow," the report said.

Key considerations for safety inspections of ships

Safety inspections of ships are a crucial and mandatory part of maritime operations, ensuring compliance with international regulations and safeguarding crew, cargo, vessels and the environment. Understanding how the process of safety inspections of ships is undertaken and maintaining readiness is essential to avoid deficiencies and ensure smooth operations. A well-prepared master plays a vital role in ensuring successful safety inspections. Masters should conduct regular self-inspections to identify and rectify potential deficiencies, maintain an updated checklist covering all inspection areas, and train crew members on emergency procedures and regulatory requirements. They should also communicate with port authorities and classification societies for guidance and keep all records well-organized and readily available for inspection.



Key guidance for safety inspections of ships and what's required:

- Documents, certificates, and publications referred to in the inspection form must be readily available, preferably in a central location, for examination and verification by the inspector.

- Publications obviously not applicable to a vessel need not be produced; e.g., dry cargo vessels need not obtain tanker safety publications, but OBO type ships should obtain them.

- The following should be made ready for the inspector: a) The official Minimum Safe Manning Certificate, b) The original National Certificate of Competence (C.O.C) and Endorsement or Certificate of Receipt of Application for same for each officer, c) For each crewmember: a Seafarers Identification Record Book with appropriate Special Qualification Stickers, d) In the case of passenger ships, the certificates of all survival craft/rescue boat crewmen in particular, and e) A copy of the current crew list and the ships emergency station bill.

- Navigation records, publications, charts, log books, oil record book, cargo record book, ballast water record book, training records (to include fire and abandon ship drills, weekly safety training exercises, and security drills), and all similar material must be available for inspection, preferably in one location, such as the chart room.

- Inspectors have the authority and have been instructed accordingly to make a spot check of lifesaving, fire-fighting, and general safety conditions covered by the SOLAS Certificate. The Master will be instructed to call in the Classification Society for examination and/or verification as may be necessary.

- The Master should have lifeboats uncovered and the vessels firefighting equipment and appliances in their normally stowed positions ready for the inspectors examination. Sufficient crew will ned to be on board and should be prepared to conduct such emergency drills as circumstances may dictate and permit.

- The engine room must be clean and free of oil leaks before any inspection. Additionally, documentation such as the Statement of Compliance for the Consumption of Oil, the SEEMP, BDNs, and records related to the energy efficiency of the ship must be up to date.

- The pilot ladder and associated gear such as gunwale steps, lights, manropes and so on should be accessible and in conformance with the latest requirements in SOLAS Regulation V/23.

- To facilitate the efficient conduct of safety inspections of ships, one of the vessels staff shall be available to accompany the inspector at all times during the process.

- If safe to do so, the inspector will take at least the following photographs of the ship: a) From the shore: bow, quarter, and stern, b) On board: bridge/wheelhouse, weather deck from both the bow and bridge, lifeboats and launching apparatus, and any damage, defect, or areas of concern.



USCG issues alert for defective heat detectors

The U.S. Coast Guard has issued a safety alert regarding the issue of defective heat detectors that were discovered during an engine room fire investigation.

The Coast Guard recently investigated an engine room fire on board an inspected towing vessel which led to the discovery of issues with the maintenance and installation of fire detection systems on board multiple towing vessels. During the investigation, several towing vessels were discovered to have defective heat detectors installed in their engine rooms.

These detectors had been recalled by the manufacturer in 2019 for failure to activate within their listed temperature range. Though the defective heat detectors identified on board these vessels were Edwards branded 280 series 135° F heat detectors, the Coast Guard wants to advise the entire marine industry that the safety recall also includes heat detectors sold under several different brandings.

Download the safety alert at **https://bit.ly/4bNDZ0L**.

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The chain was made from a low ductile steel with a high hardness value, which was detrimental to its longevity and not recommended for use in corrosive marine environments.

The original fuel pipe connections had previously been identified as a system weakness, but the manufacturer's recommended modifications had not been fitted to the engine.

The crew's response, affected by the loss of critical safety systems, was ineffective.

MAIB investigation into fatalities on board Berge Mawson

The UK Marine Accident Investigation Branch (MAIB) has published a report into the deaths of three stevedores in a cargo hold access space on board the bulk carrier Berge Mawson. The incident took place at Bunyu Island anchorage, Indonesia on 27 June 2022.

On 27 June 2022, three unconscious stevedores were recovered from a cargo hold access space on board the Isle of Man registered bulk carrier Berge Mawson at Bunyu Island Anchorage, Indonesia. Despite prompt medical attention by ship and port staff, the three men died.

Berge Mawson was loading a bulk cargo of coal from barges using a floating crane. The coal in cargo hold No.7 was being levelled by a bulldozer, when loading was paused and all hatches were closed due to heavy rain. Once the rain had stopped, a stevedore made several attempts to gain access to the bulldozer. Unsupervised, the stevedore mistakenly descended into cargo hold No.8 access space where he collapsed. As Berge Mawsons crew were collecting rescue equipment, two stevedores also collapsed in cargo hold No.8 access space as they attempted to rescue their stricken colleague.

The MAIB investigation concluded that:

- The stevedores died because they entered an enclosed space that had a noxious atmosphere that could not sustain life.
- Atmosphere testing of cargo spaces was not routinely carried out before stevedores entered the compartments.
- The stevedores were not adequately supervised on board Berge Mawson.
- Access ways to cargo spaces were not locked closed when not in use.
- The stevedores were unable to understand safety labels and warnings and cargo space identification.
- The agreed Ship-Shore Safety Checklist had limited validity after the commencement of cargo operations.
- The terminal had not trained the stevedores in line with international guidelines on safe cargo work on board bulk carriers.
- An industry-led initiative that requires bulk terminals to implement safety training and management systems could improve stevedore safety on board vessels.

Read the full PDF report at **https://bit.ly/3FC6IPB**.



Massive container explosion was caused by self-heating chemical cargo

Photo credit: CMSA



The dramatic container explosion aboard the boxship YM Mobility at Ningbo last year was caused by thermal runaway in a cargo of organic peroxides, according to China's Maritime Safety Administration (CMSA). It is the latest in a long string of container accidents involving this class of dangerous chemicals, notorious for self-heating, decomposition, fires and explosions.

The container in question was a reefer box filled with tert-butyl perbenzoate (TBPB), a common activator for making plastics like polyethylene and polyester. It is unstable at high temperatures, and has a thermal tipping point of about 140 degrees Fahrenheit, above which its self-heating tendency accelerates until combustion or explosion. This particular shipment was headed for Jebel Ali, where the terminal requires refrigerated storage for TBPB, so the manufacturer packed it in a reefer box in order that it could be plugged in on arrival.

YM Mobility's operator did not require the box to be plugged in while under way. When the container was loaded aboard YM Mobility in Shanghai on August 6, it was stowed as deck cargo on the starboard bow, packed in a reefer but unplugged and unrefrigerated. Ambient summertime temperatures were about 95 degrees Fahrenheit.

YM Mobility left Shanghai August 7 and transited to Ningbo. On August 9, a crewmember on duty smelled an "irritating odour" while up on the bow. At about 1331, he inspected the container involved and noticed a hissing noise, white smoke and a yellow liquid dripping from the door - characteristic of TPBP decomposition. Over the next six minutes, the smoke increased. The crewmembers up on the bow realized the danger and evacuated the area, and the captain sounded the fire alarm to muster the crew.

By 1338, white smoke obscured most of the starboard bow, and within minutes, it was billowing all over the foredeck. At 1346:30, the reefer box exploded violently, blowing six containers over the side and disintegrating three more. No injuries were reported, and all crewmembers safely evacuated onto the dock a few minutes later.

First responders from shore took over firefighting efforts, and the blaze was under control by the next morning. It took another day to fully put out the last hot spots in adjacent containers.

A post-accident inspection found that the force and heat from the blast were enough to warp the hatch coaming, hatch cover and adjacent structures. More than a dozen containers were burned, blown up or had their contents ruined.

CMSA noted that reefer boxes are airtight and thermally insulated, and any heat from a self-heating substance like TBPB would accumulate inside the container, particularly in hot weather. Under these conditions, the cargo could get hotter and hotter until it went into thermal runaway and exploded.

"No attention was paid to the temperature changes in the box during transportation," CMSA concluded, calling the arrangement negligent. "The transportation plan of transporting TBPB in unplugged refrigerated containers during the hot season is inappropriate. . . . TBPB shippers failed to take into account the thermal insulation and airtightness of unplugged reefers in hot weather."

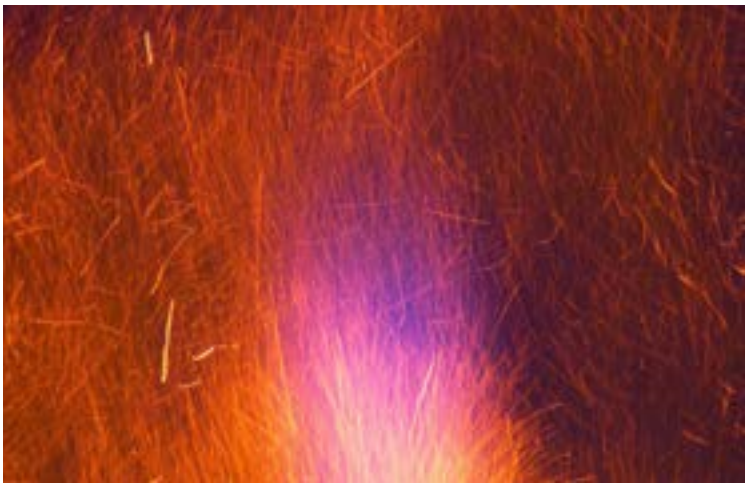


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The fixed carbon dioxide fire-extinguishing system was activated by the crew, but failed to fully operate due to a defective flexible hose assembly and leaks in the pilot system.

The position of the jockey seats at the front of the boat were unsuitable for single occupancy as they exposed passengers to high shock load as the boat slammed into the waves.

There was no passage plan to support the safe navigation of the vessel.



Lessons learned after fire sinks shrimp cutter

Germany's Federal Bureau of Maritime Casualty Investigation (BSU) has published the lessons learned following the fire and subsequent foundering of a shrimp cutter vessel.

The exact cause of the fire could not be determined after the shipwreck was salvaged because of the extensive damage done to the vessel in the incident.

In the early morning, a fire broke out in the engine room of an anchored shrimp cutter during a break in fishing. This was initially not noticed by the sleeping crew.

The main engine was running overnight to cool the fish hold, and the door to the engine room companionway was open for ventilation.

When the captain accidentally discovered the fire, the flames had already spread to the entire engine room and the open companionway, meaning that it was no longer possible for the crew to fight the fire with onboard resources. The crew of two left the burning cutter using a life raft and were rescued unharmed around an hour later. After the fire was later extinguished by external forces flown in, the cutter sank due to the progress of the fire and the entry of extinguishing agent. The water was contaminated by diesel fuel and hydraulic oil.

Why did it happen?

- No anchor or fire watch. Both crew members were asleep and therefore did not notice the dangerous situation;
- Lack of fire alarm system. It was not possible to alert the crew, so that the outbreak of the fire initially remained undetected;
- Open door to the engine room companionway. The fire was probably able to spread more quickly due to a greater supply of oxygen;
- Fire extinguishing system did not fulfil its purpose. Automatic activation of the system was not fitted, manual activation was not (or no longer) possible due to the location of the installation and the type and dimensions of the system were unsuitable for the engine room of the cutter;
- Firefighting and emergency shutdown equipment located within the danger zone. The manual release of the extinguishing system, the fuel shut-off valves and other switches could no longer be reached;
- Lack of emergency preparedness: regular safety drills and/or trainings were not customary. The crew was forced to act spontaneously and could not fall back on previously developed and practised emergency plans.

Read the full report at **https://bit.ly/3QYHfwT**.



The importance of bulk cargo trimming

In one of its recent Risk Watch bulletins, Britannia P&I Club explained that proper trimming of bulk cargo is essential for ensuring ship stability, regulatory compliance, and efficient loading and discharging operations.

The IMSBC Code provides mandatory guidelines for trimming procedures. Section 5 of the code specifies that all bulk cargoes should be trimmed 'reasonably level' to reduce risks such as cargo shifting and instability. For non-cohesive cargoes, trimming standards are determined by the calculated angle of repose. Consideration should also be given to the charter party, as this may stipulate the required method of trimming, especially for cargoes that require specific handling.

Section 5.1.3 of the IMSBC Code states: "The master has the right to require that the cargo be trimmed level, where there is any concern regarding stability based upon the information available, taking into account the characteristics of the ship and the intended voyage."

Trimming is often performed at the end of discharge, but when loading via a chute, spout, or conveyor, it makes sense to avoid the cargo stream constantly pouring onto the same point in the holds. Best practice is for the loading arm to be initially positioned as close to the tank top as safely practicable, depositing a layer of cargo over the entire surface before increasing the loading rate and raising the drop distance. Efforts should then be made to direct the loader for a more even cargo distribution. This reduces or can even eliminate the amount of trimming work needed to flatten the cargo surface at the end of loading.

NTSB investigation into fire on fishing vessel Three Girls

The failure of a component on the hydraulic system for on-deck fishing equipment likely led to a fire aboard a fishing vessel in the Gulf of Maine, according to the U.S. National Transportation Safety Board. On August 11 last year, the fishing vessel Three Girls was fishing in the Gulf of Maine when a fire broke out in the vessel's engine room.

The five crewmembers and a National Marine Fisheries Service observer abandoned the burning vessel and were rescued by the U.S. Coast Guard. No injuries or pollution were reported. Damage to the vessel was estimated at $1.3 million.

The crew of the Three Girls began fishing on August 10 2024, and collected about 20,000 pounds of various groundfish over the next two days. When the fishing net was recovered from the seafloor around 8.50pm local time on August 11, the captain noticed a burning smell that he believed was electrical in nature. He saw thick, black smoke flowing out from the engine room exhaust fan in the port stack and engine room door.

The captain determined the fire was too intense to fight and directed the crew to prepare to abandon ship. The crew launched and entered the liferaft in a quick and orderly fashion less than eight minutes from the time the captain first smelled smoke. During a postfire examination in the engine room, investigators found several exposed surfaces were heavily covered in soot, and there were a few areas of "clean burn" present between the hydraulic return oil filter housing and the winch engine that had been operating at the time of the fire.

This indicated the fire had burned hottest there and that the fire area of origin was likely in the port, forward corner of the engine room between the hydraulic return oil filter housing and the winch engine. Investigators found all hydraulic hoses from the hydraulic return oil filter box were detached from their aluminum filter housing covers, which had been melted away by the fire, indicating the hoses, their fittings, or another component of the box had failed.

The cause of the fire was likely the ignition of pressurized hydraulic oil spraying on components of the running winch engine exhaust system. "After an engine room fire ignites, it is imperative to remove the sources of available fuel and ventilation to the fire to prevent it from spreading," the report said.

"Vessel designers, builders, owners, and operators are encouraged to install, regularly test, and have emergency drills that incorporate remote shut offs for all machinery within these spaces to ensure the machinery can be remotely stopped from outside the space where it is situated. "Additionally, to prevent the reintroduction of oxygen to the space, vessel designers and owners should ensure that the ventilation, both natural and forced draft, can be completely and remotely secured to all engine rooms."

Download the full report PDF at **https://bit.ly/4cebDNp**.



The "E-cars on Board – A Safe Passage" interferry brochure is a vital new resource

The "E-cars on Board – A Safe Passage" interferry brochure addresses common concerns regarding battery electric vehicle (BEV) safety on ro-pax ferries. It provides clear, concise information based on recent research, including findings from projects such as Lash Fire, in which Interferry actively participated.

Interferry members are advised to take a look at the brochure and make it accessible to their customers in a simple way – for more informed decision-making, clarity and safety. Note: You do not have to be an Interferry member to print and distribute this brochure.

The core message is straightforward: BEVs do not present a greater fire risk than traditional vehicles.

BEVs can be stowed safely next to other vehicles on board a ship's vehicle decks, as the fire extinguishing equipment of a ro-pax ferry can handle potential incidents, no matter if it comes from an e-car or a traditional internal combustion engine vehicle (ICEV).

In a clear Q&A format, the brochure informs that BEV fires are statistically less frequent than ICEV fires. It rectifies misconceptions about common fire causes and intensity, extinguishing methods, and fume toxicity. It also clarifies safe storage practices and highlights the safety of on-board charging.

Johan Roos, Director of Regulatory Affairs at Interferry, stresses the brochure's importance. "Informed passengers are essential, especially as we approach the travel season in many parts of the world. Global e-car numbers are rising, and with it the uncertainties as to how this will affect the safety of ferry travels. Ferry operators must provide clear, accurate information, and we believe this brochure is a valuable tool. We want all ferry customers to feel safe and secure."

Read the INTERFERRY brochure at **https://bit.ly/3EEw1Lu**.

MTF report highlights critical safety issues of transporting electric vehicles



The Maritime Technologies Forum (MTF) has published a report titled "Safe Carriage of Electric Vehicles" addressing the critical issue of transporting electric vehicles (EVs) on Pure Car and Truck Carrier (PCTC) vessels.

Currently, there are no international regulations specifically dedicated to the safe carriage of electric vehicles. While some national and regional governmental organizations have issued their own guidelines, the IMO is still in the process of developing mandatory regulations for the transportation of new energy vehicles, including EVs, with a target completion year of 2027.

"This report is a significant step toward safer transportation of electric vehicles. Our goal with this report is to provide the industry with the necessary information to develop effective regulations and safety measures," said Lars Lippuner, Director of UK Customer Maritime Services, UK Maritime and Coastguard Agency (MCA).

The Maritime Technologies Forum (MTF) is a group of flag States and classification societies which aims to bridge the gap between technological progress and regulatory process.

According to the report, crews need to become familiar with electric vehicles and be well-trained to ensure safe transportation of these vehicles. In addition, providing effective information on safe carriage of EVs would be beneficial to stakeholders who are now investigating and considering the additional measures.

Download the report at **https://bit.ly/4bXoWSh**.

UK MAIB releases first safety digest of 2025

The UK Marine Accident Investigation Branch (MAIB) has published its first safety digest of the year. Safety Digest 1/2025 draws the attention of the marine community to some of the lessons arising from investigations into recent accidents and incidents. This information is published to inform the merchant and fishing industries, the recreational 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 MAIB safety digest is to prevent similar accidents happening again. In his introduction, Chief Inspector of Marine Accidents, Andrew Moll OBE, highlighted to the recent collision between container vessel Solong and tanker Stena Immaculate pointing out it appeared to be yet another collision that should not have happened.

He added that a good lookout as key to preventing collisions (COLREGs Rule 5), and also that stand-alone vessels should ready to take avoiding action when necessary (Rule 17).

The digest also featured introductions by Gary Doyle, Group Harbour Master of Peel Ports Group; Anne Hornigold, Director of Whitby & District Fishing Industry Training School; and Mark Bleecker, Director of MB Marine who contributed their expert insights to this safety digest.

Download the pdf at **https://bit.ly/4jthUaD**.



THE REPORT

The Magazine of the International Institute of Marine Surveying

SEP 2025 | ISSUE 113

The following Safety Briefings are taken from Issue 113 of The Report magazine



SEPTEMBER 2025

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Foreign objects were found in the hydraulic oil system.

The skipper had not completed the Safety Awareness and Risk Assessment course and so may not have had a full appreciation of the risks associated with his vessel's operation.

The investigation found that a drain line in the warm-up bypass line had been permanently modified without formal approval or documentation.

International Code for the Safe Carriage of Grain in Bulk update

DNV has sent out a news update on amendments to the International Code for the Safe Carriage of Grain in Bulk, which have been adopted by IMO Resolution MSC.552(108).

The Grain Code amendments enter into force 1 January 2026 and will be applicable to newbuildings with keel laid on or after this date. For existing ships, the amended Grain Code can also be applied to improve loading flexibility and demonstrate compliance with the new requirements. It is expected that there will be an increased attention on this loading pattern by inspectors in the larger grain exporting ports from 2026.

The need to implement such an update for existing ships will largely depend on the individual ship's cargo capacity, the maximum draught, and the specific gravity of the type of grain typically carried. If a ship, when operating at its normal/ fixed grain trade, can consistently load all holds fully – with untrimmed ends – without exceeding the maximum loadline draught, or only rarely encounters a fully loaded condition where one hold is partial filled within the hatch, such an update may not be necessary.

DNV says it is also worth noting that trimming can still be performed for a partial filled hold – where the grain level is below the hatch coaming – if such a service is available in the port.

Read the full story at **https://bit.ly/4mol1SI**.



NTSB highlights effective placement of smoke and fire detectors

The National Transportation Safety Board (NTSB) has highlighted the role of effective placement of smoke and fire detectors following its investigation of a fire aboard a fishing vessel last year near Tatoosh Island, Washington.

According to the NTSB report on the incident, the fishing vessel Tarka II did not have a smoke or fire detector in the engine room, where a fire broke out on Sept. 2, 2024. The Tarka II's engine room had a CCTV camera that would have been displayed in the wheelhouse, but it was not in use at the time of the fire. The captain's first indication of a fire was seeing smoke coming from the vessel's exhaust stacks. He likely would have been alerted to the fire sooner with an engine room smoke or fire detector or had the CCTV been operational.

The smoke detectors outside the engine room and in the galley did not activate until the captain opened the engine room door. The captain shut down the generator and main engine and noticed a small, smouldering fire near the hydraulic tank and hydraulic pump in the engine room.

Installation of smoke and fire detectors in spaces that are typically uncrewed when underway, such as the engine room, allows for the earliest detection and notification of a fire, maximizing the time for operators to respond to the fire or take actions to abandon the vessel, the marine investigation report said.

According to NTSB, vessel operators can improve fire safety by installing detectors in all areas susceptible to fire (such as the engine room and galley, and spaces that contain machinery, hot exhaust tubing, and fuel sources). The detectors should be capable of notifying crewmembers throughout the vessel of fire or smoke and be routinely checked to ensure they are in good working order.



Image credit: CMT

Machinery failures and engine-room incidents are sharply rising

The maritime industry is facing a sharp rise in machinery failures and engine-room incidents that modern monitoring systems could help prevent. Those are the chilling words according to CM Technologies (CMT).

With classification society DNV reporting a 20% increase in machinery damage failures during 2024 and engine room fires accounting for more than half of all marine equipment-related insurance claims, CMT points out that advanced diagnostics and monitoring solutions are not just 'nice to have' but should be considered as essential safety tools.

Uwe Krüger, Managing Director, CM Technologies, said, "Engine and machinery failures continue to catch crews and operators off guard, but effective system monitoring will alert crews to looming catastrophe."

According to DNV's 'Maritime Safety Trends 2014-2024 Preparing for Future Risks', the number of maritime safety incidents has increased by 42% between 2018 and 2024, despite the global fleet growing by just 10%. Additionally, machinery damage/failure was responsible for the highest number of casualty incidents in all years, with this climbing to 60% of all cases in 2024 – up from 38% a decade ago. Among other findings, the report notes a rise in fire and explosion incidents, with a 42% increase in the past four years.

Citing as an example the root cause of the engine-room fire aboard the cargo vessel Stride in January, Krüger said that even small oversights, such as an incorrectly installed or damaged valve, can result in fatal accidents.

He continued, "Modern acoustic sensors could have picked up abnormal pressure signatures or vibration patterns as soon as the valve began to operate. That kind of early warning can be the difference between a manageable maintenance event and catastrophic failure."

According to DNV, the data shows a clear correlation between vessel age and operational reliability with incidents involving vessels more than 25 years old, accounting for 41% of all reported cases, up from 32% in 2014. Across all age groups machinery damage/failure incidents grew by 20% in 2024.

"Too often, we see cases where seemingly minor issues spiral into significant failures. By the time these problems are identified during scheduled maintenance, the damage is already done. The early warning technology to detect these signs in real time already exists."

Commenting on the risks associated with older vessels, where maintenance is deferred or relies solely on periodic inspections, Fuhlbrügge said, "continuous monitoring can reveal the "subtle degradation" that leads to unexpected breakdowns."

In conclusion, Uwe Krüger commented, "Machinery failures rarely happen overnight; they are consequent of a series of events over a period of time. Every percentage point of efficiency lost, every small increase in vibration, every piece of debris in the lube oil system is a warning sign. We need to pay closer attention to these details."

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The vessel was likely operated beyond its stability limits, reducing its freeboard and its reserve buoyancy, which contributed to its sinking when the sea state degraded.

The investigation determined that the probable cause of the fire was the thermal runaway and explosion of the 24-volt lithium-ion battery bank due to the inoperable battery management systems, resulting in the practice of manually charging the lithium-ion batteries with a portable battery charger, which compromised the safe monitoring of the vessel's lithium-ion battery systems.



Safety alert issues about green patina build-up on water mist nozzles

The U.S. Coast Guard (USCG) has issued a safety notice highlighting the risk of green patina build-up on high-pressure water mist nozzles, which can compromise the effectiveness of onboard firefighting systems. According to the notice, while witnessing routine testing of a fixed firefighting system during an annual exam aboard a foreign passenger vessel, the Coast Guard discovered multiple high-pressure water mist nozzles that were incapable of discharging water. Consequently, the firefighting system failed to activate in multiple accommodation spaces.

Upon expanding the examination, Port State Control Officers determined that the high-pressure water mist nozzles in question were manufactured by Marioff ("a2000" series) as part of the "HI-FOG" system. The accumulation of green patina on the nozzles, a sign of corrosion, rendered them unable to release water after the glass bulb broke. The high-pressure water mist nozzles are designed to hold the standard line pressure of 25 bars (363 PSI).

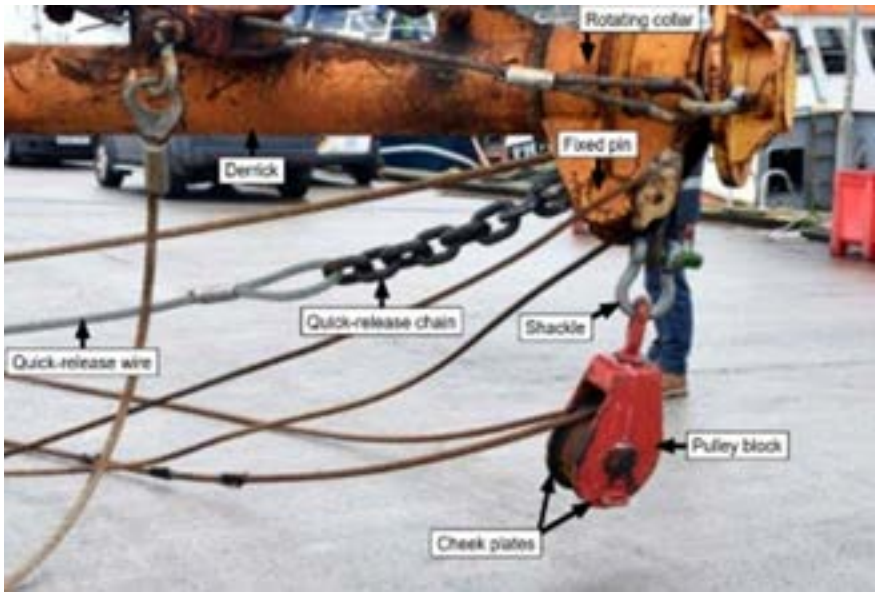
When the glass bulb thermal actuator (shown in the photo above) reaches a certain temperature, it breaks, activating the release mechanism which allows water to flow through the nozzle at the standing pressure. The system then senses the drop in pressure and activates the high-pressure pumps which increases the pressure to 140 bars (2,031 PSI).

This increased pressure is required for the system to achieve an effective release of water in a mist form. The manufacturer, Marioff, released a Service Bulletin (001/2012) and Quality Bulletin (002/2012), which originated due to failures of the "a1000" series nozzles. The bulletins describe the same failure as that noted on the "a2000" series during the recent examination and includes recommended actions that apply to both the "a1000" and "a2000' series nozzles.

Marioff recommends that if a nozzle fails to release at the standing pressure of 25 bars after the glass bulb is broken, the high-pressure pumps must be manually energized to raise the pressure to 140 bars. Doing so will activate the release mechanism allowing water to flow through the nozzle.

During the examination the Coast Guard witnessed this recommended action and observed that raising the pressure of the system to the recommended 140 bars did not activate the release mechanism of the nozzles as expected. Thus, in this case, the actions recommended by Marioff in Service Bulletin (001/2012) and Quality Bulletin (002/2012) did not raise the system pressure sufficiently to activate the release mechanisms for the nozzles.

Download the safety alert at **https://bit.ly/4mcXCnH**.



MAIB report: Fatal accident on the beam trawler Cornishman with loss of 1 life

The MAIB report into a fatality onboard the beam trawler Cornishman highlights a number of failings.

On 6 February 2021, a deckhand on the beam trawler Cornishman was fatally injured when the port trawl beam, which had been hoisted to facilitate a repair to the fishing gear, fell and struck him. It was found that a chain that was part of the trawl beam's quick-release gear had failed, causing the beam to fall.

Safety issues affecting the beam trawler Cornishman were:

- Risk assessments were not followed and stated mitigations were ineffective, placing the crew at risk while working under a suspended load
- The chain type was unsuited to marine operations, where the salt water environment caused environmental cracking
- The supplied chain had been unsuccessfully tempered during manufacture, which resulted in a high level of hardness and low ductility
- The chain's installation caused it to be led over a fixed pin, which introduced bending stresses to the chain links that were compromised due to corrosion and cracking

Recommendations

- The Maritime and Coastguard Agency has been recommended to 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. And, to update its training and guidance to surveyors to improve their ability to check compliance with these regulations during vessel ins. pections.
- W. Stevenson & Sons Limited has been recommended to ensure compliance with the lifting equipment regulations; review and update its risk assessments; confirm with chain suppliers and/or chain manufacturers before purchase that the selected chains are suitable for their intended use; and, implement the Fishing Safety Management Code for its fleet.
- Capital Group FASING S.A., Poland has been recommended to review and amend its chain quenching and tempering process and offer its customers a hardness test certificate for the lifting chains it manufactures.

Download the MAIB report at **https://bit.ly/44aZZPY**.

Download the Annexes at **https://bit.ly/4kJCDrH**.

New SOLAS requirements for Lifting Appliances

The IMO has introduced SOLAS Regulation II-1/3-13 through Resolution MSC.532(107), setting new requirements for lifting appliances and anchor handling winches. These updates will take effect on 1 January 2026, ensuring enhanced safety and operational standards across the maritime industry. Class News, released by Lloyd's Register, covers the requirements for lifting appliances, while a separate publication addressing anchor handling winches will follow. The SOLAS amendments are supplemented by the IMO MSC.1/Circ.1663 Guidelines for Lifting Appliances.

Application

The new regulation applies to a wide range of lifting appliances, including those:

- Used for cargo loading, transfer, or discharge;
- Used for raising and lowering hold hatch covers or moveable bulkheads;
- Used as engine-room cranes;
- Used as stores cranes;
- Used as hose handling cranes;
- Used for launch and recovery of tender boats and similar applications;
- Used as personnel handling cranes.

Generally, the requirements also apply to lifting appliances with a safe working load below 1,000 kg, unless the flag administration grants specific exemptions. However, certain lifting appliances — including those used on offshore construction ships — are outside the scope of this regulation.

Requirements for new lifting appliances (installed on or after 1 January 2026)

Before entering service, new lifting appliances must undergo certification, which includes:

- Plan appraisal and material verification
- Inspection and testing during fabrication
- Verification of component certification (including loose gear)
- Load testing and thorough examination once installed on board

Lifting appliances certified or classed under Lloyd's Register's Code for Lifting Appliances (CLAME) framework will be compliant with the new SOLAS requirements.

Download the full PDF at **https://bit.ly/4mla52x**.

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The pre-departure safety briefing did not include adequate instruction on the use of the seats and the passengers were unaware of the risks.

A 60-foot CFV caught fire, forcing the crew to evacuate rapidly.

The flexible sealing and tape covering the cut out failed, and diesel oil poured down into the engine room and onto operating machinery, causing a fire.



IMCA Safety Statistics Report 2024: Line of Fire incidents leading cause of LTIs

The International Marine Contractors Association (IMCA) has published its annual Safety Statistics Report, showing that 'line of fire' incidents remained the leading cause of lost time injuries (LTIs) among IMCA marine contractor Members in 2024, accounting for more than half (52%) of such injuries. The research, which IMCA has published each year since 1996, found that the total lost-time injury rate (LTIR) across its contributing Members' onshore and offshore operations remained unchanged at 0.3 incidents per million hours worked. This follows steady improvements since 2010, when the LTIR was more than twice as high as recorded in 2024. Meanwhile, the total recordable injuries rate (TRIR) rose slightly (from 1.07 to 1.1 injuries per million hours worked), a pattern seen across the energy industry, although IMCA contractor Members saw a small improvement in the total recordable injury rate recorded for offshore from 1.47 injuries per million hours worked in 2023, to 1.38 in 2024.

Just over half (52%) of lost time injuries reported were 'line of fire' related injuries. Understanding the underlying causes of these accidents and how they can be reduced will be a priority for IMCA, working with its Members and partner organisations, in 2025. Slips and trips were the second main cause of LTIs, accounting for 22% of the total in 2024. The fatal accident rate (FAR) halved from 0.63 fatalities per 100 million hours worked in 2023, to 0.3 fatalities in 2024. For offshore workers, the rate fell from 0.41 in 2023 to 0.18 in 2024 – the lowest fatality rate ever recorded by IMCA contractor Members.

This year's data for IMCA Safety Statistics Report 2024 was supplied by 198 of IMCA's contractor Members, who between them submitted a record 1,015,000 hours of data. The research is available to both IMCA Members and non-Members, enabling them to benchmark their performance against similar sized companies.

Download the report at **https://bit.ly/3FKIaPG**.



Key recommendations against blackouts

The team at Gard P&I Club has issued recommendations to help ship operators prevent blackouts and ensure that crews are prepared to respond effectively should one occur.

A blackout occurs when a ship suffers loss of electrical power from its main switchboard, typically due to an electrical or mechanical failure in the ship's power generation, distribution, or propulsion systems. All blackout situations are serious and potentially dangerous. In a best-case scenario, a standby generator will be brought online to restore the main source of electrical power within seconds. However, a sustained blackout with loss of propulsion and steering control can eventually lead to collision or grounding with loss of life, damage to the environment and even total loss of the vessel.

The risk of a serious casualty increases when a ship is operating close to shore, near other ships or infrastructure like offshore wind turbines and particularly under adverse weather conditions. The increasing complexity of the integration of operating systems on modern ships has also been shown to challenge crews' capacity to understand how these systems work. This can have a significant impact on how long it takes to recover from a blackout and restore propulsion and steering, and hence the severity of a blackout.
Key recommendations against blackouts

To prevent blackouts from occurring, ship operators must ensure that all essential machinery, electrical equipment and control systems are correctly maintained and operated. According to DNV, some of the typical failures to be aware of are:

- Loss of lube oil pressure
- Fuel-oil related issues, e.g. clogged filters
- Control, monitoring and safety system malfunctions
- Common maintenance failures. This could happen when similar maintenance is carried out on several auxiliary engines at the same time

Gard also recommends carrying out regular and realistic performance testing of auxiliary and emergency power supply systems as well as surveying switchboards with an infrared camera. Even systems with redundant power supply might fail at the worst possible time if not properly maintained.

To reduce the effects of a blackout, ship operators should develop robust operating procedures that identify ship-specific operations where a blackout could represent a particularly high risk, e.g. during berthing or navigation in heavy weather, different system failures that could occur, and how to best respond if a failure occurs. Special attention should be made to the configuration of main and auxiliary switchboards to provide redundancy in power supply for propulsion and supporting systems.

Additionally, Gard emphasises to ship operators the importance of having an alarm system that is clear and unambiguous. Every blackout will activate a large number of alarms, and it is essential that the engineers on watch can quickly recognise those that are critical. As an example, the investigation (report in Norwegian) of the above mentioned cruise ship accident revealed that the ship's alarm system in the engine control room failed to distinguish between critical and less critical alarms, and that "troubleshooting was challenging when a total of approximately 1,000 alarms sounded within the first 10 seconds after the blackout".



UKP&I guide to safe LNG bunkering practices

UKP&I Club has developed the UKP&I guide to Safe LNG Bunkering Practices (Second Edition) in collaboration with Brookes Bell.

The guide presents a practical resource for the safe and efficient bunkering of liquefied natural gas (LNG) in the maritime industry.

In response to global decarbonisation efforts and the growing adoption of LNG as a fuel in transition, this guide explores the physical characteristics of LNG, associated hazards, and recommended best practices for its handling, storage, and transfer.

It covers key technical aspects including:
- Containment systems,
- Pre-bunkering preparations,
- Operational protocols,
- Emergency response planning, and
- Crew training aligned with the IGF Code.

The publication also addresses critical considerations such as risk assessments, mooring analyses, and the complexities of simultaneous operations (SIMOPS). It outlines essential tank preparation procedures such as inerting and cool-down and emphasises the importance of establishing robust safety and security zones.

Download the PDF at **https://bit.ly/458QBg3**.

Onboard drills to test system responses triggered by different, and realistic, blackout failures should be conducted on a regular basis to improve crew awareness. The Failure Modes and Effect Analysis (FMEA) of the complete power management system would be a good resource for operations and training of crew. When used as a reference document, it can improve operator understanding of the risks and corrective actions the automation system performs should a particular failure occur. Remember, your best strategy to avoid accidents is to make sure every ship has a skilled and confident crew, who understand how to prevent and respond to a blackout in order to recover as quickly as possible.



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The report also criticizes the inspection methods on the schooner, concluding that they lacked depth due to safety constraints.

Despite a previous incident where a similar quick-release chain was found to have cracked, the safety regime within the company and on board had not recognised the design flaw in operating chains over fixed pins.

Lack of fire alarm system. It was not possible to alert the crew, so that the outbreak of the fire initially remained undetected.

Lithium-ion battery system installation alert issued by USCG

The US Coast Guard (USCG) has issued a safety alert and providing guidance regarding lithium-ion (Li-on) battery installations following an incident when an integrated Li-ion battery bank recently caught fire onboard an inspected passenger vessel when loosely crimped lugs overheated. While no one was injured and the vessel sustained minimal damage, this casualty highlights safety hazards unique to Li-ion batteries.

All integrated (installations used for propulsion and electrical power) Li-ion battery systems on inspected vessels must undergo engineering plan review, be fitted with supporting safety systems, be tested and inspected at installation and periodically afterward, and be properly maintained by competent mariners, regardless of the battery bank size or end consumer.

Unique safety considerations
Energy density: Li-ion batteries are used on vessels because their high energy densities allow for longer voyages and full electrification. However, high energy density increases risk because if a fire occurs, it will burn hotter and longer.

Thermal runaway: Upon internal failure or short circuit, Li-ion batteries may release high-temperature flammable gases that can catch fire or explode. The heat output of a fire can increase the rate of off-gassing, and those off-gasses in turn increase the size of the fire in an uncontrolled chain reaction.

Fire suppression resistance: A thermal runaway fire is very difficult to suppress once it has begun to propagate to other battery modules. Instead, fire management strategies focus on early detection, fire containment, and heat absorption with a water-based suppression system.

Toxic off-gasses: In thermal runaway, Li-ion batteries release varied toxic gases, many in excess of their "Immediately Dangerous to Life or Health" thresholds, placing passengers and crew in potential danger. Further, the composition of off-gasses varies dramatically across different Li-ion battery chemistries and manufacturer makes and models.

Battery management: Li-ion batteries will often have a battery management system to prevent degradation from overcharging, undercharging, or over-cycling. Propulsion, electrical loads, topping loads, and recharging cycles are managed by complex integration systems, which are key in mitigating the increased risks of Li-ion battery systems.

Owner and operator guidance
Li-Ion battery identification: Packaged Li-ion batteries often visually resemble traditional lead acid batteries, regardless of type, so the best way to identify them is by reading the nameplate specifications. Li-ion batteries can be identified in a variety of ways depending on electrode, electrolyte, and separator materials. Some common types in maritime use are Lithium Iron Phosphate (LFP), Lithium Nickel Manganese Cobalt Oxide (NMC), Lithium Cobalt Oxide (LCO), Lithium Nickel Cobalt Aluminum Oxide (NCA), and Lithium Titanate (LTO). New chemistries continue to emerge as technology advances.

Plan review: Plan review and proper design testing procedures (DVTPs and PSTPs) should be completed early in the construction process. If plan review and system design testing have not been approved by delivery, marine inspectors may require plan review to be completed through the Marine Safety Center.

Material condition: Batteries should be visually inspected for signs of deterioration, such as bulging cells or corroded electrical connections. Documentation on the completion of required maintenance should be maintained.

Operational and maintenance procedures: Crew members responsible for battery operation and maintenance should be well-trained in the manufacturer's guidelines and operational procedures and familiar with the functioning of the battery management system. They should also know how to respond to abnormal battery conditions or fires. Safety drills for Li-ion battery fires should be performed, and Li-ion battery system arrangements and risks should be taken into account when conducting other drills.

Download the safety alert at **https://bit.ly/4ffBKoQ**.

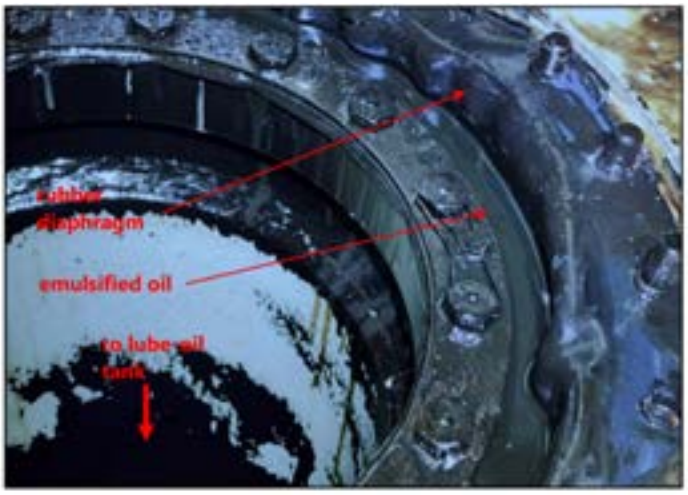


Figure 6: Engine sump showing rubber diaphragm fitted to drain port during dismantling (Source: Wärtsilä technical report)

TAIC warns against deferring ship maintenance after Shiling accident

The New Zealand Transport Accident Investigation Commission has warned against deferred ship maintenance after a ship lost control containership Shiling lost control at Wellington Harbour on 15 April 2023.

On 15 April 2023, the container ship Shiling was under pilotage outbound from the port of Wellington and had just initiated a turn into the Wellington Harbour entrance channel when it suffered a blackout that caused the main engine to stop. The momentum of the turn carried the ship into the shallow waters of Falcon Shoal, where the bridge team succeeded in using both the ship's anchors to stop the ship from grounding.

On 10 May 2023, the repairs having been made, the Shiling departed Wellington bound for Singapore. Because of forecast inclement weather for the Tasman Sea, the master decided to take shelter near the New Zealand coast and wait for about 36 hours for the weather to abate.

Because of the length of time spent at Wellington, the bilge water holding tanks and the engine-room bilges were full, and water had begun to accumulate on the engine-room tank-top . When the Shiling entered the Tasman Sea, it began to roll, and the free water on the tank-top entered the void under the main engine sump , where three rubber diaphragms were located.

The diaphragms linked the main engine sump to the main-engine lubricating oil tank (lube-oil tank) beneath. Their purpose was twofold: to compensate for the relative movement between the main engine and the solid structure of the tank; and to prevent water entering the lube-oil tank.

However, all three rubber diaphragms were in a deteriorated state and allowed the bilge water to enter the lube-oil tank, causing the lube-oil pumps to lose pressure and the main engine to stop. Without the main engine operating, the Shiling was unable to manoeuvre. The ship settled with its beam to the swell and began to roll heavily. With no option for recovering the main engine, the master made a Mayday call. A tow-capable vessel located in the nearby port of New Plymouth responded, initially taking the Shiling in tow to the sheltered waters of Golden Bay and eventually back to Wellington for further repairs.



Figure 7: One of three rubber diaphragms removed from main engine sump

Why it happened

The ship's blackout in Wellington Harbour was caused by exhaust gases from a cracked cylinder liner in one of the generators entering the centralised cooling-water system that supplied cooling water to all generators and the main engine. The running generators tripped out because of high cooling-water temperature and caused the blackout, which subsequently caused the main engine to stop.

Although the ship held valid statutory and classification society certificates, the generators and several other safety-critical systems were found to be in a deteriorated condition. It is very likely that the rubber diaphragms had not been inspected for many years, despite the issuing of several bulletins by insurance clubs and engine manufacturers warning of the critical importance of maintaining the diaphragms in good condition.

The Commission has identified several safety issues relating to the international and domestic systems for regulating international ships and the ability of ship owners to devolve their responsibilities for the safe operation of their ships to third parties without regulatory consequences.

The Commission has made recommendations to Maritime New Zealand to address these matters through the International Maritime Organization (IMO).

Lessons Learned

Deferred ship maintenance, especially of critical equipment and systems, will significantly increase the risk of accidents and incidents. Failures involving critical equipment and systems must be fully investigated for their causes and resolved before the equipment or systems are placed back in service. The creators of risks are best placed to manage them (Committee on Safety and Health at Work, 1972). A ship owner who offers a ship for service must remain responsible for its safe operation, regardless of any other entities involved in operating, inspecting and auditing the ship and its systems.

Download the report at **https://bit.ly/4nf1V2I**.

USCG issues alert on fire detection systems on towing vessels

The U.S. Coast Guard (USCG) has issued a warning regarding issues related to fire detection systems on towing vessels that are not type-approved by the Coast Guard but are instead certified by a Nationally Recognized Testing Laboratory (NRTL).

According to the USCG, even though fire detection systems may be accompanied by a certification letter issued by an authorized entity, a recent Coast Guard investigation revealed that some NRTL approved systems may have potential shortcomings and oversight gaps.

1. A system listed by a NRTL may not be rated/tested for use in a marine environment. Fire detection system components that have not been rated/tested for marine use may be more susceptible to malfunction from exposure to the moisture, temperature fluctuations, vibration, and corrosive agents (such as salt) common in the marine environment.

2. Unlike Coast Guard type-approved fire detection systems, there is currently no process or requirement in place for manufacturers to notify the Coast Guard of design defects and safety recalls for components in non-Coast Guard approved fire detection systems. This greatly increases the chances of defective or recalled components going unnoticed.

3. The certification letters provided to meet the requirements of 46 CFR 142.330 and other documentation for the installed fire detection system may not include a list of the make, model, type, number, or location of devices installed in a vessels fire detection system. Without knowing the specific equipment installed, a company or organization responsible for regulatory oversight cannot determine when a vessel is affected by a critical safety recall, or when modifications have been made to the system that warrant re-certification. Furthermore, a lack of familiarity with installed equipment may lead to improper maintenance, testing, and replacement intervals for critical detection components such as heat or smoke detectors.

The USCG strongly recommends that vessel owners, vessel crew, fire alarm servicing personnel, and third-party surveyors:

1. Ensure that fire detection systems are installed, tested, and maintained in accordance with the manufacturers design manual as required by 46 CFR 142.330.

2. Ensure that, in addition to tests and maintenance required by the manufacturers design manual, fire detection systems be inspected and tested:

   - Annually in accordance with 46 CFR 142.240, and also
   - Undergo testing required for essential systems in accordance with 46 CFR 143.245. This testing should be conducted in accordance with the manufacturer's instructions or as stipulated in the vessels Towing Safety Management System (TSMS) at a frequency of every 3 months.
   - Ensure that vessels have documentation that lists the make, model, type, number, and location of components installed on board the vessel. Ideally, this information should be documented in a letter or included in supplementary compliance documentation such as plans, drawings, or a verified installation parts list, that have been certified and reviewed by an authorized entity as required under 46 CFRÂ§ 142.330 and stamped in accordance with 46 CFR 144.145. This will enable fire detection system companies and regulators to quickly identify components installed on a vessel when safety recalls are issued, and permit servicing personnel to correctly identify the type of maintenance and testing required for installed components.
   - Register all fire detection system components with their respective manufacturer and register for their email and notification lists. This will improve the chances that component manufacturers will contact you regarding any discovered defects and safety recalls.
   - Be aware that non-restorable, fixed-temperature heat detectors cannot be field tested, and manufacturers typically require their replacement every 10 years, or in accordance with National Fire Protection Association Standard 72 (NFPA 72) which requires replacement of such devices every 15 years. Combination rate-of-rise heat detectors have both a rate-of-rise feature and a non-restorable fixed-temperature setting, and the rate-of-rise feature must be tested annually in accordance with manufacturers instructions and/or NFPA 72. These detectors often look the same, and the only way to confirm the type you have is to verify the make and model number printed/labelled on the detector against manufacturers documentation.
   - Visually examine installed detectors during inspections and surveys. Any detectors that are physically damaged or found to have the sensing element painted over should be immediately replaced.
   - When replacing components installed in the fire detection system on inspected towing vessels, unless the new components are the same or those with the same technical specifications (and listed by the manufacturer as compatible with the system), the fire detection system and new components should be re-inspected and re-certified for compatibility by an authorized entity listed under 46 CFR 142.330.

During marine inspections, the USCG will continue to verify fire detection system compliance through visual inspections, records checks, and testing.

Investigation report released on Fremantle Highway disaster



Photo credit: ANP/Marco van der Caaij

The system for responding to incidents in the North Sea needs to be put in order as soon as possible. That will require improved communication and information sharing between the Coastguard Centre and its cooperating organisations on shore. This is the conclusion of the Dutch Safety Board in its investigation of the emergency response to the fire that broke out on board the car carrier Fremantle Highway during the night of 25 to 26 July 2023.

Problems in the emergency response system are not prioritised, because they do not seem serious enough when considered on their own. The vulnerability of the system only becomes apparent when there is a complex request for assistance that demands coordinated action on the part of multiple coordinating organisations in the emergency response chain, both at sea and on shore.

Dutch Safety Board member Erica Bakkum said: "The Dutch Safety Board has repeatedly pointed out in recent years that the Coastguard Centre is insufficiently capable of assuming control when it needs to collaborate with other parties. It doesn't help that several ministries share administrative responsibility for the Coastguard. That setup makes it harder to take rapid action. We therefore advocate the appointment of a mandated director who can coordinate the necessary improvements in the response to emergencies."

In the case of the Fremantle Highway incident, the emergency response focused for a long time on fighting the fire rather than rescuing those on board. In the meantime, seven people jumped overboard and were seriously injured; one of them eventually died. The remaining 16 people on board were ultimately airlifted off by helicopters. The initial focus on firefighting and the limitations in sharing information meant that the Security Regions were not sufficiently prepared for the arrival of the 16 casualties from the helicopters, who also required medical care. There was therefore a delay in transporting them to hospitals in the region.

Safety briefing shorts

Fatigue reliability of offshore wind turbine structures – A case study

Offshore Wind Turbines face relentless environmental forces—especially fatigue from wind and waves - that can lead to costly failures in blades, towers, and foundations. Traditional maintenance methods often fall short in predicting these risks effectively.

Read the paper at **https://bit.ly/4ePZorX**.

IMPA Safety Campaign 2025

The International Marine Pilots Association (IMPA) Safety Campaign 2025 is an annual initiative dedicated to improving the safety of pilot transfer arrangements worldwide.

This year's results reveal that observed non-compliance remains high, at 14%, based on over 5,000 reports received in May 2025. This underscores the ongoing need for strict compliance and shared responsibility among all parties involved.

Read the report at **https://bit.ly/4mkL9xx**.

Denmark launches world's first test program for remote pilotage

Danelec and DanPilot have partnered up to unveil a test program for the world's first data-driven remote pilotage. After six years of development and approved by the Danish Emergency Management Agency, the test program created by DanPilot and Danelec allows pilots to guide ships from land, using only data transmitted directly from the vessels.

The aim is to improve pilot safety and reduce fuel consumption for ships without compromising navigational safety. Furthermore, the approval has been granted as part of a broader effort to enhance safety and preparedness at sea. The test will serve as a foundation for future regulation and possible broader application, both nationally and internationally.

Incorrect storage and handling of 'jumbo bags' can lead to significant claims

The London P&I Club has renewed its warning to shipowners, operators, and charterers over the risks linked to loading dry chemicals in Flexible Intermediate Bulk Containers (FIBCs), or 'jumbo bags' with the launch of a new video that provides loss prevention advice.

The alert follows several incidents involving cargo fires and damage—particularly on bulk carriers and general cargo ships, with many cases reported at Chinese ports. The Club warns that failure to strictly comply with all relevant International Maritime Organization (IMO) regulations and guidance governing the storage and handling of jumbo bags could even prejudice P&I cover.

Watch the 8 minute YouTube video at **https://youtu.be/e0SEQkCFIbo**.

PFOS banned in fire-extinguishing media from January 2026

Lloyd's Register (LR) has issued a regulatory update stating that, from January 1st, 2026, the use or storage of fire-extinguishing media – including firefighting foams – containing perfluorooctane sulfonic acid (PFOS) will be prohibited. This applies to both fixed and portable systems and equipment.


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THE REPORT

The Magazine of the International Institute of Marine Surveying

DEC 2025 | ISSUE 114

The following Safety Briefings are taken from Issue 114 of The Report magazine



DECEMBER 2025

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The manual release of the extinguishing system, the fuel shut-off valves and other switches could no longer be reached.

The survey identified sprung and rotten hull planking and the certificate held by the vessel Elaine was not renewed. The craft did not hold a valid certificate for the voyage undertaken on the day of the grounding.

The skipper was not wearing a PFD and it would have taken considerable effort to remain afloat in the developing swell.



Tokyo MOU on maintenance and rigging of pilot transfer arrangements

Tokyo MOU has reinforced an awareness of the potential risks associated with the improper maintenance and rigging of pilot transfer arrangements. Therefore, they released a guidance on maintenance and rigging of pilot transfer.

Tokyo MOU has reported that recent reports and Port State Control (PSC) inspections have highlighted recurring issues related to pilot ladders and hoist/pilot transfer arrangements, the improper rigging of pilot transfer arrangements.

In 2020, there were 197 deficiencies, and 1 detention related to pilot transfer arrangements. By 2024, these numbers had risen sharply to 523 deficiencies and 12 detentions. This significant increase is a cause for concern and underscores the urgent need for ship's crew and operators to take prompt corrective action.

Despite previous safety bulletins addressing concerns such as the use of D-shackles for securing the pilot ladders, several other issues continue to persist.

These include:

- Failure to properly secure pilot ladders and accommodation ladders to the ship's side
- Inadequate securing of stanchions with locking pins
- General complacency regarding ladder maintenance
- Lack of clear identification and differentiation between pilot ladders and other types of ladders

These repeated issues suggest a need for improved crew training and awareness regarding pilot ladders and pilot transfer arrangements. Separately, a Focused Inspection Campaign (FIC) was also carried out by the Tokyo MOU member Authorities in February 2025 on Pilot Ladders/Pilot Transfer Arrangements. During the campaign period, a total of 2,357 inspections were conducted. Three ships were detained and 176 deficiencies related to the FIC were identified on 169 ships.

Read the guidance note at **https://bit.ly/4qIsHly**.

Industry-first AI Cargo Safety Program launched

The World Shipping Council (WSC) has launched its new Cargo Safety Program – an industry-led initiative to detect misdeclared and undeclared dangerous goods.

It aims to prevent ship fires, protect crews, vessels, customers' cargo, and the marine environment.

The program combines AI-powered cargo screening and common inspection standards to identify misdeclared and undeclared high-risk shipments before they are loaded.

Ship fires are at their highest level in over a decade, according to Allianz's Safety and Shipping Review 2025. Misdeclared dangerous goods are a leading cause of ship fires, reported as responsible for more than a quarter of all cargo-related incidents.

"We have seen too many tragic incidents where misdeclared cargo has led to catastrophic fires, including the loss of life," said Joe Kramek, President and CEO of the World Shipping Council. "The WSC Cargo Safety Program strengthens the industry's safety net by combining shared screening technology, common inspection standards, and real-world feedback to reduce risk."

At the heart of the program is a digital cargo screening tool powered by the National Cargo Bureau's (NCB) technology. It scans millions of bookings in real time using keyword searches, trade pattern recognition and AI-driven algorithms to identify potential risks. Alerts are reviewed by carriers and, when needed, verified through targeted physical inspections.

The program also establishes common inspection standards for verifying shipments and an incident feedback loop to ensure lessons from real-world cases strengthen prevention. At launch, carriers representing more than 70 percent of global TEU capacity have joined the program.

Find out more at **https://bit.ly/493e0U0**.





Beware of the fire risks in scrap metal cargoes

NorthStandard P&I Club has issued guidance on the rising fire risks associated with scrap metal cargoes, particularly those coming from East Coast USA and Ghent, Belgium. They highlight the need for strict vigilance.

Scrap metal cargoes: Follow the code
'SCRAP METAL' is a bulk cargo shipping name (BCSN) found in the IMSBC Code. It is a Group C cargo but it must not contain fine metal turnings known as 'swarf'. If it does contain swarf, then it would likely fall under the schedule 'FERROUS METAL BORINGS, SHAVINGS, TURNINGS or CUTTINGS UN 2793', which is a Group B cargo.

The causes of these incidents appear to be due to a combination of factors:

- The cargo is sprayed on loading: Stevedores or longshoremen may spray the cargo on load to reduce dust generation.
- The cargo is loaded during rain: Sometimes there is a request to load the cargo in rain, with shippers/ charterers offer to issue a 'rain letter' in exchange for owners agreeing to continue loading. This should be resisted as P&I cover is at risk where an owner loads or discharges a cargo in the rain in circumstances where it was entitled to refuse to do so. In such circumstances a rain letter, under which the issuer indemnifies the carrier against the consequences of loading or discharging in the rain may stand as an alternative to cover.
- The cargo contains swarf. Often there is a large proportion of swarf, cuttings, borings and shavings in the cargo which means that the cargo does not meet the requirements to be considered a Group C 'SCRAP METAL' cargo.
- The cargo contains contaminants. Typically, the cargo is contaminated with rags or timber. However, more recently in Ghent there have been more instances of lithium batteries being found in the cargo. The presence of these contaminants significantly increases the risk of fire once heated. On one occasion issues were caused by a scrap metal cargo containing gas canisters which still contained flammable gas.

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The stevedores were unable to understand safety labels and warnings and cargo space identification.

The flexible hose installed in the fuel system during a modification did not meet the required standard, was fitted in an inappropriate position, and had not been subject to approval or oversight by the responsible classification society.

Atmosphere testing of cargo spaces was not routinely carried out before stevedores entered the compartments.

NTSB alerts land-based firefighters to risks of vessel fires

The U.S. National Transportation Safety Board (NTSB) has issued a safety alert urging greater awareness and training for land-based firefighters who may be called to fight fires aboard vessels in local ports.

The safety alert follows several NTSB investigations into deaths and injuries to firefighters.

The NTSB found land-based firefighters often lack the necessary training and familiarity with vessel layouts and fire protection systems to effectively fight in-port vessel fires. They also may be unaware of how to use the structural fire protection built into most commercial vessels.

NTSB recommends fire departments that serve ports improve the safety of their firefighters when responding to vessel fires by:

- Developing training plans to ensure all firefighters understand how to fight vessel fires, including the resources needed, the best tactics, strategies and methods for communicating while on a vessel and with vessel crew, and vessel layouts
- Identifying supplemental training areas and developing a training plan and operational procedures in reference to National Fire Protection Association publication 1405: Guide for Land-Based Fire Departments that Respond to Marine Vessel Fires, and NFPA 1010: Standard on Professional Qualifications for Firefighters (formerly NFPA 1005: Standards for Professional Qualifications for Marine Fire Fighting for Land- Based Fire Fighters)
- Working in advance with local ports to organize vessel familiarization tours and to coordinate vessel firefighting response preparedness and training in conjunction with the drills and exercises required for certain vessels
- Coordinating with the U.S. Coast Guard on standard operating procedures during emergencies
- Learning from the circumstances of other in-port vessel fires to improve contingency planning

The safety alert cited three vessel fires the NTSB has investigated that resulted in land-based firefighters injured due to the firefighters' lack of training in vessel firefighting.

Most recently, the NTSB investigated the 2023 fatal fire on the roll-on/roll-off container vessel Grande Costa D'Avorio in Newark, New Jersey. The Grande Costa D'Avorio was docked at Port Newark when a vehicle used by shoreside workers to push used vehicles onto the vessel caught fire on an interior garage deck. While attempting to put out the fire, two land-based firefighters were unable to find their way out of one of the smoke-filled garage decks and died. Newark Fire Division leadership directed the firefighters to actively engage the fire in the fire protection zone where the carbon dioxide gas extinguishing system had already been activated, which allowed more carbon dioxide out and more oxygen in, increasing the severity of the fire.

The NTSB found the Newark Fire Division's lack of marine vessel firefighting training resulted in an ineffective response, led to the firefighter casualties, and contributed to the severity of the fire.

Read the safety alert at **https://bit.ly/3LGJwx8**.



TSB says cracked exhaust silencer cause of fishing vessel fire

A 30cm crack along the main engine exhaust silencer led to a fire on board scallop fishing vessel Fundy Leader, according to the Transportation Safety Board of Canada (TSB).

On 06 December 2024, the fishing vessel Fundy Leader, with 13 people on board, was reported having sustained a fire 100 nautical miles southwest of Cape Sable, Nova Scotia. The crew extinguished the fire, and the vessel was escorted to Shelburne, Nova Scotia, by the Atlantic Preserver, and later by the Canadian Coast Guard ship Sir William Alexander. There were no injuries.

Origin of the fire
Data collected post-occurrence indicated that the source of ignition originated from a crack in the main engine exhaust silencer. The crack was approximately 30 cm in length and near the top of the silencer, on the side that faced the bulkhead separating the exhaust trunking from the cabin. Low-flame-spread wall panelling was attached to the wood framing on the side of the bulkhead facing the cabin.

In this occurrence, hot exhaust gases were escaping from the cracked silencer and heating up the steel on the bulkhead, which was less than 10 cm away. By conduction, the heated steel ignited the wood framing and caused the fire.

Structural fire protection
The Large Fishing Vessel Inspection Regulations require certain areas of large fishing vessels to have low-flame-spread characteristics. The Fundy Leader met the requirements of the Large Fishing Vessel Inspection Regulations for low-flame-spread characteristics.

Inspecting exhaust pipes
The main engine exhaust pipe (including the silencer) was covered with a type of lagging that could not be removed without damaging the lagging. The pipe was located next to a generator exhaust pipe. Both pipes were in a small area adjacent to the bulkhead, which meant that it was difficult to visually inspect the entire circumference of either. Exhaust trunking on fishing vessels typically provides limited access to exhaust pipes.

Large fishing vessels like the Fundy Leader fall under Transport Canada's Delegated Statutory Inspection Program and are subject to periodic inspections by recognized organizations. At the time of the occurrence, the Fundy Leader was certified by the recognized organization Lloyd's Register, on behalf of Transport Canada. Exhaust pipes and silencers may be inspected by recognized organizations for signs of damage, leaks, and degradation, but this is typically limited to a visual inspection without removing the lagging. The last inspection conducted by the recognized organization was on 15 October 2024. During this inspection, the exhaust pipes and silencers were observed to have intact lagging.

It was not possible to determine how long the crack in the silencer had been present on the Fundy Leader prior to the occurrence. Some signs of a crack in a silencer may include visible discolouration of lagging or increases in noise, exhaust odours, or heat. The master and the crew members on the Fundy Leader were unaware of the crack in the silencer before the occurrence. The silencer was original to the construction of the vessel.

Vessel exhaust pipes and silencers may pose a fire hazard in the event they sustain cracks or other failures. It is important that vessel owners and masters ensure these pipes and silencers are inspected and maintained regularly and that vessel builders design exhaust trunking and lagging to facilitate access to pipes and silencers for inspection and maintenance.

Download the report at **https://bit.ly/4qGmZkb**.

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The investigation revealed that the operator failed to perform a thorough safety assessment.

Throughout the period that the flexible fuel hoses were in place on the vessel, none of the inspections or surveys conducted by classification surveyors and the ships engineers identified the noncompliance or potential risk from such an installation.

Although the mate had prior experience, they lacked formal training in mast and wood inspection.



Jean Elaine, dive support vessel not certified for operation, says MAIB report

A dive support vessel, Jean Elaine, which grounded in the Scotland in 2024 was not certified for operation at the time of the accident said a report published by the UK Marine Accident Investigation Branch (MAIB). On 22 July 2024, the dive support vessel Jean Elaine grounded on a falling tide in Saint Peter's Pool in the Orkney Islands, Scotland. The vessel developed a severe port list and suffered water ingress. Despite efforts to save the vessel, it was ultimately abandoned. There were no injuries or fatalities.

At the time of the accident, Jean Elaine was not certified for operation and the skipper's certificate of competence had expired. Heriot-Watt University, which was using the vessel for a research project, had not verified validity of the vessel or crew certification before its use.

The investigation identified that the accident occurred due to a lack of adequate planning and ineffective communication between the skipper and research team. The incident also highlighted the importance of effective oversight, risk management, and adherence to regulatory requirements when operating vessels in support of educational or scientific activities.

In May 2019, Jean Elaine was surveyed to the requirements of Marine Guidance Note (MGN) 280 (M): Small Vessels in Commercial Use for Sport or Pleasure, Workboats and Pilot Boats – Alternative Construction Standards published by the Maritime and Coastguard Agency (MCA). The vessel was certified as an Area Category 2 workboat, permitting it to carry up to 12 passengers a maximum of 60 nautical miles from a safe haven. The certificate was valid until 28 April 2024.

On 29 April 2024, Jean Elaine was examined out of the water for the renewal of its certificate. The examination was carried out by MECAL Ltd, a certifying authority authorised by the MCA to survey and certify vessels under MGN 280 (M). The survey identified sprung and rotten hull planking (Figure 3) and the certificate held by Jean Elaine was not renewed. The suspension of certificate notice issued by MECAL Ltd to the skipper of Jean Elaine stated that, While this suspension notice is in force, the vessel must not operate commercially.

Jean Elaine did not hold a valid certificate for the voyage undertaken on the day of the grounding.

Read the report at **https://bit.ly/3Lqja2o**.

NTSB report says lithium-ion battery bank cause of yacht fire



The US National Transportation Safety Board (NTSB) has said in a report that inoperable battery management systems was the probable cause of a fire on yacht Flagship last year.

On April 28, 2024, at 1031 local time, a fire started on board the uncrewed yacht Flagship while it was docked at an enclosed bay of a shipyard on the Miami River in Miami, Florida. Shoreside firefighters moved the vessel to a nearby sea wall, where they extinguished the fire. The vessel eventually sank at the sea wall. There were no injuries, and no pollution was reported. The Flagship was declared a total loss, valued at $5 million.

Investigation

The NTSB report said the yacht Flagship was docked with no personnel on board at a shipyard on the Miami River in Miami when an explosion and fire occurred. Shoreside firefighters moved the vessel to a nearby sea wall, where they extinguished the fire. The vessel eventually sank at the sea wall.

The video from the security camera at the shipyard showed an explosion at 1031 that originated from the hatch for the space below the floor where the 24-volt lithium-ion battery bank was located. The explosion expanded from the hatch and into the interior of the vessel. Following the explosion, smoke and fire were visible on the Flagship, and the fire continued to grow, eventually engulfing the entire vessel. Investigators later identified extensive damage to the aluminum deck and hull structure in the area around and above the location of the 24-volt lithium-ion battery bank. Based on the security video and the location of the most extensive fire damage, a lithium-ion battery cell within the 24-volt battery bank was most likely the initiating source of the explosion and fire.

Since the vessel's arrival in the US, the BMSs for the battery banks of the 24-volt system and the three 48-volt battery systems were inoperable; they did not safely monitor and maintain the charge level of the batteries. This problem with the BMSs was not immediately resolved. In the interim, the vessel manufacturer, shipyard personnel, an electrician, and the vessel owner's representative developed a new procedure to increase the charging speed of the lithium-ion batteries by bypassing the BMS of each battery bank. A wire was attached to bypass each BMS so the batteries could be manually charged at a faster pace by an external charger. As a result, the charge level within the vessel battery banks was not automatically maintained by the BMSs, and, due to an unidentified electrical drain within the vessel, the batteries became fully discharged (0% charge) on several occasions for extended periods. In addition, routinely charging the batteries using a portable battery charger could have resulted in overcharging, since the external battery charger was not connected to and monitored by a BMS and the battery charge level was instead monitored by personnel at the shipyard. Therefore, the practice of externally charging the lithium-ion batteries without resolving the BMS issues resulted in fluctuations in the level of charge on the battery bank.

Extensive fluctuation in the level of charge within the batteries may have caused one of the cells to become unstable, eventually resulting in thermal runaway. A thermal runaway occurs when a battery cell overheats and combusts; it is a chemical reaction that can occur to any type of battery cell if it is damaged, shorted, overheated, defective, deep discharged, or overcharged. The heat produced from a thermal runaway of a lithium-ion battery cell can exceed 1,100°F, which can easily cause the adjoining cells of the same battery bank to ignite, as well as cause significant damage to aluminum structures. Lithium-ion battery cell explosions are typically caused by a thermal runaway. Therefore, the explosion on the Flagship was likely the result of one of the cells of the 24-volt battery bank undergoing a thermal runaway.

Probable Cause

The National Transportation Safety Board determines that the probable cause of the fire on the yacht Flagship was the thermal runaway and explosion of the 24-volt lithium-ion battery bank due to the inoperable battery management systems, resulting in the practice of manually charging the lithium-ion batteries with a portable battery charger, which compromised the safe monitoring of the vessel's lithium-ion battery systems.

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The ship's crew were insufficiently trained to inspect engine fuel systems.

It is very likely that the rubber diaphragms had not been inspected for many years, despite the issuing of several bulletins by insurance clubs and engine manufacturers warning of the critical importance of maintaining the diaphragms in good condition.

A fitting on a fuel injection return line loosened and disconnected, creating a fuel spray.



Hong Kong SAR lessons learned on enclosed space death

The Marine Department of the Hong Kong Special Administrative Region (SAR) has shown the results of an investigation into a death in an enclosed space on cargo ship Seren last year.

The vessel was anchored at the Suez anchorage. A team of shore workers was employed to clean the FOT and then repair the ruptured bulkhead of the FOT, which was damaged during the cargo loading operation at the last port. Following the toolbox meeting between the ship crew and the shore cleaning team, the cleaning operation commenced and continued intermittently. In the early hours of the fourth day, two shore workers rushed out of the FOT and reported that a fellow worker had been injured inside the FOT. Upon being notified of the incident, the foreman immediately entered the FOT in haste, carrying a flashlight and wearing a breathing apparatus mask. Under the ship crew's effort, the injured worker was successfully rescued from the FOT about three hours later. He later regained consciousness. However, the foreman could not be found inside the FOT until around five hours after he had entered it. He was eventually rescued from the lower platform of the FOT but showed no vital signs.

The investigation revealed that the main contributory factors leading to the accident were:

- the ship crew, the safety engineer of the shore cleaning team and the foreman failed to strictly follow the safety requirements for enclosed space entry and did not carry out a detailed risk assessment for the cleaning operation in accordance with the shipboard safety management system (SMS);
- communication between the ship crew and the shore cleaning team, or among the team members themselves during the cleaning operation was ineffective; and
- both the foreman and the shore workers demonstrated a lack of safety awareness and underestimated the risks and potential hazards associated with enclosed space entry.



UK MAIB report into engine room fire on Finnmaster published

The UK Marine Accident Investigation Branch has released its findings and issued 12 recommendations in a report into a auxiliary engine room fire on the Finnmaster Ro-Ro cargo ship as it departed a UK port in 2021.

At 2013 on 19 September 2021, a fire broke out in the auxiliary engine room on the Finland registered roll-on/roll-off cargo ship Finnmaster during departure from Hull, England. Finnmaster lost power, but the fire was later extinguished and the vessel safely re-berthed with the assistance of tugs. The auxiliary engine room was significantly damaged but there were no injuries.

The investigation found that:

- The fire started after mechanical failures on one of the auxiliary engines allowed fuel to leak from a flexible hose onto a hot surface where it ignited.
- The flexible hose was installed in the fuel system during an unapproved modification and did not meet the required standard.
- A fault in Finnmaster's emergency generator circuit breaker prevented it from supplying power to the emergency systems on board.
- The fixed carbon dioxide fire-extinguishing system failed to fully operate due to defects in the system.
- The crew's response, affected by the loss of critical safety systems, was ineffective.

Download the report at **https://bit.ly/47nQYG5**.

China MSA releases report into explosion onboard the YM Mobility

On 9 August 2024, a major explosion occurred aboard the container vessel YM Mobility at the Beilun Second Container Terminal in Ningbo-Zhoushan, China. The explosion originated from a container near the bow, loaded with dangerous goods. Although declared by the shipper as a reefer container used as a substitute for a dry container, it was not connected to a power supply. The incident resulted in an estimated economic loss of approximately CNY 90 million (US$13 million).

According to the China Maritime Safety Administration (CMSA), the container held tert-Butyl peroxybenzoate (TBPB), a thermally unstable compound capable of self-decomposition at room temperature, releasing significant heat and gas. The unplugged reefer, which lacked adequate heat dissipation, allowed heat from the TBPB's self-decomposition reaction to accumulate. This triggered a thermal runaway, leading to the explosion and subsequent fire.

The CMSA also linked the incident to extreme summer temperatures. When TBPB was packed in Shanghai on 25 July, the ambient temperature was around 35°C. From that date until the explosion on 9 August, both Shanghai and Ningbo experienced sustained high heat, with daytime temperatures reaching up to 40°C.

Containers stored outdoors would have been exposed to even higher temperatures, exacerbating the risk by raising the internal temperature of the unplugged reefer, increasing the chance of decomposition and explosion during transport.

The investigation revealed that the operator failed to perform a thorough safety assessment. No consideration was given to the compound's thermal sensitivity, seasonal temperature extremes, or the heat retention properties of an unplugged reefer. By approving the use of this container type for TBPB, the operator overlooked the serious temperature-related hazards.

Image : China MSA investigation report



EXTRACTS FROM
ACCIDENT REPORTS

It is virtually certain that the way the rudder pintle assembly was reinstalled did not ensure that the pintle would remain in place during normal shipboard operations.

The report determines that the probable cause of the container loss aboard the containership was the input of incorrect cargo weight for 39 containers when the cargo loading plan was developed by shoreside planners, resulting in the containers being loaded in overweight and reverse-stratified stacks, causing cargo-securing equipment to fail while the vessel was drifting.

IMCA releases annual eCMID Inspection Findings and Quality Assurance Report to highlight key safety trends

IMCA has published its annual eCMID Inspection Findings and Quality Assurance Report, offering a comprehensive review of vessel inspection results and quality assurance processes for the 2024/25 period. The report continues to serve as a vital resource for the offshore industry, highlighting immediate priorities and mapping a long-term course for safety and compliance.

The eCMID system, comprising both the eCMID Vessel Inspection and the eCMID Small Vessel Inspection, recorded a significant rise in inspection activity. Figures to April 2025 show a 16% increase in inspections year-on-year, reflecting greater industry engagement with IMCA's safety and assurance initiatives.

Based on a total of 1,896 inspections conducted over the period, the eCMID Inspection Findings and Quality Assurance Report shares valuable insights into vessel compliance across a range of categories.

Read the annual report at **https://bit.ly/3XaoUzX**.



IUMI best practice for safely transporting EVs

IUMI has released an update to its best practice and recommendations for safely transporting EVs.

In 2023, IUMI published a set of best practice and recommendations for the safe carriage of electric vehicles. This was part of its ongoing support of loss prevention guidance to the global marine insurance and shipping sectors.

In September 2025, IUMI issued an updated version titled "Risk mitigation for the safe ocean and short-sea carriage of electric vehicles".

Several parts of the paper have been updated and new content added, for instance:

- risks related to potential gas accumulation;
- information on total energy release and peak temperatures;
- challenges with PCTC ship design;
- the "Fixed First" approach for PCTCs; and
- limitations of foam-based extinguishing systems.

A list of key points has been added at the end which summarizes the main findings in one page.

Download the document at **https://bit.ly/3JGGNTU**.



Insulation on turbocharger showing gaps in the way the insulation had been installed on the turbocharger outlet from the side (Source: TSB)

Cuyahoga engine room fire report by Canada TSB

The Transportation Safety Board of Canada (TSB) has published its investigation report into the engine room fire onboard the bulk carrier Cuyahoga that occurred in May 2023. The Cuyahoga was loaded with granular crushed stone as she left Marblehead, Ohio, U.S., bound for Kingsville, Ontario on Lake Erie. Almost three hours into the voyage, a fire ignited in the engine room. The crew initiated an emergency response, cut the fuel supply to the main engine, and attempted to activate the CO2 fixed fire suppression system remotely, without success. An attempt to locally activate the fixed fire suppression system also failed and resulted in the cylinder room flooding with CO2. Due to the cessation of fuel flow, the engine stopped, and the fire extinguished itself soon after.

Findings as to causes and contributing factors in the Cuyahoga incident
These are the factors that were found to have caused or contributed to the occurrence:

- The retaining clamps on the fuel injection lines were not in place, increasing the fuel lines' exposure to the effects of engine vibration.
- Rectifying the fuel injection line leaks was incorporated into routine maintenance tasks. Consequently, there was no evaluation of the cause of the repeated leaks.
- Without accurate, documented procedures available to them, crew members developed their own practices for managing fuel injection line leaks; this led to fittings not being adequately tightened to resist the vibration-loosening process. As a result, these deviations from the manufacturer's instructions likely contributed to the loosening of the fittings.
- A fitting on a fuel injection return line loosened and disconnected, creating a fuel spray.
- Gaps in the insulation exposed hot surfaces on the exhaust gas piping at the turbocharger outlet, and the fuel spray ignited on contact with those surfaces.
- The remote release cables for the fixed fire suppression system were located in an exposed location in the engine room and were damaged by the fire. Consequently, the cables failed and carbon dioxide (CO2) was not discharged into the engine room, requiring a crew member to attempt a local release.
- Unknown to the crew, an isolation valve in the fire main piping was corroded and it obstructed the flow of water to the fire.

Safety action
During the repairs to the carbon dioxide (CO2) fixed fire suppression system, the remote cables between the engine room access door and the cylinder compartment were routed outside of the engine room along the deck and skylight on the boat deck. The instructions for operating the CO2 system controls were modified, directing the crew to operate the directional stop valve before operating the control heads on the cylinders.

Read the report at **https://bit.ly/4hElT4k**.

New guidelines to enhance efficiency of container stowage



ClassNK has released new guidelines for those involved in container shipping, aiming to enhance the efficiency of container stowage while ensuring safety measures such as preventing cargo collapse.

According to ClassNK, these guidelines apply the latest expertise in weather forecasting, ship motion, and digital twin technologies. The newly released guidelines enable safer and higher-capacity container shipping by optimizing stowage based on weather forecasts for short-term voyages and by taking advantage of the roll reduction effects of anti-rolling devices.



Guidelines for the safety of maritime cargo based on weather forecasts
Route selection based on metocean information is one of the key factors in the safe transportation of cargo. Although weather forecasts are a valuable source of information when the forecast period is sufficiently short, it is necessary to take their uncertainties into account to ensure safety. However, there have been no specific standards until now, and each company has handled it individually.

By clarifying the correlations between the AIS records accumulated by ClassNK, over one million cases of past metocean data, and actual sea conditions through big data analysis, this guideline specifies new technical requirements for uncertainty qualification of weather forecast values and safety assessments of cargo, and describes corresponding standard evaluation methods.

In addition, this guideline also specifies a calculation method for a load correction factor based on weather forecasts for short-term voyages, related to container loading and lashing strength assessments for container carriers. By applying this guideline, safe and optimized stowage operations can be achieved in short-term voyages based on weather forecasts.

Guidelines for anti-rolling devices
Anti-rolling devices such as anti-rolling tanks have been increasingly installed on cargo ships in recent years for the purpose of improving safety, comfort, and work efficiency by reducing ship rolling. With growing concerns about cargo collapse accidents, attention to anti-rolling tanks has increased. While their installation on large merchant ships has started to spread, there have been no common safety standards so far.

This guideline specifies technical and inspection requirements for anti-rolling devices installed on ships, making use of the expertise on ship motions gained during the development of the Guidelines for Parametric Roll Countermeasures, and sets out a method for evaluating the effect of anti-rolling tanks on reducing roll motion.

By applying this guideline, safe container stowage operations considering the roll reduction effects of anti-rolling devices can be realized.

Guidelines for container stowage and securing arrangements (Revised)
The Guidelines for Container Stowage and Securing Arrangements (Edition 3.0), released in 2023, has contributed to balancing safety and economic efficiency by enabling optimized stowage operations that take into account the effects of routes and seasons, in response to the enlargement of container ships and advances in lashing technology.
With the release of the guidelines on weather forecasts and anti-rolling devices, the related requirements have now been revised to enable container stowage that also reflects these factors.

Download the new guidelines at **https://bit.ly/48W5Nkm**.

Fires dominate 2025 major claims, says Cefor



Cefor, the Nordic Association of Marine Insurers, has released the 2025 mid-year hull report with the latest fleet and casualty trends, plus a special focus on fires as fires dominate 2025 major claims.

In the report, fires represented the four costliest losses by end of June. It added 2025 is the third consecutive year with claims above USD 50 million, after a benign period 2015-2022 with only an occasional claim exceeding $30 million USD. Fires had significant impact in the first half year of 2025. Four out of seven claims above $10 million USD were fires and the costliest claims.

The report highlighted:

- A burning issue – Fires dominate 2025 major losses. 4 claims exceeding $20 million USD were reported by 30th June, far more than the ten-year average of 1.5 claims per 6 months. All 4 claims were fires. Since 2015, 16 out of 26 claims in all above $20 million USD were fires, thus representing the highest share of the costliest claims (62%). Other claims in that cost range typically are navigational-related (collisions, groundings, contact), and only occasionally another type. Another aspect is that 11 of in all 16 fires above $20 million USD reported since 2015 hit vessels older than 20 years – illustrating the risk of an ageing fleet.
- Third consecutive year with elevated claims costs. A combination of repair cost inflation and the return of major losses drove up claim costs from 2020 to 2023. While the increase seems to flatten out, 2024 and 2025 claims costs stay at a similar level as in 2023.
- The silver tsunami rolls on. The ageing of the world fleet continues, rolling wave-like through the NoMIS portfolio. While old vessels may be well maintained, from a statistical perspective old vessels are more prone to fires, machinery claims and consequential damages.
- Engine-room fires: highest occurrence on the oldest vessels and in the passenger, container and car/RoRo segment. While headline losses often are about fires caused by dangerous cargo, especially on container or car/RoRo vessels, engine room fires do not need less attention. An ageing fleet heightens the risk of machinery-related problems. Chapter 4 therefore dives into that issue.

Read the report at **https://bit.ly/3LIcSex**.

Global Shipping Business Network report argues that dangerous goods reshape the fires at sea landscape

The Global Shipping Business Network report focuses on the risk mitigation of the transportation of lithium-powered products in the maritime industry, which finds itself under increasing pressure to safely transport larger volumes of dangerous goods, which have reshaped the fires at sea landscape.

According to the Global Shipping Business Network report "Fires at Sea, A New Landscape – Risk Mitigation Strategies for Safe Transport" dangerous goods (DG) given their potential consequences, have received significant attention in conversations surrounding cargo handling.

For some special categories of hazardous non-dangerous goods, such as lithium batteries, existing guidelines cannot fully mitigate the risks associated with improper handling.



In the case of lithium batteries, mechanical damage, thermal stress, or overcharging can trigger the release of toxic, flammable and explosive gases, among other issues. Furthermore, fires caused by these batteries are uniquely dangerous due to their rapid and intense nature. Additionally, the toxic gases released pose serious health risks to the crew.

Of particular concern to insurers and the shipping industry at large is the risk of thermal runaway — a rapid, self-sustaining fire that can lead to explosions.

Read more on page 92 or download the report at **https://bit.ly/4nWuKA9**.


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This section of the Compendium is dedicated to a series of bulletins, articles and loss prevention advice and guidance that has been developed and published by the major P&I Clubs, and subsequently posted on the IIMS website during 2025. IIMS greatly values and appreciates the output from the P&I Clubs and is only too happy to share it with those involved in the maritime world. We have linked the headlines to the original story, so it is easy to access the content should you want to read the detailed information.



Loss prevention articles published on the IIMS website



Cashew nutshell marine biofuel warning sent out

Several ships in Singapore and Rotterdam have recently reported issues after using cashew nutshell marine biofuel. Reported operational problems included fuel sludging, injector failure, filter clogging, system deposits and corrosion of turbocharger nozzle rings.

Read the full story at **https://bit.ly/4126ioh**.



Proactive measures to mitigate fire hazards including thermal imaging

The American P&I Club urges operators to implement proactive measures such as maintenance and thermal imaging to mitigate fire hazards. Thermal imaging inspections are highlighted as an effective tool by the American Club in identifying early heat signatures caused by electrical faults, which could escalate into a fire if left unchecked.

Read the full story at **https://bit.ly/45uERoz**.



Best practices to avoid bunker quantity disputes

Britannia P&I Club has emphasized the importance of understanding the various bunker delivery methods and establishing reliable, transparent relationships with reputable suppliers. According to Britannia, bunker quantity disputes pose a common challenge in the maritime industry, arising from disagreements between the supplier and the receiver regarding the amount of bunker fuel delivered.

Read the full story at **https://bit.ly/41BWZeN**.

ABS reminder on firefighting suits

The American Bureau of Shipping (ABS) has sent out a reminder on appropriate firefighting suits. It is essential for shipowners to equip their crew with suitable firefighting gear to ensure the preservation of lives and vessels in the event of a fire. Appropriate equipment should enable crew members to effectively combat fires in open-air environments and enclosed spaces, all while ensuring their personal safety.

Read the full story at **https://bit.ly/4fwrMQ8**.

IACS interpretation on hydrocarbon gas detection

The International Association of Classification Societies (IACS) published a new Unified Interpretation UI SC307 on hydrocarbon gas detection and bilge high level alarms in cargo pumprooms. The UI is set to be implemented by IACS societies on ships contracted to be built on or after 1 January 2026. The interpretation says: Characteristics of the cargoes and their vapours should be taken into consideration to determine the type and arrangement of detectors.

Read the full story at **https://bit.ly/3HubIlb**.

Fire damper location importance highlighted in circular

Companies should review the placement and labelling of fuel quick-closing valves and assess the operation of fire dampers, advises the Norwegian Maritime Authority. The recommendation comes following a fire on a Norwegian vessel. During the incident, quick-closing valves were used to shut off the diesel supply to the auxiliary and main machinery. However, the control handles for the quick-closing valves for the emergency generator were located in the same cabinet, leading to the unintended shut-down of the emergency generator.

Read the full story at **https://bit.ly/45L2Lx6**.

MAIB voices “serious concern” over Red Sea dive boat accidents

The UK Maritime Accident Investigation Branch (MAIB) has shared an update on Red Sea dive boat accidents.

The MAIB has been notified of three accidents within the last 20 months affecting UK citizens on Egyptian dive boats operating in the Red Sea.

Read the full story at **https://bit.ly/4m7eUST**.

Proper stowage of mixed cargoes on bulk carriers

The American P&I Club has raised concerns that have arisen regarding the loading of finished and unfinished steel products alongside break-bulk, containerized, and project cargoes in the same cargo hold of bulk carriers. Examples of break-bulk, containerized, and project cargoes include large, heavy, oversized items, machinery parts, crates, and heavy-duty wheeled items such as trucks, cranes, or pay loaders. Unlike vessels dedicated to carrying break-bulk, containerized, or project cargoes, bulk carriers are not fitted with suitable lashing and securing arrangements.

Read the full story at **https://bit.ly/45xTEPi**.

PUBLISHED IN JANUARY 2025

Carriage of plastic pellets by sea in freight containers

The Liberia Maritime Authority has sent out recommendations for the carriage of plastic pellets by sea in freight containers. These recommendations are the first step in a two-stage approach aimed at reducing the environmental risks associated with the carriage of plastic pellets in packaged form by sea, pending IMO’s consideration of future mandatory measures for their carriage.

Read the full story at **https://bit.ly/4mFfgQB**.



U.S.C.G. releases Lithium Battery Guide for Shippers

The United States Coast Guard has published a helpful compliance resource, Lithium Battery Guide for Shippers. The publication aims to assist shippers to safely package lithium cells and batteries for transport by all modes, including vessel shipments, with new regulatory requirements based on cell or battery configuration as well as Watt-hour (Wh) rating.

Read the full story at **https://bit.ly/4m4JEUF**.



Counterfeit pilot ladders lead to USCG warning

The United States Coast Guard (USCG) has issued a safety alert after discovering counterfeit pilot ladders during a Port State Control examination at the Port of Baltimore. The identification plate on the ladder contained several errors, including referencing ISO 779-1 instead of the correct standard, ISO 799-1, and lacking the ISO 799-1 designation type.

Read the full story at **https://bit.ly/41D5O8a**.



Safety recommendations for Emission Capture and Control

OCIMF has issued an interim information paper to provide minimum functional requirements for the safe application of barge-based Emission Capture and Control (ECC) to oil, chemical and oil product tankers operating at onshore conventional berths, such as piers, jetties and quays.

Read the full story at **https://bit.ly/46MNX2d**.



Marshall Islands issues fatal falls from height warning

The Republic of the Marshall Islands Maritime Administrator has published Yacht Safety Advisory 13-24 on fatalities due to falls from height. Since 2019, falls from height on RMI-flagged commercial vessels have been the leading very serious marine casualty (VSMC) by incident type. It accounts for 31% of VSMCs and has resulted in 22 deaths.

Read the full story at **https://bit.ly/3Hvic3j**.



Morco gas water heaters the subject of an urgent product recall

A safety issue has been identified with Morco open-flued gas water heaters which may be installed in canal boats and houseboats as well as in domestic and commercial settings. The product presents a risk of fire, explosion and injuries. There is a risk of gas leaking which, if ignited, may cause burns, explosions and injuries. The products are not in conformity with the requirements of Regulation 2016/426.

Read the full story at **https://bit.ly/4ovkbFq**.

Shipping carriers move to prevent deadly charcoal fires

The shipping industry is taking proactive steps to implement improved safety measures for transporting charcoal, ahead of mandatory IMO regulations in 2026, according to a press release from the World Shipping Council (WSC). In response to a series of devastating fires caused by improperly handled charcoal, shippers should be ready to see carriers phase in new tighter regulations this year.

Read the full story at **https://bit.ly/45bKjO9**.

IACS releases new guidelines on safety standards for surveyors

The International Association of Classification Societies (IACS) has introduced new recommendations to enhance safety standards for surveyors. The new guidelines, Rec. 184, recognise that surveyors continue to face significant occupational health and safety (OHS) risks at work. There is growing recognition that some of the safety challenges that surveyors' face would benefit from improved collaboration and sharing of experience to establish a more consistent approach.

Read the full story at **https://bit.ly/410nWZD**.

Special campaign in China on illegal enclosed space entry

P&I club Britannia has highlighted a Huatai Marine circular announcing the start of a special campaign against illegal enclosed space entry onboard ships. The nine-month campaign, launched by the China Maritime Safety Administration (China MSA), began on 15 January and is intended to run until 14 October 2025.

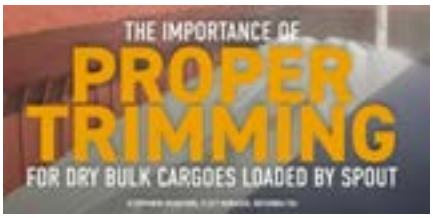
Read the full story at **https://bit.ly/4mdQdV0**.

PUBLISHED IN FEBRUARY 2025

Liberian Registry issues notice on recall of rocket parachute flares

The Liberia Maritime Authority has published marine advisory 04/2025 on the Voluntary replacement and recall of rocket parachute flares Kokusai Kakoh Co., Ltd / Type: KP-16. Kokusai Kakoh Co., Ltd recalled the flare due to concerns regarding the specified altitude and burning time when fired.

Read the full story at **https://bit.ly/4osAmTU**.



The importance of bulk cargo trimming

In one of its recent Risk Watch bulletins, Britannia P&I Club explained that proper trimming of bulk cargo is essential for ensuring ship stability, regulatory compliance, and efficient loading and discharging operations.

Read the full story at **https://bit.ly/3H4dutm**.



Key considerations for safety inspections of ships

Safety inspections of ships are a crucial and mandatory part of maritime operations, ensuring compliance with international regulations and safeguarding crew, cargo, vessels and the environment. Understanding how the process of safety inspections of ships is undertaken and maintaining readiness is essential to avoid deficiencies and ensure smooth operations.

Read the full story at **https://bit.ly/3UokvZ0**.

PUBLISHED IN MARCH 2025



The explosion hazards of shipping coal

On November 27, 2024, approximately 100 nautical miles off the coast of Virginia, a bulk carrier shipping a type of coal called "Bailey High Vol Coking Coal" experienced consecutive explosions in the two forward cargo holds. While still under investigation, the explosions are likely a result of the accumulation of methane gas that created an explosive atmosphere and resulted in significant damage to the two associated cargo holds.

Read the full story at **https://bit.ly/45Ldqb6**.



MTF report highlights safety issue of electric vehicles transport

The Maritime Technologies Forum (MTF) has published a report titled "Safe Carriage of Electric Vehicles" addressing the critical issue of transporting electric vehicles (EVs) on Pure Car and Truck Carrier (PCTC) vessels. Currently, there are no international regulations specifically dedicated to the safe carriage of electric vehicles. While some national and regional governmental organizations have issued their own guidelines, the IMO is still in the process of developing mandatory regulations for the transportation of new energy vehicles, including EVs, with a target completion year of 2027.

Read the full story at **https://bit.ly/40Wec2r**.

New loading conditions for transporting grain in bulk

The American Bureau of Shipping (ABS) has released guidance on an update to International Code for the Safe Carriage of Grain in Bulk, which is set to take effect on 1 January 2026. The IMO Maritime Safety Committee (MSC) adopted resolution MSC.552(108) at its 108th session in May 2024, which includes amendments to the Grain Code.

Read the full story at **https://bit.ly/45ubkLs**.

USCG issues alert for defective heat detectors

The U.S. Coast Guard has issued a safety alert regarding the issue of defective heat detectors that were discovered during an engine room fire investigation. The Coast Guard recently investigated an engine room fire on board an inspected towing vessel which led to the discovery of issues with the maintenance and installation of fire detection systems on board multiple towing vessels.

Read the full story at **https://bit.ly/46RXhSy**.

Management of Asbestos and PFOS

The Liberia Maritime Authority has released a marine notice on how to deal with asbestos on board all ships that are in service, under repair/modification/conversion and alteration. Guidance is also provided on the prohibition of the use or storage of extinguishing media containing perfluorooctane sulfonic acid (PFOS) on new vessels and the requirement to remove PFOS on existing vessels. Notice SAF-018 Rev. 3/25 applies to all ships, including Mobile Offshore Units and High Speed Craft. The notice breaks down its guidance of management of asbestos containing materials on board ships certified under SOLAS into separate categories.

Read the full story at **https://bit.ly/4lle2sA**.



Structural and stowage issues of CTUs in Australian ports

The Australian Maritime Safety Authority (AMSA) has issued a safety alert, which aims to raise awareness of structural and stowage issues for shipping containers and other CTUs in Australian ports. This is in response to an increase in improperly stowed CTUs and structural issues identified during inspection. Two recent incidents involved improperly packed CTUs which led to catastrophic structural failures.

Read the full story at **https://bit.ly/4mvpG5c.**

Guidelines for developing an SMS for Ammonia-Fuelled Ships

The Nautical Institute is proud to support the Maritime Technologies Forum's (MTF) initiative in developing the Guidelines for Developing and Implementing a Safety Management System for Ammonia-Fuelled Ships. This document is a critical first step in addressing safety gaps associated with the use of ammonia as a marine fuel, providing industry stakeholders with a structured approach to integrating safety measures within their Safety Management Systems (SMS).

Read the full story at **https://bit.ly/47ogew8**.

PUBLISHED IN APRIL 2025



Vehicle Carrier Safety Forum publishes guidance on fire response

The Vehicle Carrier Safety Forum (VCSF) publishes its second industry good practice guidelines entitled 'Fire Response – High Level Guidelines'. The VCSF recognises that responding to vehicle fires onboard PCCs, PCTCs, RoRo and Ro-Pax vessels is both dangerous and challenging. These guidelines have been designed to reduce the risk to the safety of crews, passengers, the environment, the vessel and the cargo. The guideline's sole aim is to assist vessel operators and crews to be better prepared to meet the challenges presented by vehicle fires.

Read the full story at **https://bit.ly/3J7Pztv**.

Why Are There So Many Soya Bean Claims?

In 2023, the global soya bean market (also known as soybeans and soyabeans) was valued at over USD 200.37 billion, and it is projected to grow to USD $259 billion by 2032.The shipping industry plays a significant role in supporting this global industry, but behind these impressive figures lies a perilously narrow window for safe ocean transport. Despite being loaded in sound condition and carried by well-maintained vessels on unexceptional voyages, soya beans continue to arrive in a deteriorated condition far too often. Claims related to spoilage frequently run into millions of dollars, exposing shipowners, operators, and marine insurers to significant financial risk.

Read the full story at **https://bit.ly/3JreliQ**.

Understanding hull fouling with Britannia P&I Club

Britannia P&I Club has published loss prevention guidance on the consequences that need to be considered regarding hull fouling.

Read the full story at **https://bit.ly/4fC84mc**.

PUBLISHED IN MAY 2025

USCG uncovers significant lack of hazardous material compliance



US Coast Guard Sector New York personnel conducted three warehouse spot checks at the Port of New York and New Jersey during the last week of April, uncovering a 60% deficiency rate in hazardous material compliance. The targeted inspections, driven by Customs and Border Protection (CBP) container screening data, are part of an expanded effort to detect undeclared hazardous cargo before it can pose a threat to port safety or vessel crews.

Read the full story at **https://bit.ly/46KZMWC**.

PUBLISHED IN JUNE 2025

Hidden dangers of fire initiating cargoes explained

The industry bodies of the Cargo Integrity Group expand on their concerns relating to cargoes that can catch fire and cause significant damage and casualties under certain conditions. Circumstances created by an alignment of mistakes, oversights, or failed controls can turn a minor incident into a major event.

Read the full story at **https://bit.ly/3UjRmhx**.



Best practices and insights on sampling procedures

West P&I Club has published a loss prevention bulletin addressing the issue of cargo contamination claims and highlights best practices on sampling procedures. According to West, cargo contamination claims are a major risk for tanker operators, often resulting in expensive disputes.

Read the full story at **https://bit.ly/45ps6eM**.

USCG issues alert on fire detection systems on towing vessels

The U.S. Coast Guard (USCG) has issued a warning regarding issues related to fire detection systems on towing vessels that are not type-approved by the Coast Guard but are instead certified by a Nationally Recognized Testing Laboratory (NRTL).

According to the USCG, even though fire detection systems may be accompanied by a certification letter issued by an authorized entity, a recent Coast Guard investigation revealed that some NRTL approved systems may have potential shortcomings and oversight gaps.

Read the full story at **https://bit.ly/4li1VMZ**.

Guidance on vetting bunker suppliers

Steamship Mutual Club has issued an alert about vetting bunker supplies, which offers valuable guidance about managing and reducing the risks associated with purchasing marine fuel amid the growing complexity of the issue due to different Emission Control Area (ECA) regulations.

Read the full story at **https://bit.ly/4opZJWt**.



CINS issues guidance on shipping lithium-ion cells in containers

The International Safe Containerised Cargo Organisation (CINS) has published safety guidelines for shipping lithium-ion cells in containers. Lithium-ion cells are the primary elements of a battery and can exist in various forms. Commonly used in portable electronics and electric vehicles, their defining characteristic is the ability to accumulate, store and release electrical energy through the movement of lithium ions between a positive and a negative electrode.

Read the full story at **https://bit.ly/4mtLkaF**.

PUBLISHED IN JULY 2025

PSC CIC on ballast water management

This year's Port State Control Concentrated Inspection Campaign (PSC CIC) will focus on ballast water management, DNV has announced. The CIC is set to take place from 1 September to 30 November 2025.

Read the full story at **https://bit.ly/4fB2Ff0**.



UKP&I guide to safe LNG bunkering practices

UKP&I Club has developed the UKP&I guide to Safe LNG Bunkering Practices (Second Edition) in collaboration with Brookes Bell. The guide presents a practical resource for the safe and efficient bunkering of liquefied natural gas (LNG) in the maritime industry.

Read the full story at **https://bit.ly/45J0Rgt.**

International Code for the Safe Carriage of Grain in Bulk update

DNV has sent out a news update on amendments to the International Code for the Safe Carriage of Grain in Bulk, which have been adopted by IMO Resolution MSC.552(108). The Grain Code amendments enter into force 1 January 2026 and will be applicable to newbuilds with keel laid on or after this date.

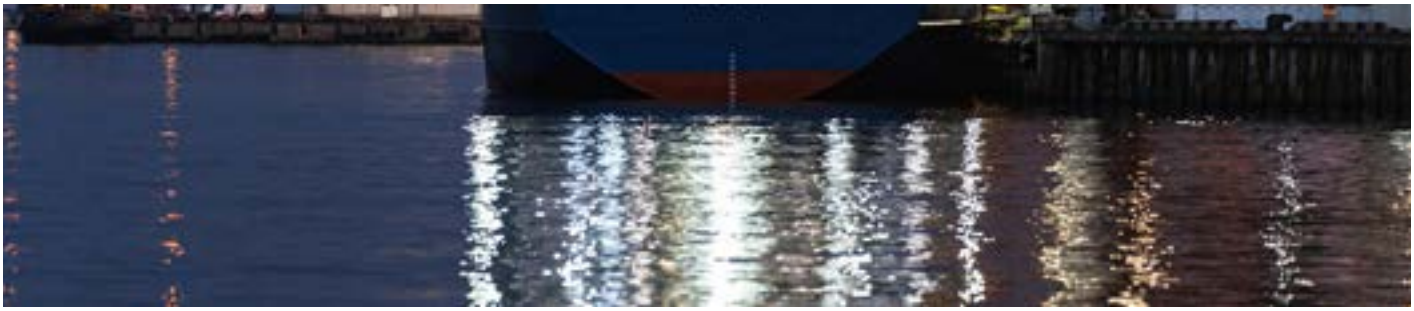
Read the full story at **https://bit.ly/3J9jCky**.



Safety alert issues about green patina build-up on water mist nozzles

The U.S. Coast Guard (USCG) has issued a safety notice highlighting the risk of green patina build-up on high-pressure water mist nozzles, which can compromise the effectiveness of onboard firefighting systems. According to the notice, while witnessing routine testing of a fixed firefighting system during an annual exam aboard a foreign passenger vessel, the Coast Guard discovered multiple high-pressure water mist nozzles that were incapable of discharging water. Consequently, the firefighting system failed to activate in multiple accommodation spaces.

Read the full story at **https://bit.ly/4ormhq5**.





Valve failures is the lead cause of ammonia-related maritime accidents

The European Maritime Safety Agency (EMSA) in its newest series of reports regarding the safety of ammonia use in ships has reviewed critical causes and patterns in ammonia-related maritime accidents. The comprehensive review of accidents however, highlighted on EMSA's report "Safety of Ammonia for Use in Ships", has underscored critical causes of these incidents that allow identifying recurring patterns and highlighting critical areas for preventive or corrective measures for application in the maritime sector.

Read the full story at **https://bit.ly/4ap1fUa**.



Meeting the requirements of the IMSBC Code

Britannia P&I Club has issued information about what actions to take when loading different bulk cargoes to meet the requirements of the International Maritime Solid Bulk Cargoes (IMSBC) Code. The shipper is responsible for providing the master (or their representative) with sufficient information in advance to allow safe preparation for loading, stowage, and carriage of the nominated cargo under the requirements of the IMSBC code.

Read the full story at **https://bit.ly/48wfBzy**.



Tokyo MOU on maintenance and rigging of pilot transfer arrangements

Tokyo MOU has reinforced an awareness of the potential risks associated with the improper maintenance and rigging of pilot transfer arrangements. Therefore they released a guidance on maintenance and rigging of pilot transfer.

Read the full story at **https://bit.ly/3XrXA0n**.

Australian Government
Australian Maritime Safety Authority

AMSA on using exhaust gas cleaning systems (EGCS)

The Australian Maritime Safety Authority (AMSA) has released guidance on how to use an exhaust gas cleaning system (EGCS) to meet the fuel sulphur limit of 0.50% m/m, as required under MARPOL Annex VI and Australian law.

Read the full story at **https://bit.ly/48wirVe**.



IMCA releases annual eCMID Inspection Findings and Quality Assurance Report to highlight key safety trends

IMCA has published its annual eCMID Inspection Findings and Quality Assurance Report, offering a comprehensive review of vessel inspection results and quality assurance processes for the 2024/25 period. The report continues to serve as a vital resource for the offshore industry, highlighting immediate priorities and mapping a long-term course for safety and compliance.

Read the full story at **https://bit.ly/4rywmTx**.



MCA releases MGN 591 Amendment 3 to remind about safe access

The Maritime and Coastguard Agency (MCA) has updated its guidance on safe access for small vessels and fishing boats with the release of MGN 591 (M+F) Amendment 3. While the amendment itself only updates references, the message is clear: unsafe boarding arrangements continue to cause serious – and sometimes fatal – accidents. Recent MAIB reports highlight falls from ladders, poorly lit pontoons, and gaps between vessels as recurring risks.

Read the full story at **https://bit.ly/3MizvGQ**.

IUMI best practice for safely transporting EVs

IUMI has released an update to its best practice and recommendations for safely transporting EVs.

Read the full story at **https://bit.ly/3Y4cj1E**.

Fires dominate 2025 major claims, says Cefor

Cefor, the Nordic Association of Marine Insurers, has released the 2025 mid-year hull report with the latest fleet and casualty trends, plus a special focus on fires as fires dominate 2025 major claims.

Read the full story at **https://bit.ly/4rwsL8j**.



New guidelines to enhance efficiency of container stowage

ClassNK has released new guidelines for those involved in container shipping, aiming to enhance the efficiency of container stowage while ensuring safety measures such as preventing cargo collapse.

Read the full story at **https://bit.ly/3MfdV68**.



Preventing the next lithium fire at sea: A data-driven blueprint for safer transportation

With new data and technological innovation, the maritime industry must re-evaluate cargo handling protocols and develop more resilient fire mitigation strategies to address growing risks at sea, argues Alicia Lee, Chief Operating Officer at GSBN.

Read the full story at **https://bit.ly/4ovlx1Q**.



Beware of the fire risks in scrap metal cargoes

NorthStandard P&I Club has issued guidance on the rising fire risks associated with scrap metal cargoes, particularly those coming from East Coast USA and Ghent, Belgium. They highlight the need for strict vigilance.

Read the full story at **https://bit.ly/4phJpau**.





Guidelines for the safe inspection of methanol dual-fuel ships

The Maritime Technologies Forum (MTF) has issued new guidelines for the safe inspection of methanol dual-fuel ships. As the maritime industry accelerates its transition to alternative fuels under increasingly stringent IMO emission regulations, methanol as fuel has emerged as a particularly attractive option, as documented by the increasing number of orders.

Read the full story at **https://bit.ly/3Y32p0d**.

PUBLISHED IN OCTOBER 2025



AMSA issues safety bulletin highlighting i mproperly secured cargo

The Australian Maritime Safety Authority (AMSA) issues a safety bulletin highlighting that improperly secured cargo continues to contribute to container losses, prompting renewed focus on inspections, crew training and weather preparedness.

Read the full story at **https://bit.ly/4iEtyAm**.



ABS shares guidance on ladders and stairways as a means of escape from engine rooms

Following Port State Control findings on the design and installation of heat shielding ladders forming an escape route from machinery spaces, ABS has provided guidance on ladders and stairways as a means of escape from engine rooms.

Read the full story at **https://bit.ly/48KICZE**.

DNV: Deficiencies in CO2 fire-extinguishing systems

DNV has recently identified cases of deficiencies in CO2 fire-extinguishing systems that had multiple depleted CO_2 cylinders, potentially compromising fire safety and vessel integrity.

Read the full story at **https://bit.ly/4pQ6K2Z**.



Ship to Ship Transfer Guide for Petroleum, Chemicals and Liquefied Gases update published

The Chemical Distribution Institute (CDI), International Chamber of Shipping (ICS), Oil Companies International Marine Forum (OCIMF) and the Society of International Gas Tanker and Terminal Operators (SIGTTO) have released the second edition of 'Ship to Ship Transfer Guide for Petroleum, Chemicals and Liquefied Gases'.

Read the full story at **https://bit.ly/4rQ7w1N**.



Key considerations for mitigating accidents during fumigation

Photo credit: Gard

Gard P&I Club has provided key recommendations to mitigating accidents during fumigation operations, especially while in transit. Fumigation of cargo holds using aluminium phosphide tablets, which release phosphine gas, is essential to protect products from infestation and ensure they arrive in good condition. The heavier-than-air phosphine gas penetrates the cargo to eliminate insects and pests.

Read the full story at **https://bit.ly/4peK3oY**.

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The following pages of the Compendium are devoted to a number of incident and accident reports published on the IIMS website during 2025. Many of the reports have been generated by renowned worldwide investigation bodies, including the NTSB (US), MAIB (UK), and TSB (Canada), as well as others from around the world. Most of the stories have links to enable you to access the full details and the investigation reports.



Incident and accident reports published on the IIMS website

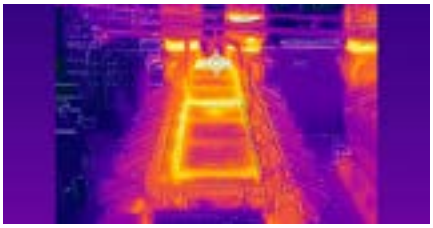
PUBLISHED IN DECEMBER 2024



Man overboard from potting vessel Pioneer with loss of 1 life

The MAIB investigation found that Pioneer had a low bulwark at its aft deck, which did not prevent the skipper's fall into the water. At the time of the accident neither the skipper nor deckhand were wearing a personal flotation device, although two were available on board.

Read the full story at **https://bit.ly/4mx53FM**.



MAIB report into fire on board ro-ro ferry

The fire ignited on a main engine when pressurised fuel from a loose fuel pipe connection sprayed onto a high temperature exhaust pipe. Neither of the designed protections against fuel fires (spray shielding on fuel pipes and insulation of hot surfaces) were effective.

Read the full story at **https://bit.ly/3J4UYlc**.

MAIB voices "serious concern" over Red Sea dive boat accidents

The UK Maritime Accident Investigation Branch (MAIB) has shared an update on Red Sea dive boat accidents.
The MAIB has been notified of three accidents within the last 20 months affecting UK citizens on Egyptian dive boats operating in the Red Sea. These include:

- the capsize of Carlton Queen on 24 April 2023 resulting in abandonment of the vessel with all passengers and crew rescued;
- a fire on Hurricane on 11 June 2023 resulting in the deaths of 3 UK nationals;
- the capsize of Sea Story on 25 November 2024 resulting in up to 18 fatalities/people missing, including 2 UK nationals.

Read the story in full at **https://bit.ly/443unMV**.

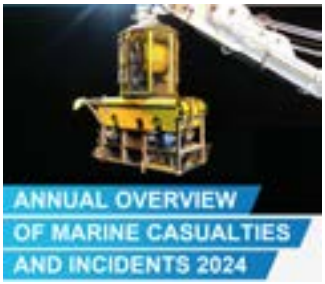


Photo credit: EMSA

EMSA Annual Overview of Marine Casualties and Incidents 2024

The EMSA has published its Annual Overview of Marine Casualties and Incidents 2024, which presents statistics on marine casualties and incidents that cover the period from 1 of January 2014 to 31 of December 2023.

Read the full story at **https://bit.ly/3Y4HhGY**.

PUBLISHED IN JANUARY 2025



NTSB report on dinner cruise vessel Spirit of Boston fire

An improperly extinguished chafing fuel heating canister, canned heat used to keep food and beverages warm, led to a fire on the passenger vessel Spirit of Boston last year while moored at the Commonwealth Pier in Boston Harbor.

As a result of the investigation, the National Transportation Safety Board (NTSB) issued four new safety recommendations and reiterated a safety recommendation to the U.S. Coast Guard.

Read the full story at **https://bit.ly/3XtmoFl**.



Transport Malta investigation into boiler explosion death

Transport Malta has released an investigation report into the boiler explosion on board oil/chemical tanker Torc, resulting in the death of a crewmember.

Read the full story at **https://bit.ly/445x6FB**.



Marshall Islands publishes Blue Cecil report after enclosed space entry deaths

The Republic of the Marshall Islands Maritime Administrator has released its Blue Cecil report after enclosed space entry deaths in 2023.

The vessel's C/E, ETO and Fitter died after they were found unconscious inside of Cargo Hold No. 1. Despite a rescue attempt, with all three being recovered from the hold, they were unresponsive and did not respond to CPR. A post-mortem examination by the Philippine authorities determined their deaths was "asphyxia by suffocation."

Read the full story at **https://bit.ly/4oxK2vl**.



Photo credit: DGS Mumbai, India

DGS India investigation report into M T Patriot tanker explosion

The Directorate General of Shipping, Mumbai has issued a casualty circular into the death on board a tanker while undergoing repairs at berth. The circular highlights an incident on Indian-registered tanker M T Patriot that resulted in the loss of one life and injuries to three shore-contracted personnel on board.

The casualties occurred due to an explosion inside the port-side Slop tank while cutting of nuts and bolts, using hot work, was being carried out on the Inert Gas line at the main deck.

Read the full story at **https://bit.ly/44IEF5e**.



Image courtesy of Nigel Burgess Limited

MAIB investigation into death on board motor yacht Baton Rouge

On the morning of 23 February 2024, the chief engineer on the Isle of Man registered motor yacht Baton Rouge was electrocuted while working on the engine room ventilation system. The chief engineer was replacing a damper actuator, which was situated in a ventilation overpressure duct compartment. The chief engineer's heart could not be restarted, and he was pronounced dead later that morning.

Read the full story at **https://bit.ly/44ApYBe**.

PUBLISHED IN FEBRUARY 2025



Photo Credit: ATSB

ATSB says ambiguous procedures led to vessel steering failure

CMA CGM is revising its steering guidance across the fleet after ambiguous procedures contributed to one of its ships colliding with a navigational beacon in the Yarra River, according to the Australian Transport Safety Bureau (ATSB).

Read the full story at **https://bit.ly/48NfYHo**.

Transport Malta: crewmember death after steam valve failure onboard Chemical Hunter

On 28 January 2024, an able bodied seafarer (AB) on board Chemical Hunter was severely scalded by steam. The accident happened during cargo tank washing and steaming operations. Chemical Hunter had just left the port of Altamira, Mexico when the accident occurred. The vessel returned to port where the injured crew member was transferred to a hospital. Despite the first aid given on board, and the more specialised treatment in hospital, the injured crew member succumbed to his injuries about two weeks after the accident.

Read the full story at **https://bit.ly/4izzE4R**.





Photo credit: Bar Pilot, marinetraffic.com

NTSB reveals cargo on President Eisenhower lost due incorrect cargo weight data

The U.S. National Transportation Safety Board has published a report after cargo on President Eisenhower lost due incorrect cargo weight data.

The input of incorrect container cargo weight data when developing the cargo loading plan led to the shipping containers falling off a cargo ship and others becoming damaged while the vessel was drifting off the coast of California.

Read the full story at **https://bit.ly/3MfHpAO**.



NTSB investigation after incorrect valve led to a fatal fire

The U.S. National Transportation Safety Board have released the results of a report after the installation of an incorrect valve led to a fatal fire aboard a cargo vessel docked in LaPorte, Texas.

Read the full story at **https://bit.ly/4pg4wtP**.



NTSB investigation into fire on fishing vessel Three Girls

The failure of a component on the hydraulic system for on-deck fishing equipment likely led to a fire aboard a fishing vessel in the Gulf of Maine, according to the U.S. National Transportation Safety Board. On August 11 last year, the fishing vessel Three Girls was fishing in the Gulf of Maine when a fire broke out in the vessel's engine room.

The five crewmembers and a National Marine Fisheries Service observer abandoned the burning vessel and were rescued by the U.S. Coast Guard. No injuries or pollution were reported. Damage to the vessel was estimated at $1.3 million.

Read the full story at **https://bit.ly/3XwBkm4**.

PUBLISHED IN MARCH 2025



Photo Credit: Courtesy of Komite Nasional Keselamatan Transportasi

MAIB investigation into fatalities on board Berge Mawson

The UK Marine Accident Investigation Branch (MAIB) has published a report into the deaths of three stevedores in a cargo hold access space on board the bulk carrier Berge Mawson. The incident took place at Bunyu Island anchorage, Indonesia on 27 June 2022.

Read the full story at **https://bit.ly/48P7gbC**.

Lessons learned after fire sinks shrimp cutter

Germany's Federal Bureau of Maritime Casualty Investigation (BSU) has published the lessons learned following the fire and subsequent foundering of a shrimp cutter vessel.

The exact cause of the fire could not be determined after the shipwreck was salvaged because of the extensive damage done to the vessel in the incident.

Read the full story at **https://bit.ly/4pmd7ey**.

Canadian transport investigation report into fire on board fishing vessel Elite Navigator

The Transportation Safety Board of Canada has published the results into an investigation into the fire and sinking of fishing vessel Elite Navigator.

Read the full story at **https://bit.ly/4orNYO3**.



Photo credit: Anguilla Fire and Rescue Service

MAIB report after two people died in boat accident in Anguilla

The UK Marine Accident Investigation Branch (MAIB) has published a report after two people died in boat accident in Anguilla in 20203 whilst onboard the small commercial vessel Calypso 2 in Anguilla in 2023. The vessel was also lost.

On 11 March 2023, the small commercial vessel Calypso 2 entered a cove near West End, Anguilla. The boat was overwhelmed by the force of the large ground seas that had developed near the coast and the four passengers and two crew were ejected into the water. Tragically, the mate and a female passenger lost their lives.

Read the full story at **https://bit.ly/4oyv8Fg**.



Photo credit: TAIC

TAIC publishes report into five fatalities after i-Catcher capsized

The New Zealand Transport Accident Investigation Commission (TAIC) after five people died when the i-Catcher, fishing vessel, capsized off the coast of Goose Bay on 10 September 2022.

Read the full report at h**ttps://bit.ly/3MKRshq**.



MAIB publishes interim report on North Sea collision

The UK Marine Accident Investigation Branch (MAIB) has released an interim report on the fatal North Sea collision between the container ship Solong and the oil/chemical tanker Stena Immaculate. One of Solong's crew has never been found and is presumed to have died in the incident which took place 14 nautical miles north-east of Spurn Head at the entrance to the Humber Estuary, England on 10 March 2025. The report has revealed that neither ship had a dedicated lookout on the bridge.

Read the full report at **https://bit.ly/48EBjBp**.



Investigators publish report on 2024 YM Mobility blast in China's Ningbo Port

The China Maritime Safety Administration (CMSA) has published a report on its investigation into the explosion and subsequent fire on the Taiwanese-owned container vessel YM Mobility blast in China's Ningbo Port on 9 August 2024. An explosion occurred in a container loaded with dangerous goods on board near the ship's bow. According to the shipper's declaration, the container was a reefer used as a substitute for a dry container, without requiring power connection. The estimated economic loss resulting from in the incident was about CNY90 million (US$13 million).

Read the full story at **https://bit.ly/48rEZrD**.



Photo credit: NTSB

NTSB report on Ocean Navigator engine failure

Debris in an engine's lube oil system led to a diesel engine failure and an engine room fire aboard a passenger vessel docked in Portland, Maine, the National Transportation Safety Board (NTSB) said. The passenger vessel Ocean Navigator was moored at the Ocean Gateway Terminal on Oct. 18, 2023, when the no. 2 auxiliary diesel generator engine suffered a catastrophic mechanical failure that seriously injured one crewmember and resulted in an engine-room fire. Crewmembers secured ventilation to the engine room, and the fire self-extinguished. None of the 128 passengers onboard were injured, and no pollution was reported.

Read the full report at **https://bit.ly/4rKrYRw**.





Photo credit: East Marshall Fire Department

NTSB report on fire on board towing vessel Johnny M

The National Transportation Safety Board (NTSB) has said a catastrophic engine failure led to a fire aboard a towing vessel, Johnny M, on the Tennessee River last year. An engine-room fire broke out on January 30, 2024, aboard the towing vessel Johnny M, which was pushing four barges on the Tennessee River near Grand Rivers, Kentucky. The six crewmembers aboard were unable to extinguish the fire using the CO2 fixed-fire-extinguishing system and abandoned ship to a Good Samaritan vessel. Local fire departments extinguished the fire. No injuries or pollution were reported. Damage to the vessel totalled $3 million.

Read the full report at **https://bit.ly/4pqRJEU**.

BSU report into Endurance collision with pier

The German Federal Bureau of Maritime Casualty Investigation (BSU) has released its report into the collision with a pier/dry dock by the car carrier Endurance due to broken lines in Bremerhaven on 13 March 2021.

Read the full report at **https://bit.ly/3YeQi0c**.



TAIC warns against deferring ship maintenance after Shiling accident

The New Zealand Transport Accident Investigation Commission has warned against deferred ship maintenance after a ship lost control containership Shiling lost control at Wellington Harbour on 15 April 2023.

Read the full report at **https://bit.ly/4iMLAQT**.



Photo credit: ANP/Marco van der Caaij

Investigation report released on Fremantle Highway disaster

The system for responding to incidents in the North Sea needs to be put in order as soon as possible. That will require improved communication and information sharing between the Coastguard Centre and its cooperating organisations on shore. This is the conclusion of the Dutch Safety Board in its investigation of the emergency response to the fire that broke out on board the car carrier Fremantle Highway during the night of 25 to 26 July 2023.

Read the full report at **https://bit.ly/44frvfZ**.



MAIB issues interim report on the sinking of the Bayesian

The key headline from the Bayesian interim report is that the yacht took less than 15 seconds to heel irrecoverably. The UK-based Marine Accident Investigation Branch (MAIB) report is the first official such document to be published into the sinking of the Bayesian which resulted in seven deaths off Sicily, including that of the yacht's owner Mike Lynch, and his 18-year-old daughter Hannah in August 2024. As part of the Bayesian interim report, MAIB investigators have pieced together the sequence of events, the movements of the 10 crew and 12 guests onboard, and the rapid timeline of the sudden tragedy.

Read the full story at **https://bit.ly/3Ms6uZl**.



MAIB report: Fatal accident on the beam trawler Cornishman

On 6 February 2021, a deckhand on the beam trawler Cornishman was fatally injured when the port trawl beam, which had been hoisted to facilitate a repair to the fishing gear, fell and struck him. It was found that a chain that was part of the trawl beam's quick-release gear had failed, causing the beam to fall.

Read the full report at **https://bit.ly/4iS4pCk**.

BMA investigation of capsizing of Master Ru, four presumed dead

The Bahamas Maritime Authority has published a report into the investigation of the capsizing of Master Ru, with four presumed dead and ro-pax vessel sank in The Bahamas in 2024.

Read the full report at **https://bit.ly/48GYk6S**.

Investigation report after crewmember falls to death on Yuka D

Transport Malta has released a report into a fatality on board bulk carrier Yuka D while it was at anchor off Paradip, India on 22 May 2024. The vessel Yuka D discharged a cargo of steel scrap at the port of Chittagong, Bangladesh, using its cargo cranes operated by shore personnel. Upon completion of unloading operations, the vessel proceeded in ballast to the port of Paradip, India, to load a new cargo of steel slabs. Yuka D arrived and anchored off Paradip on 20 May 2024. On the morning of 22 May 2024, while still at anchor awaiting berthing instructions, two ordinary seafarers were assigned to clean the interiors of the cargo crane cabins, which required cleaning following the cargo operations at Chittagong.

Read the report at **https://bit.ly/3KgEaIY**.

PUBLISHED IN JULY 2025



Photo credits: U.S. Coast Guard and Tarka II captain.

NTSB highlights fire detector placement after Tarka II

The National Transportation Safety Board (NTSB) highlighted effective fire detector placement after Tarka II. A fishing vessel that caught fire last year near Tatoosh Island, Washington. "Installation of smoke and fire detectors in spaces that are typically uncrewed when underway, such as the engine room, allows for the earliest detection and notification of a fire, maximizing the time for operators to respond to the fire or take actions to abandon the vessel," the marine investigation report said.

Read the report in full at **https://bit.ly/4pnsOSq**.



Photo credit: Steven Watkins

Achilles Bulker rudder broke off near Tauranga nearly runs aground

The New Zealand Transport Accident Investigation Commission (TAIC) has published a report after bulk carrier Achilles Bulker lost its rudder in 2023.

Read the report in full at **https://bit.ly/4pWWxBL**.

PUBLISHED IN AUGUST 2025



Rotten wood caused historic Grace Bailey dismasting

The is a distressing case about a fatal accident that should never have happened. And as the investigation has revealed, a series of poor, inadequate and ineffective inspections and surveys that failed to discover serious rotten wood, would appear to be largely to blame. The U.S. Coast Guard (USCG) has released a critical report on the dismasting of a historic schooner, blaming the catastrophic incident on rotten wood that had gone unnoticed for years due to poor inspections.

Read the full report at **https://bit.ly/3XCQA0K**.





Lundy Explorer report published by MAIB

The Marine Accident Investigation Branch (MAIB) has published the Lundy Explorer report, an incident which left one passenger severely injured. On 7 June 2023, the rigid inflatable boat (RIB) Lundy Explorer departed Ilfracombe Harbour for a sea safari trip. While leaving the harbour the boat encountered a high wave, which caused it to slam into an oncoming wave. A passenger sitting in a jockey seat in the front of the RIB, where the highest shock loads were experienced, was dislodged from their seat and suffered a fracture of their spinal column that resulted in permanent paralysis.

Read the full report at **https://bit.ly/3Kmj0Js**.



RMI maritime authority investigation into enclosed spaces deaths

The Republic of the Marshall Islands (RMI) Maritime Administration has released an investigation report into two enclosed spaces deaths on board drill ship Valaris DS-17.

Read the full report at **https://bit.ly/4rGGwS4**.



China MSA releases report into explosion onboard the YM Mobility

On 9 August 2024, a major explosion occurred aboard the container vessel YM Mobility at the Beilun Second Container Terminal in Ningbo-Zhoushan, China. The explosion originated from a container near the bow, loaded with dangerous goods. Although declared by the shipper as a reefer container used as a substitute for a dry container, it was not connected to a power supply. The incident resulted in an estimated economic loss of approximately CNY 90 million (US$13 million).

Read the full story at **https://bit.ly/3KIIZuu**.



Photo credit: NTSB

NTSB investigation into grounding of barge Cordova Provider

The US National Transportation Safety Board (NTSB) has published a report into the grounding of barge Cordova Provider which happened in January 2025.

Read the full report at **https://bit.ly/48EtfAR**.

PUBLISHED IN SEPTEMBER 2025



Cuyahoga engine room fire report by Canada TSB

The Transportation Safety Board of Canada (TSB) has published its investigation report into the engine room fire onboard the bulk carrier Cuyahoga that occurred in May 2023. The Cuyahoga was loaded with granular crushed stone as she left Marblehead, Ohio, U.S., bound for Kingsville, Ontario on Lake Erie. Almost three hours into the voyage, a fire ignited in the engine room.

Read the full report at **https://bit.ly/4oC70Bl**.

海事處
Marine Department

Hong Kong SAR lessons learned on enclosed space death

The Marine Department of the Hong Kong Special Administrative Region (SAR) has shown the results of an investigation into a death in an enclosed space on cargo ship Seren.

Read the full report at **https://bit.ly/4pSZLpL**.

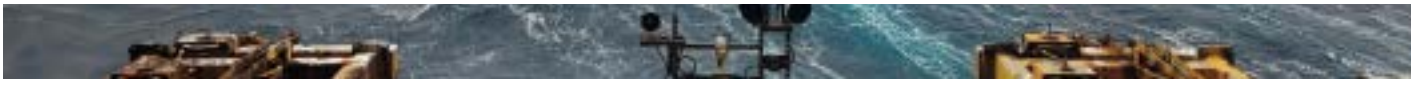




Photo credit: Flagship Marine LLC

NTSB report says lithium-ion battery bank cause of yacht fire

The US National Transportation Safety Board (NTSB) has said in a report that inoperable battery management systems were the probable cause of a fire on yacht Flagship last year.

Read the full report at **https://bit.ly/4oF8quU**.



Photo credit: TSB

TSB Canada report shows detector false alarm contributed to Heemskerkgracht grounding

Transportation Safety Board of Canada (TSB) released its investigation report into the 2024 grounding of the general cargo vessel Heemskerkgracht in the South Shore Canal of the St. Lawrence Seaway off Kahnawake, Quebec.

Read the full report at **https://bit.ly/4pp1JOX**.



Photo credit: TSB

RMI Maritime Administrator report reveals reason for fatal fall on bulk carrier Asteris

The Republic of the Marshall Islands Maritime Administrator has concluded an investigation after a sailor fell and died on board bulk carrier Asteris.

Read the full report at **https://bit.ly/3MnI4jW**.



Photo credit: MAIB

UK MAIB report into engine room fire on Finnmaster published

The UK Marine Accident Investigation Branch has released its findings and issued 12 recommendations in a report into a auxiliary engine room fire on the Finnmaster Ro-Ro cargo ship as it departed a UK port in 2021.

Read the full report at **https://bit.ly/4oE9tew**.



Photo credit: Clearwater Seafoods

TSB says cracked exhaust silencer cause of fishing vessel fire

A 30cm crack along the main engine exhaust silencer led to a fire on board scallop fishing vessel Fundy Leader, according to a report by the Transportation Safety Board of Canada (TSB).

Read the full report at **https://bit.ly/4oFmwg0**.

BSU
Bundesstelle für Seeunfalluntersuchung
Federal Bureau of Maritime Casualty Investigation

BSU lessons learned after loss of steering caused ships to collide

The German BSU has shared lessons learned following two ships collided on a canal after loss of steering.

Read the full story at **https://bit.ly/3KINXaC**.

PUBLISHED IN OCTOBER 2025



Photo credit: TSB

TSB Canada: Overloaded barge led to crewmember and cargo overboard

The Transportation Safety Board of Canada (TSB) has published its investigation report into an overloaded barge which led to a crewmember and cargo overboard in Frobisher Bay, Nunavut in 2023 due to an overloaded barge.

Read the full report at **https://bit.ly/4rQN94v**.



M/V Wakashio Court Investigation

One of the most eye-catching and devastating incidents of recent times – and totally avoidable – involved the grounding and subsequent breakup of the MV Wakashio. The tragic event caused immense environmental damage in and around the Mauritius area. Five years on, and the Court of Investigation has now issued its report into the grounding of M/V Wakashio which ran aground off Mauritius on 25 July 2020, spilling about 1,000 tons of fuel oil.

Read the full report at **https://bit.ly/48Lp9ab**.



Photo credit: MCIB

LPG gas likely caused DollFinn motor cruiser fire on the River Shannon

The Irish Marine Casualty Investigation Board (MCIB) has called on the Minister for Transport to consider reviewing and updating the regulations on the use of liquefied petroleum gas (LPG) installations and systems on merchant vessels, fishing vessels, pleasure craft and other marine craft. The call for action comes in the wake of a series of recommendations published in the MCIB's report into the death of Detective Garda Deirdre Finn in a fire on board the DollFinn motor cruiser at Carrick-on-Shannon in early August 2023.

Read the full report at **https://bit.ly/48Lpg5B**.



Photo credit: NTSB

Component failure cause of BBC Africa collision according to NTSB

The US National Transportation Safety Board has said a steering control system component failure on a multi-purpose carrier was the cause of a collision with a bulk carrier in the Houston Ship Channel. The multi-purpose carrier BBC Africa lost steering as it was departing the channel on August 25, 2023, and struck the moored bulk carrier Common Faith. No injuries or pollution were reported. Damage to the vessels was estimated at $1.1 million.

Read the full story at **https://bit.ly/4a3tJ5Y**.



Photo credit: Aitor Campos Jordan

Jean Elaine, dive support vessel not certified for operation, says MAIB report

A dive support vessel, Jean Elaine, which grounded in the Scotland in 2024 was not certified for operation at the time of the accident said a report published by the UK Marine Accident Investigation Branch (MAIB).

Read the full report at **https://bit.ly/4a4IUfe**.

PUBLISHED IN NOVEMBER 2025

Fatal Silver Condor sinking reflects long-standing safety issues in commercial fishing

The Transportation Safety Board of Canada has published its final investigation report into the fatal Silver Condor sinking, which resulted in the deaths of three crew members near La Tabatière, Quebec.

Read the full report at **https://bit.ly/44gQLCF**.



Photo credit: ATSB

Crew steam injuries due to undocumented modifications on Wisdom Venture

An undocumented modification on Wisdom Venture oil tanker resulted in burns to three crew members, according to the Australian Transport Safety Bureau (ATSB).

Read the full report at **https://bit.ly/4pT2IXn**.



Photo credit: NTSB

NTSB: loose wire on containership Dali led to Scott Key Bridge collision

The US National Transportation Safety Board said a single loose wire on the Dali containership caused an electrical blackout that led to the vessel hitting the Francis Scott Key Bridge, which then collapsed, killing six highway workers. At a public meeting, investigators said the loose wire in the ship's electrical system caused a breaker to unexpectedly open – beginning a sequence of events that led to two vessel blackouts and a loss of both propulsion and steering near the 2.37-mile-long Key Bridge on March 26, 2024. Investigators found that wire-label banding prevented the wire from being fully inserted into a terminal block spring-clamp gate, causing an inadequate connection.

Read the full story at **https://bit.ly/4oFo8q4**.



TSB Canada highlights importance of safeguards to prevent accidental lifeboat releases

The Transportation Safety Board of Canada (TSB) is urging stronger safety measures after a crew member was seriously injured aboard the bulk carrier Golden Zhejiang's lifeboat in 2023. The TSB highlights the need for proper procedures for risk assessments, equipment-specific training, and a safety management system supported by a mature safety culture with a trusted process for communication between crew and shore personnel to prevent accidental lifeboat releases.

Read the full report at **https://bit.ly/44hbYfD**.

PUBLISHED IN DECEMBER 2025



Photo credit: Gopal Vijayaraghavan (via Wikimedia Commons) CC BY 2.0

ATSB investigation into serious fall injury in engine room of Spirit of Tasmania I

Safety management system procedures were not effectively implemented when the Spirit of Tasmania I's second engineer was seriously injured in a fall during engine maintenance earlier this year, said the final report from the Australian Transport Safety Bureau.

Read the report in full at **https://bit.ly/4rFflHv**.

BRITANNIA P&I
TRUSTED SINCE 1855

Benzene vapour death following unauthorised tank entry

Britannia P&I Club have cautioned its members on the dangers of entering an enclosed space after a benzene vapour death in the cargo hold of a tanker.

Read the full report at **https://bit.ly/4ozMW2x**.

MAIB
MARINE ACCIDENT INVESTIGATION BRANCH

MAIB publishes preliminary report on scrap metal fire on Altay

A report regarding a scrap metal fire in the cargo hold of bulk carrier Altay has highlighted the importance of cargo loading monitoring and cargo pre-loading inspection. The UK Marine Accident Investigation Branch (MAIB) has released a preliminary assessment of the incident which took place in 2025. Nearby residents and business owners had been advised to keep their doors and windows securely closed while firefighters tackled the blaze.

Read the full story at **https://bit.ly/4oJOkj7**.



Photo credit: ATSB

Gaschen Homer blackout due to generator issue in port of Brisbane

The gas tanker had just left its berth at the Port of Brisbane when it lost propulsion for two minutes as two of its three electrical generators were not properly configured causing the Gaschen Homer blackout, according to an Australian Transport Safety Bureau (ATSB) final report.

Read the full report at **https://bit.ly/4ppwgfm**.

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Regular regulation changes are something we learn to tolerate and accept. The list of upcoming new and revised regulations looks daunting and likely to be burdensome for some. We have curated these in one space in an attempt to guide you through what's new.



Regulation news and updates



Upcoming IMO requirements for lifting appliances

DNV has provided an overview of the upcoming IMO requirements for lifting appliances, outlining obligations that will apply to newbuildings, retrofits, and existing fleets from 1 January 2026 onward.

According to DNV, new IMO requirements for lifting appliances will apply for vessels with a safety construction certificate (CCC, CSSC or PSSC). To comply, cranes, moveable decks, and ramps lifted with cargo, as well as other lifting appliances, must meet the following criteria:

- Be designed, constructed and installed/certified according to the rules of the vessel's class society or equivalent standards (non-certified appliances installed prior to 1 January 2026 may alternatively be covered by a "Factual statement")
- Undergo annual thorough examination and load testing every 5 years. Occasional load test and/or examination shall be performed when deemed necessary, e.g. to verify a repair
- Be subject to regular maintenance and inspection

Note: Flag administrations may have exempted lifting appliances with an SWL below 1 tonne. These requirements apply upon delivery of a newbuilding, upon installation of new lifting appliances or latest upon first renewal survey after 1 January 2026.

Newbuildings delivered after 1 January 2026
Upon delivery of the newbuilding, any lifting appliances fitted shall follow the new IMO requirements independent of the date of the contract. An IMO electronic cargo gear book shall be issued, stating compliance as described above.

Retrofit of new lifting appliances after 1 January 2026
Any lifting appliances installed on or after 1 January 2026 will require compliance with the new rules and may trigger implementation of the IMO cargo gear book for the vessel.

Periodical surveys for existing fleet
For a fleet in service, the transition to the new regime will normally apply upon the first class renewal survey completed on or after 1 January 2026.

The periodical surveys and tests are similar to what is required for ILO152, or the cargo gear book, today, but the scope has now been extended beyond the application for ILO152, which is limited to lifting appliances and ramps handling cargo. Provision cranes, engine room cranes and other lifting appliances or moveable decks and ramps lifted with cargo will need to be included in the cargo gear book.
Note: Lifeboat davits, life raft and rescue boat launching appliances are excluded, unless they have a dual purpose, e.g. as a provision crane.

Harmonized surveys
Certificates issued after load testing and thorough examinations confirm compliance with SOLAS Regulation II-1/3-13. To maintain harmonization after implementation, we have aligned the new IMO survey requirements with class surveys. As a result, lifting appliance surveys will be scheduled accordingly and, by default, included in survey requests for main class annual and renewal surveys. This approach minimizes the number of vessel visits and aligns activities with docking schedules, enabling more efficient load testing and timely repairs.
Note that SOLAS Regulation II-1/3-13 also includes requirements for anchor handling winches which typically apply to offshore service vessels and anchor handling tugs used to install, arrange, shift and remove anchors of offshore vessels/units and subsea installations.

Recommendations
- Report SOLAS-relevant lifting appliances and movable decks or ramps lifted with cargo, missing in the current DNV ILO/OLA scheme, via DATE for addition to the new DNV IMO scheme.
- Order SOLAS-relevant lifting appliances and movable decks or ramps lifted with cargo, to be installed on board as of 1 January 2026, with design approval and a product certificate from the vessel's class society and with a SOLAS-conform rigging plan.

Prepare for the first renewal survey after 1 January 2026.



New IMO Requirements for reporting loss of containers at sea

These changes require Masters to report both the loss and observation of containers without delay, ensuring timely communication with nearby vessels, coastal States, and flag Administrations. The amendments aim to improve navigational safety, environmental protection, and the traceability of lost containers.

Regulation V/31 –
Danger Messages

- The master of every ship involved in the loss of container(s) shall report the incident without delay to ships in the vicinity, to the nearest coastal State, and the flag State.
- If the ship is abandoned or unable to report, the company (as defined in SOLAS IX/1.2) shall assume the reporting obligations.
- The flag State, once informed, shall report the incident to the IMO via GISIS (Global Integrated Shipping Information System).
- The Master of every ship observing drifting containers is required to report the incident as well to the ships in the vicinity, to the nearest coastal State, and the flag State.

Regulation V/32 –
Information Required in Danger Messages
For container losses, the report shall include:

- Type of report: Loss of freight container(s) from a ship
- Ship's identity (IMO number/Name/Call Sign/MMSI), time (UTC), and position of the incident (actual, estimated or discovered)
- Number or estimated number of containers lost
- Whether dangerous goods are involved (including UN number, if known)
- Description of containers (e.g. size, type, whether empty)
- Any additional relevant information such as cargo spill, weather, sea state and estimated drift.

A follow-up report shall be sent once the number of lost containers is verified, clearly marked as "final".

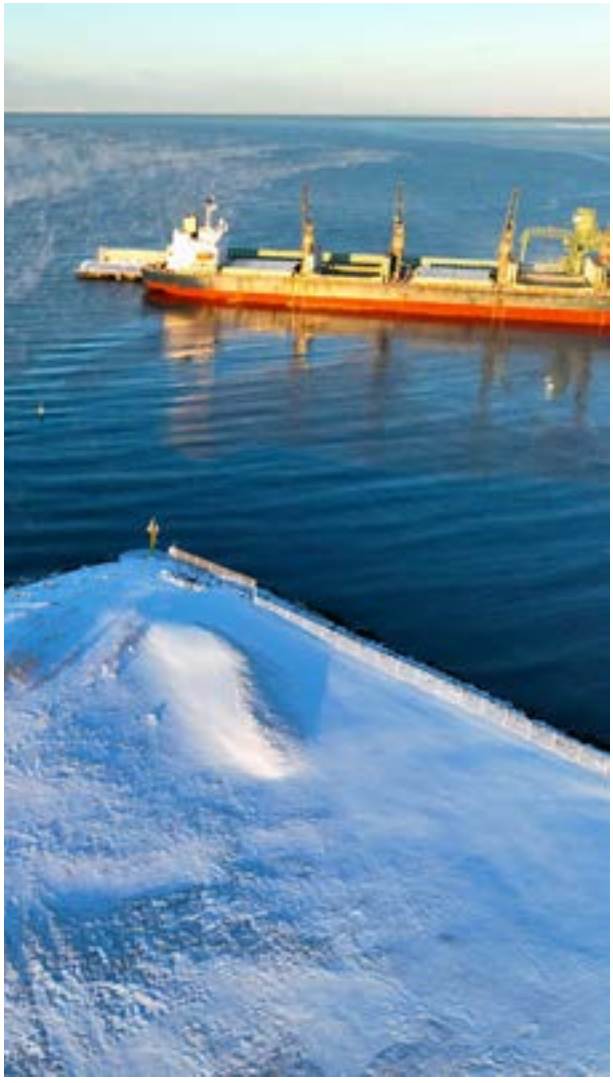
For observations of drifting containers, similar information shall be reported, but in this instance as type of report "Observation of freight container(s) drifting at sea.

Amendments to the International Code for Ships Operating in Polar Waters (Polar Code)

The Maritime Safety Committee (MSC) of the International Maritime Organization (IMO) at its 107th session adopted the resolution MSC.538(107) on 8 June 2023 to amend the Polar Code to mandate navigation and voyage planning requirements for certain non-SOLAS ships operating in polar waters. The amendments will enter into force on 1 January 2026.

The amendments to Polar Code will be applicable to the following types of non-SOLAS ships on all voyages within polar waters:

(a) fishing vessels of 24 meters in length overall and above;
(b) pleasure yachts of 300 gross tonnage and upwards not engaged in trade; and
(c) cargo ships of 300 gross tonnage and upwards but below 500 gross tonnage.



Lifeboat ventilation

From 2 January 2026, new regulations will mandate ventilation for all new totally enclosed lifeboats installed on ships, with a minimum required rate of 5 m^3/h per person. The new requirements, adopted by the International Maritime Organization (IMO), are a result of incidents where high temperatures and carbon dioxide levels in enclosed spaces compromised crew safety.

New requirements for totally enclosed lifeboats
The amendments to the International Life-Saving Appliance (LSA) Code apply to totally enclosed lifeboats installed on or after January 1, 2029. All totally enclosed lifeboats must now provide:

- A minimum ventilation rate of 5 m^3/h per person, for the number of people the boat is certified to carry.
- A 24-hour runtime for the ventilation system, independent of the vessel's main power.
- An independent power source, such as a dedicated battery or the lifeboat's engine. If the engine is used, a sufficient fuel supply must be provided. The radio batteries cannot be used as a power source.
- Interior controls to operate the ventilation system from inside the lifeboat.
- Watertight closures for ventilation openings, operable from inside to prevent water ingress.

Ventilation for partially enclosed lifeboats and liferafts
Following the adoption of the regulations for totally enclosed lifeboats, the IMO began developing similar ventilation requirements for partially enclosed lifeboats and liferafts.

- The draft requirements propose a long-term CO_2 concentration below 5,000 ppm, potentially requiring an active ventilation rate of 5 m^3/h per person.
- These draft amendments are expected to be finalized in 2026, with potential application to new lifeboats and liferafts installed on or after 1 January 2032.

Maintenance and testing updates
Additional maintenance and inspection requirements that come into force on January 1, 2026, will also affect the ventilation systems of lifeboats.

- Enhanced maintenance standards for lifeboats and rescue boats, adopted via Resolution MSC.559(108), include specific inspection and testing of the ventilation systems during annual thorough examinations.
- The amendments reinforce the need for certified service providers to conduct these checks.





Key amendments affecting fire safety

Amendments to SOLAS will enter into force on 1 January 2026, introducing a ban on perfluorooctane sulfonic acid (PFOS)-containing fire-extinguishing media, enhancing fire safety in passenger and cargo ship vehicle spaces, adding fire detection and alarm systems to control stations of cargo ships, and requiring specific fire protection in Ro-Ro passenger spaces. These changes were adopted by the IMO Maritime Safety Committee (MSC) during its 108th session.

PFOS Prohibition

- The use and storage of fire-extinguishing media containing PFOS are prohibited from January 1, 2026, impacting both fixed and portable systems.
- Ships constructed before this date must not use or store PFOS-containing media above a concentration of 10 mg/kg.

Vehicle and Special Category Spaces

- There are new and enhanced fire safety requirements for passenger ship vehicle spaces, special category spaces, and Ro-Ro spaces (open and closed).
- The amendments also introduce new requirements for weather decks used for vehicle transport.
- Compliance deadlines are in place for these new requirements, especially for passenger ships built before January 1, 2026.

Fire Detection and Alarms

- Cargo Ships: Control stations and cargo control rooms on cargo ships built on or after January 1, 2026, must be fitted with a fire detection and alarm system.
- Passenger Ships: For passenger ships, fixed fire detection and alarm systems are required in service spaces, control stations, and accommodation areas, though not in private bathrooms or galleys.

Oil Fuel Safety
A new regulation in Chapter II-2 requires that oil fuel used on ships must not compromise the ship's safety, machinery performance, or the health of personnel.



Dangerous goods transport

The most recent IMDG Code changes are from Amendment 42-24, which became voluntary on January 1, 2025, and will become mandatory internationally on January 1, 2026. Key changes in Amendment 42-24 include new UN numbers and updated classifications for sodium-ion and lithium-ion batteries and vehicles, revised packing instructions, and the requirement to include subsidiary hazards on stowage plans. Businesses should update their processes and documentation to comply with these new regulations.

Implementation Timeline
2026: Amendment 42-24 becomes mandatory internationally.

Key Changes
- Battery and Vehicle Classification:
- New UN entries (e.g., UN 3556, UN 3557, UN 3558) for vehicles powered by lithium-ion, lithium-metal, and sodium-ion batteries.
- Revised classification criteria for lithium cells and batteries to ensure more accurate risk identification.
- Clarification that damaged lithium batteries must be handled under specialized instructions.

Stowage Plans:
A new requirement mandates that stowage plans must record both the primary and subsidiary hazards for dangerous goods.

Dangerous Goods List (DGL):
- Over 60 revisions to existing entries, including the addition of 11 new UN numbers.
- Changes to existing entries, such as the reclassification of UN 1891 ETHYL BROMIDE from Class 6.1 to Class 3 with a 6.1 sub-hazard.
- Removal of the exemption for carbon (UN 1361) from the IMDG Code by removing Special Provision (SP) 925.

Packing Instructions:
- More than 50 updates to existing packing instructions.
- Introduction of new packing instructions (P303 and P912).



UN High Seas Treaty to enter into force starting January 2026

The UN High Seas Treaty looking to safeguard marine biodiversity on the high seas has now met the required 60 ratifications for entry into force, clearing the way for it to take effect in January 2026.

Morocco and Sierra Leone joined the list of States ratifying on Friday, becoming the 60th and 61st parties to the pact. The treaty, formally known as the Agreement under the United Nations Convention on the Law of the Sea on the Conservation and Sustainable Use of Marine Biological Diversity of Areas beyond National Jurisdiction (BBNJ agreement), was adopted by UN Member States in June 2023 after nearly two decades of negotiations.

What is the High Seas Treaty?
The UN High Seas Treaty aims to protect marine biodiversity in areas of the ocean that lie beyond national jurisdiction (the "high seas"), which make up about two-thirds of the world's ocean.

Why it matters
- The high seas are international waters, not owned by any single country, and have historically been difficult to regulate.
- They are vital for regulating the Earth's climate, supporting fisheries, and maintaining biodiversity.
- But they've been threatened by overfishing, mining, pollution, and climate change.

Main goals of the treaty
- Conservation and sustainable use of marine biodiversity on the high seas.
- Creation of marine protected areas (MPAs): allowing countries to designate and enforce protected zones in international waters.
- Regulation of resource exploitation: ensuring fair sharing of potential benefits from marine genetic resources (e.g., from deep-sea organisms that might have medical or biotech applications).
- Environmental impact assessments (EIAs): requiring activities in the high seas to be evaluated for potential harm.
- Capacity building and technology transfer: supporting developing countries so they can also benefit and participate in ocean research and management.

Revised IMO guidelines for means of embarkation and disembarkation

New safety guidelines requiring crew to wear life jackets and safety harnesses when rigging ladders and gangways will become effective from 1 July 2026 according to Lloyd's Register.

The International Maritime Organisation (IMO), through MSC.1/Circ.1331/Rev.1, has revised the following: Guidelines for the Construction, Installation, Maintenance and Inspection/Survey of Means of Embarkation and Disembarkation to bring them in line with the latest international standards and introduce clearer definitions and safety practices.

The applicable ISO standard version for each type of means of (dis)embarkation is dependent on the date of equipment installation and the ship's construction date, Lloyd's Register points out.

The applicability of these standards is summarised in the table below:

New definitions
"Installed on or after 1 July 2026" means the date of: ship building contract or, in the absence of contract, the keel laying, or contractual date of equipment delivery or, in its absence, the actual delivery date of the equipment to the ship.

"Safety Net" is a net which is rigged between the ship's side and the means of (dis)embarkation to prevent a person from falling into the water or onto the quayside from a means of (dis) embarkation.

Installation Date	Ship Construction Date	Recommended International Standard*	Equipment
Before 1 July 2026	On or after 1 January 2010	ISO 5488: 1979 ISO 7061: 1993 ISO 7364: 1983	Accommodation ladders Aluminium shore gangways Accommodation ladder winches
On or after 1 July 2026	On or after 1 January 2010	ISO 5488: 2015 ISO 7061: 2015 or 2024 ISO 7364: 2016	Accommodation ladders Aluminium shore gangways Accommodation ladder winches
On or after 1 July 2026	Before 1 January 2010	† ISO 5488: 1979 or 2015 † ISO 7061: 1993, 2015 or 2024 † ISO 7364: 1983 or 2016	Accommodation ladders Aluminium shore gangways Accommodation ladder winches

* and/ or national standards and/or other requirements recognised by the Administration.
† insofar as is reasonable and practicable.

Image credit: Lloyd's Register

Mandatory safety practices
It has become mandatory for the crew to wear life jackets and safety harnesses while rigging the accommodation ladder, gangway and the safety net.

The revised guidelines have also introduced the possibility to use "side nets" on ladders as alternatives to a "safety net". A safety net is not required if the hazard of falling through the sides of the means of embarkation and disembarkation is adequately mitigated by a top railing of rigid construction that is at least 1m high and a "side net" is rigged between this railing and the base of the accommodation ladder, including its upper and lower platforms.

The safety net and/or side nets must be regularly checked and maintained and, if deemed necessary, be replaced. They should be properly stored in ventilated places, avoiding sunlight and chemical contamination.

Testing of ladders and gangways
MSC.1/Circular.1331/Rev.1 includes amendments to clarify that:

- The five-yearly testing of accommodation ladders and gangways are done statically using the maximum working load.
- For the five-yearly testing of accommodation ladders, the winch should be operationally tested by raising and lowering the unloaded accommodation ladder.
- The tests should be carried out with the ladder or gangway in the horizontal position, and the accommodation ladder should be suspended by the wire(s) and supported by the winch.

Shipowners, ship operators, ship masters and officers, as well as manufacturers, are advised to familiarise themselves with the new guidelines and to train and instruct the crew accordingly.

The International Marine Contractors Association

The International Marine Contractors Association (IMCA) is a leading UK-based trade association representing the majority of contractors and the associated supply chain in the offshore marine construction industry worldwide.

Their members play a key role in the offshore oil, gas, and renewable energy industry sectors. Principally, this is through the engineering, procurement, construction, and installation of offshore wind farms and hydrocarbon production facilities, together with the ongoing life of field support and maintenance requirements of these assets.

IMCA runs the successful eCMID inspection programme which encompasses a wide range of specialist vessel types from anchor handling tugs to jack-up barges. Inspectors are assessed and accredited on their behalf by IIMS, which manages the scheme.

IMCA Safety Flashes are released at regular intervals each month. The next section of the Compendium is dedicated to some of the key safety reports issued in 2025 that are of most relevance to marine surveyors and vessel inspectors.



Safety Flash: Published on 6 February 2025. IMCA SF 02/25

MAIB: Vessel cook injured by spillage of burning cooking oil

On an offshore support vessel, a cook was deep-frying fish in a shallow-sided gimballed "gyro" frying pan. Unbeknown to the cook the pan's thermostat was faulty. The oil overheated, started smoking and ignited shortly afterwards. The cook activated the fixed wet chemical fire-extinguishing system. As the wet chemical filled the gimballed frying pan the burning oil spilled out onto the galley deck, covering the cook's legs and feet in boiling oil. The cook's screams were heard by a passing crew person, who ran into the galley and dragged the cook out of danger. The wet chemical had successfully extinguished the fire in the pan but had made a mess of the galley and severely injured the cook. The electric supply to the gyro pan was isolated and the oil was left to cool in the pan before being removed. The cook was airlifted to hospital and treated for burns.

Read the article at **https://bit.ly/47pSYwj**.





Safety Flash: Published on 20 February 2025. IMCA SF 03/25

MSF: A broken stretcher could have led to injury

A medevac from a vessel required a patient to be transferred to the hospital. As the patient was being moved to a hospital bed, the stretcher cracked into two pieces with the patient on it. The patient was not further injured, but a more serious situation could have arisen had the patient been suffering from a back injury.

Read the article **https://bit.ly/3KYirFD**.



Safety Flash: Published on 19 March 2025. IMCA SF 05/25

Crane cab fire caused by fridge

At 03:52 the fire alarm panel on the bridge sounded, displaying an indication that fire detection within the crane cab had activated. There were no work tasks being conducted on the crane at the time of the alarm. Two team members were sent to investigate. Upon accessing the crane cab platform, the attending riggers confirmed there was a fire within the crane cab. The fire was confined to the crane cab, which was destroyed. The incident is suspected to have originated from an electrical fault within the small refrigerator located in the cab. During the incident, the challenge of accessing the area with firefighting equipment was identified as a significant issue.

Read the article **https://bit.ly/3L74TYe**.



Safety Flash: Published on 29 April 2025. IMCA SF 08/25

BSEE: Nitrogen cylinder rupture causing worker injuries and equipment damage

At the time of the incident, rig personnel had positioned a rack with 12 nitrogen cylinders to begin pre-charging the accumulator system cylinders with nitrogen. One of the nitrogen cylinders within the rack subsequently ruptured at its base, resulting in the dispersion of both the nitrogen cylinders and debris that was within the rack, as well as of the remaining cylinders situated in the immediate and port aft areas of the rig. Three rig personnel sustained minor injuries from shrapnel. BSEE notes that "the failure of the nitrogen cylinder, which is attributed to corrosive wall loss exacerbated by environmental factors and structural conditions, highlights critical vulnerabilities in the storage and maintenance of nitrogen cylinders, particularly in marine environments..."

Read the article **https://bit.ly/4osAjXp**.



Figure 1: Faulty grating covered in scaffold boards

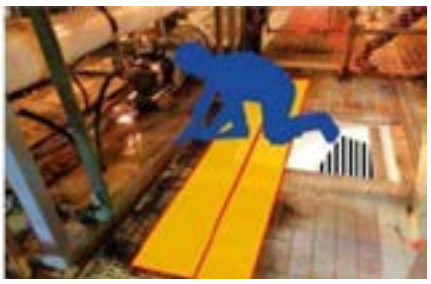


Figure 2: Operator's body position at time of incident

Safety Flash: Published on 4 June 2025. IMCA SF 10/25

BSEE: Failure to identify and restrict access to faulty gratings

During a facility walkthrough, operator personnel had identified grating near a skid as a hazard due to corrosion and installed hard barricades to prevent access. However, shortly thereafter, operator personnel installed two scaffolding boards on top of the previously identified grating hazard and removed the hard barricades so work could proceed. A worker tasked with installing a pump in the skid above the unsafe grating was kneeling on the scaffolding boards with the tip of his boots resting on the grating when the corroded section of grating suddenly gave way. The worker was able to quickly react, grabbing hold of a nearby section of piping to support himself. Upon further inspection, the worker later realized the 90cm x 90cm piece of grating beneath the scaffolding boards he was kneeling on had collapsed and fallen into the water.

Read the article **https://bit.ly/3Jbrd2s**.



Warning sign



Where the warning sign appears on the floor

Safety Flash: Published on 6 February 2025. IMCA SF 02/25

MAIB: Parted mooring rope leads to fatality

A deck officer was killed during mooring operations when a mooring rope parted and struck him on the head. The incident happened alongside on an ultra large container vessel. Cargo operations had been suspended due to very strong winds of over 50kts and the Master had taken the precaution of posting a crew member at the vessel's forward and aft mooring stations to monitor and adjust its lines. A deck officer was inspecting the safety and security of the vessel, and on reaching the forecastle, went forward of the mooring winches to inspect the lines. While the officer was in this exposed position, standing close to a mooring line, a strong gust of wind hit the vessel and the rope parted close to the bollard ashore. On board, a bight of the mooring line flew up as the tension was released, striking the deck officer's head. The ship's crew quickly raised the alarm and paramedics attended the vessel. The injured deck officer was taken to hospital but died a few days later.

Read the article at **https://bit.ly/4o40lRe**.



Safety Flash: Published on 18 June 2025. IMCA SF 11/25

MAIB: Is your lead-acid battery safe?

A crew member on a barge escaped injury when a bank of four lead-acid batteries exploded on starting a generator engine after completing the start-up checks. The four batteries simultaneously exploded as the start solenoid closed to power up the starter motor. Fortunately, the bank of batteries was housed in a secure steel battery locker that contained the explosion and limited the damage.

Read the article **https://bit.ly/4qsg520.**

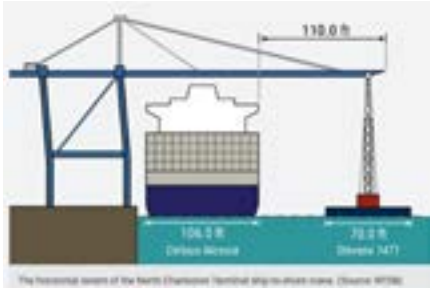


Safety Flash: Published on 18 June 2025. IMCA SF 11/25

Dropped object hazard: access hatch to the communication dome

An access hatch cover to the communication dome was found to have dropped off. During a routine scheduled safety inspection of the main mast, it was discovered that the access hatch to one of the communication domes had fallen off. Further examination revealed that the secondary means of securing the hatch was severely compromised. This posed a significant risk, as the next high wind or squall could have resulted in a dropped object with the potential to cause injury or damage.

Read the article at **https://bit.ly/47oAyfv**.



Safety Flash: Published on 18 June 2025. IMCA SF 11/25

NTSB: Vessel crane contact with shore-side crane

The National Transportation Safety Board of the United States (NTSB) has published Report MIR-25-09 and Investigation DCA24FM014 into an incident in which a crane on a crane barge came into unplanned contact with a shore-side crane, causing $4.5 million worth of damage. A towing vessel was pushing crane barge Stevens 1471 in the Cooper River at North Charleston, SC, when the barge crane contacted a dockside crane at the North Charleston Terminal. There were no injuries, and no pollution was reported. Damage to the terminal's crane was estimated to be over $4.5 million.

Read the article at **https://bit.ly/3LnXW59**.



Safety Flash: Published on 3 July 2025. IMCA SF 12/25

Near miss: worker suffers electric shock

The incident occurred whilst the worker was performing a small oil clean up on a 50t crane pedestal. The worker suffered the electrical shock when he brushed his hand against one of two disconnected cables coiled on nearby cable trays. The worker was subsequently visited by the vessel medic and was unharmed.

Read the article at **https://bit.ly/49fZIom**.



Safety Flash: Published on 31 July 2025. IMCA SF 13/25

Near miss: High voltage arc inside tether termination manifold

A high voltage arc occurred inside a ROV tether termination manifold. The ROV HPU Breaker tripped during the return of the ROV to the TMS. Initial investigation into the trip was conducted and findings indicated no hard fault was present. The ROV crew performed a reset of the breakers and restarted the ROV HPU to recover it to the TMS. Approximately 3 hours later, it was noted that the line insulation monitoring system for the ROV HPU was reading 12 M/Ohms, which under normal operation would read >60 M/Ohms. Upon investigation after recovery to deck, the crew found there was approx. 80mm of gas at the top of the tether termination manifold. The system was isolated; the gas was vented out and the oil was drained out of the manifold. Inside the manifold it was noticed that one of the ROV HPU conductors had dislodged from its crimp which had in turn caused electrical arcing in the manifold.

Read the article at **https://bit.ly/4oxcu0P**.



Safety Flash: Published on 14 August 2025. IMCA SF 14/25

Head injury in engine room

A Chief Engineer sustained a head laceration injury after accidentally striking his head on the sharp edge of a lighting protection grille rod installed at a height of 168 cm in the engine room.

Read the article at **https://bit.ly/4qmJHgZ**.



Safety Flash: Published on 14 August 2025. IMCA SF 14/25

Shore-side crane boom collides with vessel mast

As a result of the collision, a wind sensor and GPS sensor were dislodged and fell to deck. Additionally, a fixing clamp was later found on the main deck, approximately 30m away. This was a high potential incident; both the wind sensor and the fixing clamp could have struck a person, potentially causing serious injury or even fatality.

Read the article at **https://bit.ly/49gkJd7**.



Safety Flash: Published on 4 September 2025. IMCA SF 16/25

MSF: Watertight door fatality

An individual at a marine worksite was found in between the sliding hydraulic watertight door and the door frame. He was found unconscious and not breathing. He was brought to sick bay and assessed with no signs of life. Although actual causes have yet to be determined since the investigation is still ongoing, the purpose of sharing this alert is to facilitate reflective discussions with vessel marine crews and interested parties on the dangers posed by watertight doors.

Read the article at **https://bit.ly/4ndlM0N**.



Safety Flash: Published on 4 September 2025. IMCA SF 16/25

BSEE: Electromagnetic lifting device dropped steel plate

The United States Bureau of Safety and Environmental Enforcement (BSEE) has published Safety Alert 500 relating to a defective lifting device dropping a steel plate during drilling operations, and two persons were injured. The incident occurred while transferring a partial 3/8" (95mm) steel plate sheet using a magnetic lifting device. During the lift, the steel plate unexpectedly detached from the magnet and fell approx. 1.2m, landing on top of both individuals' left feet. Both personnel reported bruising and swelling and were evacuated for medical evaluation.

Read the article at **https://bit.ly/4opkUau**.



Safety Flash: Published on 4 September 2025. IMCA SF 16/25

Two hand injuries caused during mooring

Following the replacement of a damaged mooring line on an FPSO, two crew members installed protection to secure the new line. The task occurred during rough weather. As the mooring line slackened, one of the workers grabbed it to position the protective material. As they did so, the swell caused the vessel to move. The mooring line tightened, trapping and injuring the hand of the worker, who was not wearing suitable gloves at that point.

Read the article at **https://bit.ly/47CA9ag**.





Safety Flash: Published on 17 September 2025. IMCA SF 17/25

Uncoordinated emergency shutdown due to pipe failure

During tanker cargo discharging operations at a terminal, all three cargo pumps (No. 1, 2, and 3) tripped simultaneously due to Emergency Shutdown (ESD) activation. The duty AB observed a minor leak during a routine pump room patrol and triggered an emergency stop for all cargo pumps without prior coordination with the Cargo Control Room (CCR). This led to an immediate halt in operations, although the situation was later assessed to be non-critical. No injuries were reported, and cargo discharge resumed after safety confirmation. The duty AB had "stopped the job" by activating the ESD but did not communicate the situation with the CCR before acting.

Read the article at **https://bit.ly/47ApGMB**.



Safety Flash: Published on 17 September 2025. IMCA SF 17/25

Unsafe lifting practices during dry dock

During vessel repairs in a dry-dock, an unsafe attempt was made by employees of a dry-dock contractor to lift 14 empty oil drums using only a web sling, without clamps, certified frames, or proper securing. The job was stopped immediately, and a stand-down was held with contractors and vessel crew to stress safe lifting practices for personnel health and vessel integrity.

Read the article at **https://bit.ly/3WiXaJ1**.



Safety Flash: Published on 2 October 2025. IMCA SF 18/25

USCG: Lithium-ion battery system installations

An integrated Li-ion battery bank recently caught fire onboard an inspected passenger vessel when loosely crimped lugs overheated. While no one was injured and the vessel sustained minimal damage, the event highlights safety hazards unique to Li-ion batteries. The USCG recommended that integrated (installations used for propulsion and electrical power) Li-ion battery systems should undergo engineering plan review, be fitted with supporting safety systems, be tested and inspected at installation and periodically afterward, and be properly maintained by competent mariners, regardless of the battery bank size or end consumer.

Read the article at **https://bit.ly/4ngvqzG**.



Safety Flash: Published on 2 October 2025. IMCA SF 18/25

Crane cab access platform collapsed

The incident occurred as the Crane Operator (Bosun) was starting work. While the Bosun was climbing the ladder to the cab, the access platform with its protective cage, connected to the crane base, suddenly failed. As a result, the Crane Operator fell within the ladder's protective enclosure, which partially mitigated the fall. The Crane Operator was shaken but not injured.

Read the article at **https://bit.ly/3JotPKj**.

Case studies follow extracted from the MAIB Safety Digest of 2025

MAIB
MARINE ACCIDENT INVESTIGATION BRANCH

SAFETY DIGEST

Lessons from Marine Accident Reports

1/2025







Featuring introductions by Gary Doyle | Anne Hornigold MBE | Mark Bleecker

Is your battery safe?

barge | explosion

A barge crew member escaped injury when a bank of four lead acid batteries exploded on starting a generator engine after completing the start-up checks. The four batteries simultaneously exploded as the start solenoid closed to power up the starter motor. Fortunately, the bank of batteries was housed in a secure steel battery locker that contained the explosion and limited the damage (Figure 1).

An investigation found that the batteries, which had been in service on the vessel for more than 5 years, were of a low maintenance, valve-regulated lead acid (VRLA) type that was incorrect for their intended purpose due to the battery circuit being maintained by a continuous float charge. The battery charging system was found to be working correctly, maintaining the required rate of trickle charge.

Given the wet cell nature of the batteries and the length of time they had been in service, it is most likely that the electrolyte level had gradually dropped because of continuous float charging. This exposed the top of the cell plates, which probably started to corrode. The cells shorted out when the batteries were subjected to a high discharge load, causing the explosion (Figure 2).



Figure 1: Battery locker after the explosion

The Lessons

1. **Equipment** → It is important to select the right type of lead acid battery for the intended purpose:

   Flooded or wet cell batteries contain an electrolyte of sulphuric acid/distilled water and require regular maintenance to retain the correct electrolyte level in the cells. These batteries must be stored upright to prevent leakage. This type of battery is most suitable for installations that utilise float charging in the battery circuit to maintain the charge. The service lifespan is 5 years to 7 years;

   Low maintenance wet cell VRLA batteries have sealed cells with a valve arrangement to release the gases created by charging the battery. The electrolyte level cannot be maintained by topping up. These batteries are most suitable for intermittent use where the battery circuit is not maintained by a float charge. The service lifespan is 5 years to 7 years, although batteries installed in a system using a continuous float charge should be replaced after 2 years of use due to the increased risk of explosion under high discharge loads;

   Maintenance free gel type VRLA batteries have similar properties to wet cell VRLA batteries and are most suitable for intermittent use. Batteries installed in a system using a continuous float charge should be replaced after 2 years of use;

   Absorbent glass mat (AGM) batteries are a type of VRLA battery. The electrolyte is absorbed and suspended between AGM plates to provide extended life and durability. These batteries are designed for intermittent charging use and should be replaced after 2 years if installed in a system using a continuous float charge.

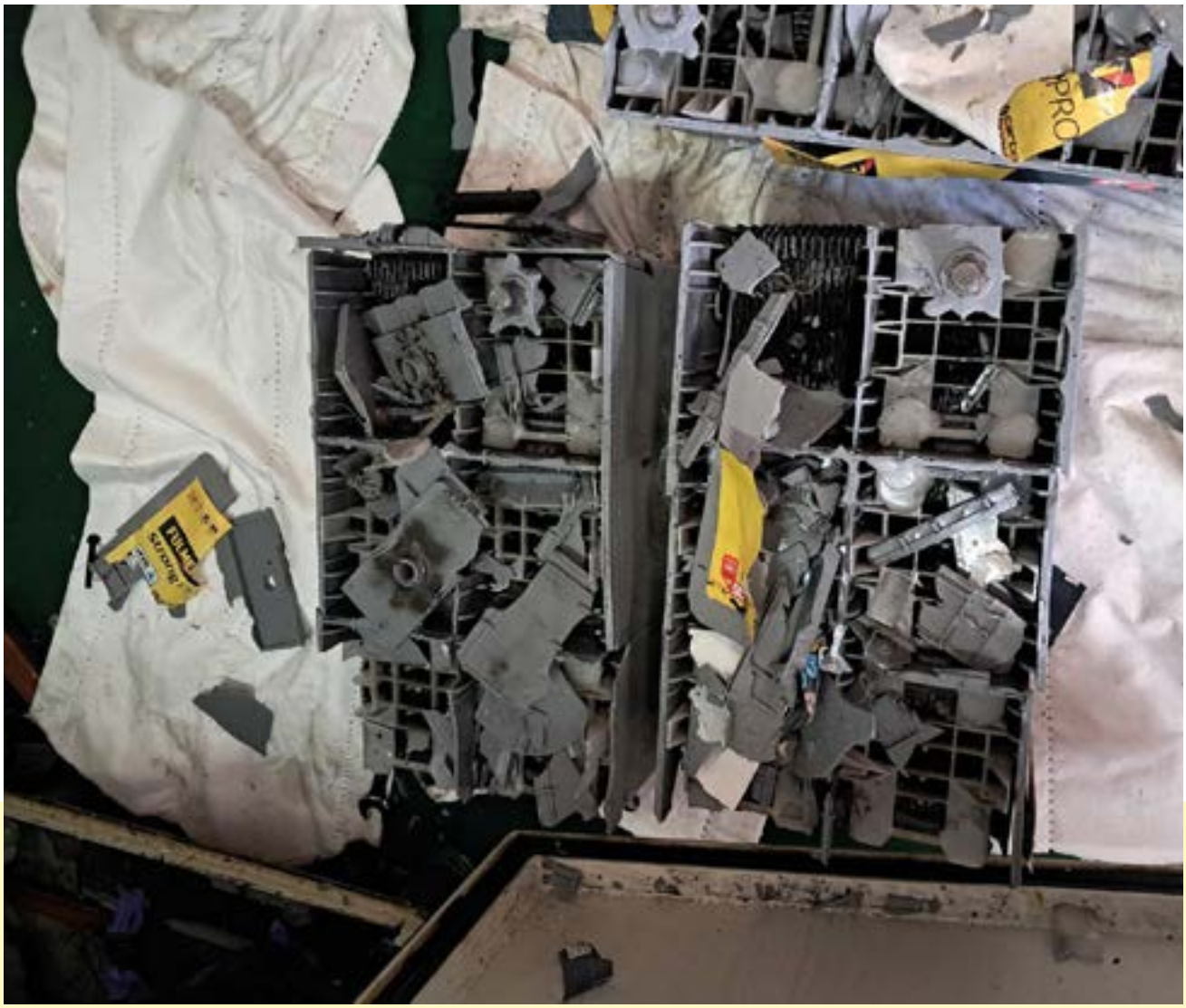


Figure 2: Destroyed batteries

2. **Maintain →** Batteries are a piece of machinery and require a documented service and maintenance log. The record should individually list the type of battery; where it is located on board; when it entered service; dates and details of any inspections or maintenance and, if applicable, what corrective action was taken; and when it is due for replacement.

3. **Hazard →** Safe stowage of battery installations is crucial to contain and minimise impact in the event of a fire or explosion. To prevent a build-up of gases from the charging process batteries should be kept in a purpose-built, well-ventilated locker in a cool, dry location away from the elements. Light fittings in a battery compartment should be corrosion-resistant and flame/explosion-proof.

That was not supposed to happen

chemical tanker | explosion

A chemical tanker was moored alongside waiting for another vessel on its offshore side to finish purging its cargo tanks with nitrogen. Without warning one of the cargo tanks exploded, sending a large fireball skywards towards a major road bridge (Figure 1). Remarkably, just one crew member on each ship was injured.

The tanker had loaded a multiple parcel cargo some weeks before. Some of the cargoes required heating, inert atmospheres and/or inhibiting chemicals for stabilisation. One of the cargoes, styrene monomer (an aromatic hydrocarbon used to manufacture plastic, rubber and polystyrene products), was inhibited for the voyage. However, the inhibitor was only effective for a time-limited period within a specific temperature range.

Under normal circumstances, styrene monomer was a benign cargo that did not create any issues when stowed in ambient temperatures away from heated cargoes. Consequently, the chemical was not monitored by the crew, and alarm systems were not enabled.

The styrene monomer was in three of the chemical tanker's 39 cargo tanks. The other tanks contained various chemicals, some of which were heated (Figure 2).

Unfortunately, the heated cargoes in this case were adjacent to cargoes that readily absorbed heat and transferred it to the styrene monomer cargo. The raised temperatures affected the polymerisation inhibitor, reducing its time-limited efficacy. The ineffective inhibitor had triggered a thermal runaway incident that caused high pressure to breach the tank and ignite, likely due to static electricity.

The Lessons

1. **Check →** There are strict rules and regulations for the safe carriage of chemicals. However, while the cargo might be correctly stowed to meet both these and the requirements of the charterer there is a risk that less apparent issues could be missed. Check loaded cargoes frequently to determine whether they are behaving as expected and, if they are not, contact the ship's operating company or the chemical's supplier for advice.

2. **Equipment →** Liquid cargo monitoring equipment usually has a temperature alarm function. Check the safety data sheet and carriage instructions for crucial temperatures and set the alarms in line with these.

3. **Plan →** A phone call ashore could offer solutions, but might prove ineffective mid-voyage when the ship is several days from port. The preparation of a robust shipboard response procedure will ensure that you are well-equipped to deal with unexpected events during the carriage of sensitive cargoes.

4. **Risk →** Inhibited cargoes are stable for a limited amount of time. The inhibitor could lose its effectiveness if the voyage is extended, causing the cargo to become unstable and change to a hazardous state. Make sure risk assessments account for this possibility and that appropriate mitigations are in place.

Source: @803_Gorani (X.com)



Figure 1: The major road bridge

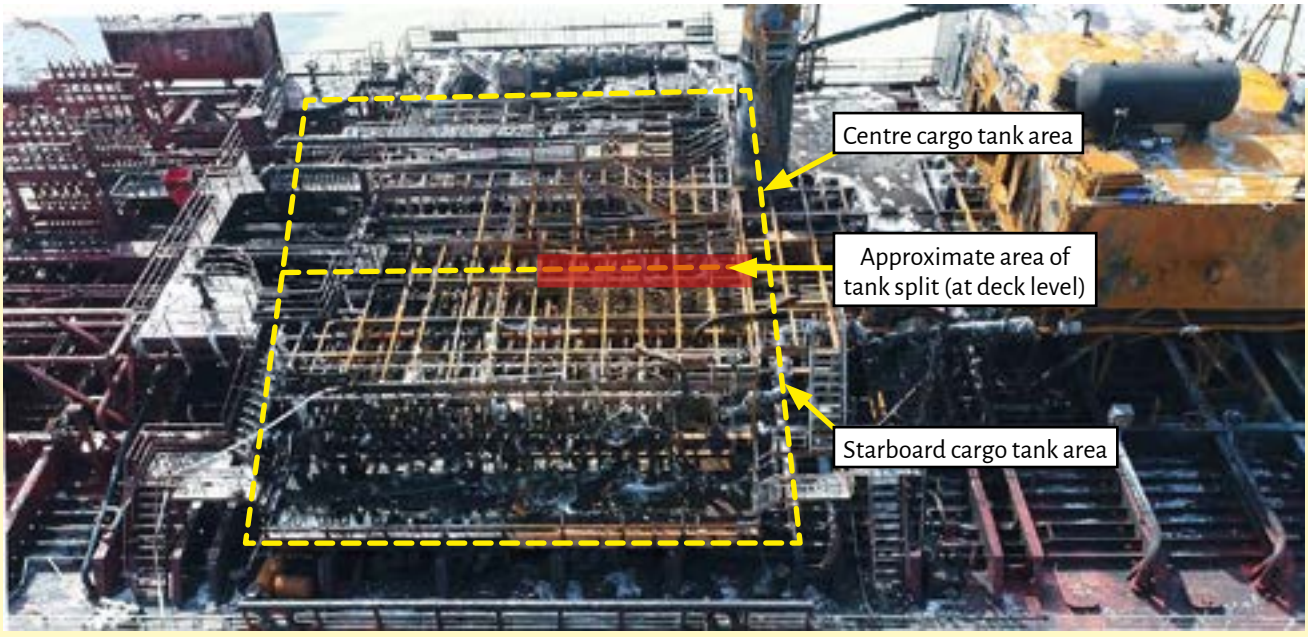


Figure 2: The chemical tanker's main deck

A little too much flexibility

oil tanker | fire

On a chilly but calm autumnal morning, an oil tanker was approaching its destination berth where it was to discharge a cargo of naphtha, a flammable hydrocarbon mixture used to manufacture fuels and solvents.

The bridge team worked together to bring the vessel into position alongside the berth on schedule. The crew on the mooring boats had just collected the first forward and aft lines and were running them to shore when the tanker's local fire suppressant system in the engine room activated, triggering the fire alarm.

From the engine control room, the chief engineer (C/E) and second engineer (2/E) could see smoke in the vicinity of the combined exhaust/oil-fired boiler. The C/E grabbed a fire extinguisher and started to make their way to the boiler. As they approached, they could see fuel oil running down the side of the boiler and realised that something was amiss with the fuel system. The C/E hurried down two ladder flights and stopped the fuel pumps while the crew closed the quick closing valves on the fuel oil system, causing the ship to lose power. The 2/E started to gather and prepare the engine room fire team.

The master led the coordination of the on board response to the fire and the pilot informed the shore authorities. Mooring operations were suspended, tugs were called to stand by the vessel in case the situation worsened and the local fire and rescue service was notified.

The oil tanker's crew set up boundary cooling and a fire team made an entry into the engine room, targeting the combined boiler and the lagging below it. Twenty minutes after the initial alarm, the fire was declared extinguished. The oil tanker was later secured to the berth without further incident, where the fire and rescue service confirmed that the fire was out.

The fire had started when a connection on the flexible fuel return hose failed where it was joined to the burner unit on the boiler (Figure 1). Fuel from the detached connection had sprayed onto adjacent hot surfaces, causing a fire of such intensity that it caused serious damage to the equipment in that area (Figure 2).

The Lessons

1. **Equipment →** The fire was caused by the failure of a flexible hose connection containing fuel under pressure. The history of the hose assembly could not be traced, and it is possible that it had not been changed since the tanker was built. In 2023, the MAIB issued a safety bulletin[1] to emphasise the hazards of such flexible hose installations and highlight that flexible hoses had a higher risk of failure than properly fitted metal pipes. It is vital that flexible hoses are inspected and changed out at regular intervals, and that detailed records are kept.

2. **Action →** Early reaction to an alarm can prevent escalation. Once alerted to the fire both the bridge and engine room teams acted quickly to ensure the safety of the oil tanker, crew, and the terminal. The master's efficient coordination of the individual teams facilitated a quick and early response to the emergency from the very first alarm and the well-prepared actions taken by the crew prevented a serious situation becoming catastrophic.

1 MAIB Safety Bulletin 1/2023 https://www.gov.uk/maib-reports/safety-warning-issued-about-the-hazards-of-flexible-hose-installations

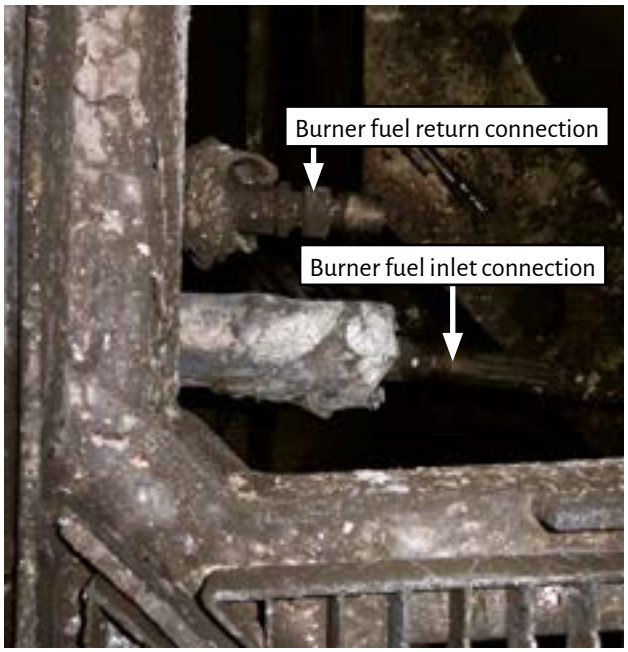


Figure 1: Return line connection

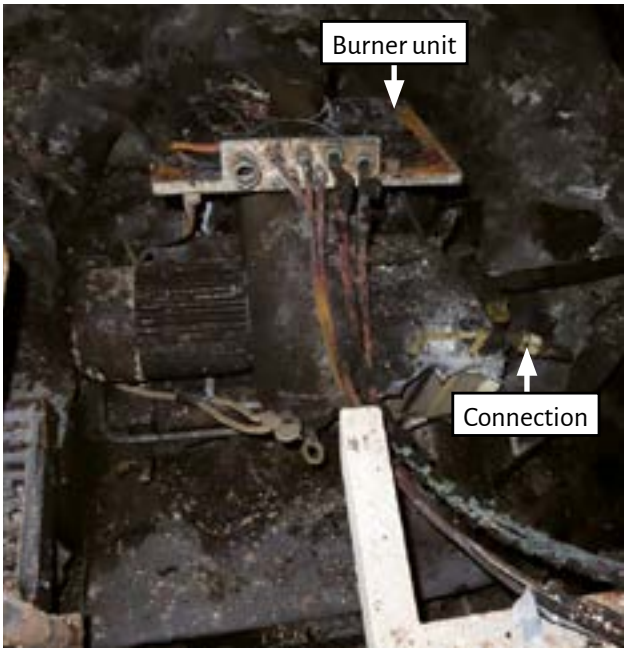


Figure 2: Damage to the boiler

3. **Teamwork →** The crew had completed regular drills, including a simulated engine room fire exercise only the day before the accident. Practising various scenarios is an opportunity to develop crew skills, test emergency procedures and ensure that equipment and systems are in place and working. There is no guarantee that every situation can be brought under control. However, the chances increase substantially when the crew are well-drilled in their individual and collective responsibilities.

Plucked from danger

potter | capsize

Source: Stock image by Olivier Rouge via Unsplash



On a November morning, the lone skipper of a small creel fishing vessel was thrown overboard into cold water when their boat capsized in swell near a rocky coast. The skipper was wearing a lifejacket, but had no means of raising the alarm from the water. Fortunately, the incident was witnessed by the crew of a rescue helicopter who were conducting a training exercise in the area and spotted the skipper clinging to their vessel's upturned hull. The rescue helicopter immediately responded and the skipper was recovered from the water and treated for hypothermia by the on board medic during the transfer to the local hospital.

The skipper underwent a thorough examination before being discharged from hospital later the same day with no severe injuries. Despite remaining afloat and visible from ashore for a while after its capsize, the fishing vessel later sank.

The Lessons

1. **Cold water shock →** A prompt rescue was critical to avoid the skipper succumbing to the increased risk of drowning or heart failure due to the immediate effects of cold water shock, which is associated with a gasp reflex, hyperventilation and a rapid increase in heart rate and blood pressure. The skipper was wearing a lifejacket and managed to cling to the upturned hull, but lacked a means of raising the alarm from the 12°C water. Given the circumstances, it was remarkably fortunate that the rescue helicopter happened to be in the right place at the right time.

2. **Equipment →** Staying afloat is futile without rescue, particularly when operating alone. Having the means to send a distress alert via an Emergency Position Indicating Radio Beacon registered to your vessel or a personal locator beacon attached to your lifejacket enables search and rescue teams to identify and find you.

3. **Teamwork →** Operating a vessel alone is dangerous and challenging, especially in emergency situations. The presence of other crew could have facilitated a better working arrangement and might have prevented the accident from occurring.

4. **Check →** Adverse conditions such as high winds, sea swells or sudden waves might have contributed to the capsize of the vessel involved in this case. Make sure the prevailing and forecast weather conditions are suitable for your planned activities, particularly when operating alone.

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Too low and too heavy

gill netter | fatal accident

On the day of this accident, the sea conditions were choppy and a 2m swell was running. Few local boats from the same port had ventured out.

The 8m gill netter had a bulwark of 60cm, about knee height, around its entire deck. The bulwark had been supplemented by a guardrail around the forward deck area, raising the height of the barrier to 97cm. Aft of the small wheelhouse, the only protection was provided by the low bulwark (Figure 1).

The skipper and deckhand had worked together for many years and had left their home port early to fish. By about 0830, they retrieved their nets and decided to head back to port. Neither crew member was wearing a PFD. After helping the skipper to move some nets on the aft deck, the deckhand went to the wheelhouse to adjust the vessel's course. About 30 minutes after turning for port, the deckhand heard a shout and, looking out of the open wheelhouse door, saw the skipper had fallen over the low bulwark into the water and was struggling to stay afloat off the vessel's starboard quarter. The deckhand quickly threw a lifebuoy into the water and manoeuvred the vessel alongside the skipper. Despite the deckhand's best efforts, the skipper was too heavy to be recovered by one person. About 30 minutes after hearing the initial shout for help, the deckhand managed to tie the now unconscious skipper to the vessel's side to keep their head above the water and went to the wheelhouse to make a "Mayday" call on the VHF radio (Figure 2).

On hearing the call, the coastguard deployed both a rescue helicopter and a lifeboat to assist. The helicopter was the first on scene and lowered a winchman down to the fishing vessel's deck. The deckhand and the winchman worked together to lift the skipper from the water onto the deck and started CPR. The skipper was airlifted to hospital and later declared deceased.

The Lessons

1. **Procedure →** Both the skipper and deckhand had encountered man overboard (MOB) events before, but had not completed emergency drills on board this vessel. This was a missed opportunity to understand the difficulty of recovering a person from the water, especially someone who is unable to assist in their own rescue. Well-prepared and practised vessel-specific emergency procedures can be lifesaving.

2. **Risk →** The skipper and the deckhand had worked together for decades and were familiar with the vessel and each other. The obvious risk presented by a low bulwark on a small boat in rough seas was overlooked simply because they 'always did it that way.' Risk assessment does not need to be complicated: a simple step-by-step walk through of a routine on board task can help highlight hazards that might otherwise go unnoticed.

3. **Action →** Every second counts in an emergency. The deckhand in this case responded quickly to the skipper's situation but did not immediately call for help. It takes seconds to raise the alarm by pressing a digital selective calling (DSC) alert button and just a few minutes to complete a "Mayday" call via VHF radio: whichever method you have to hand, making an early call to the emergency services can save lives.

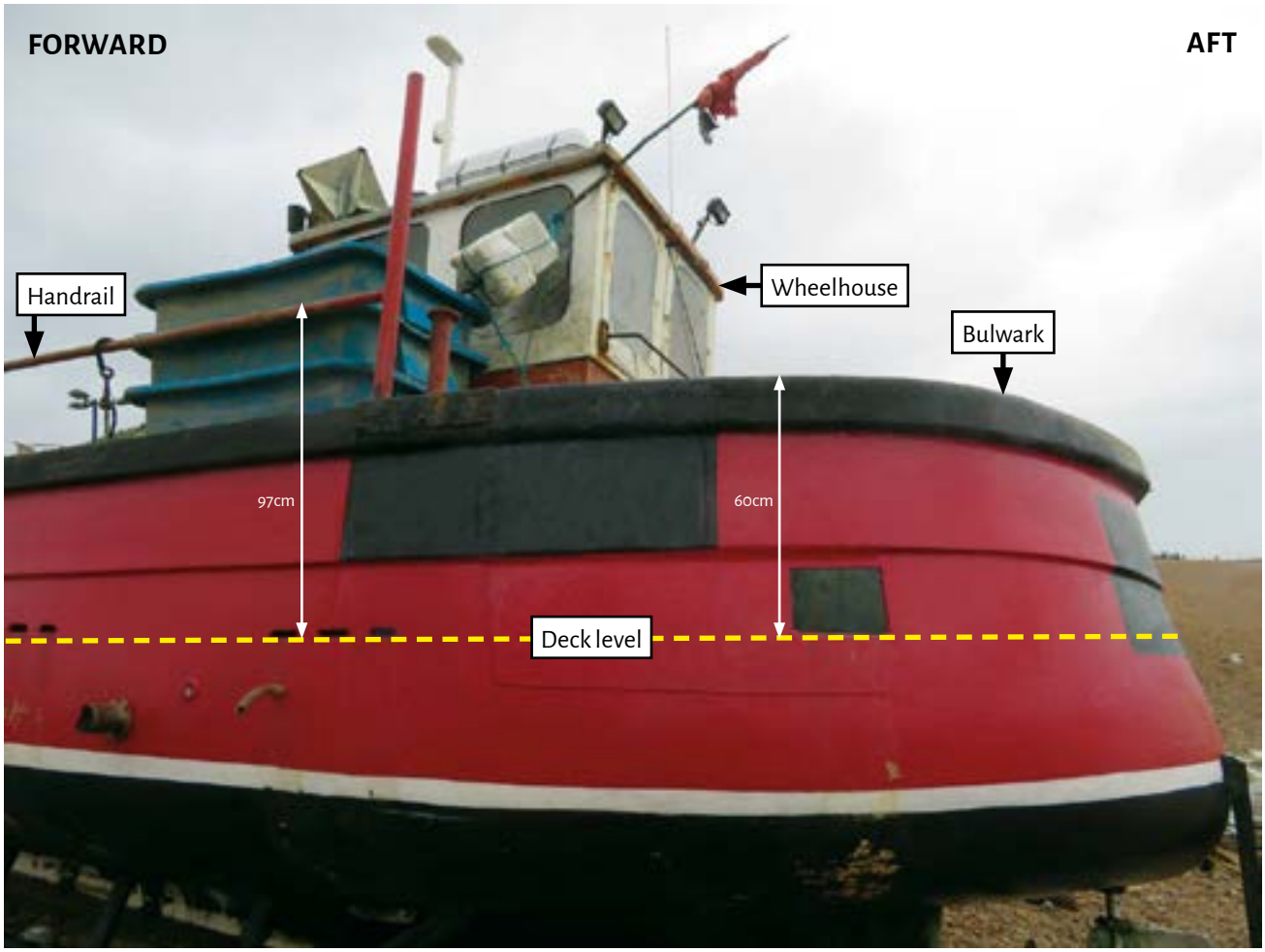


Figure 1: The low bulwark on the fishing boat

Source: Made Smart Group BV 2023

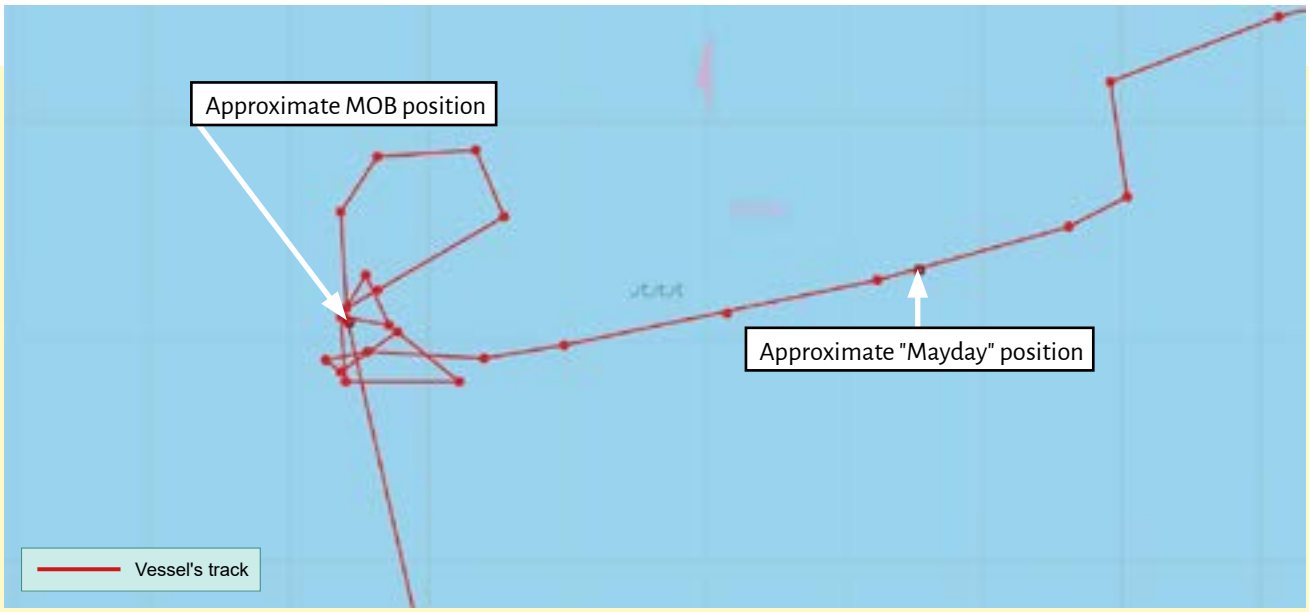


Figure 2: The "Mayday" call via VHF radio

Escape from an inferno

trawler | fire

A UK registered beam trawler was fishing in fine weather when its running starboard generator overheated and stopped, leading to a total loss of electrical power. The mate asked a deckhand to go below to the engine room and start the port generator to restore power. Shortly after starting the port generator the deckhand noticed a fire near the main engine.

The fire alarm sounded and smoke filled the accommodation spaces. Crew there tried to escape through a hatch onto deck but found it obstructed by vegetable boxes stowed on the other side (Figure 1). They were able to make their way out safely by another route. The location of the fire prevented the deckhand from using the usual access ladder out of the engine room, forcing them to exit by climbing on top of the main engine through the flames, and using an open emergency escape hatch onto deck. Once out, the deckhand was doused with water by their fellow crew members. They had sustained serious burns to around 40% of their body (Figure 2).

A "Mayday" call was transmitted and a local angling boat was first on scene. The injured deckhand was transferred across to it and taken ashore at high speed to be placed into the care of the medical services. They required hospitalisation in a specialist burns unit.



Figure 1: The blocked escape hatch



Figure 2: The deckhand's burnt clothing

In the 3 months leading up to the fire, the vessel's main engine fuel system had become difficult to prime due to debris in the fuel tanks causing the fuel lines to clog. In an attempt to resolve

The Lessons

1. **Maintain →** The vessel's fuel system had a build-up of debris in the storage tanks, leading to the blockages in the pipework. Rather than deep cleaning the fuel system, the owner had opted to install the fuel oil day tank. It is always better to fix the underlying issue than devise a way around the problem it creates.

2. **Inform →** The addition of a fuel oil day tank was a major modification that posed a huge fire risk that the owner had not appreciated. The Maritime and Coastguard Agency (MCA) need to approve modifications before they are undertaken to make sure that a vessel's safety is not affected by any proposed changes. Early engagement with the relevant authorities can prevent costly delays and ensures compliance with the standards in place to protect the crew and equipment.

the problem, a small additional fuel oil day tank serving the main engine had been fabricated and fitted in the engine room. Its installation had not been completed before the vessel resumed fishing.

The day tank was designed to be replenished automatically using a fuel transfer pump controlled by two float switches, but the work to install the wiring for the pump control was not completed. The lack of automatic control meant that the tank needed to be topped up manually by the crew every 30 minutes. This was done by plugging the fuel transfer pump into a 240-volt extension lead until the tank was showing full on the gauge pipe, after which it was unplugged. The fuel oil day tank had an open vent pipe on top of it, into which a plastic hose had been loosely inserted (Figure 3).

On the day of the accident, when the boat first lost power, the deckhand had thought that the problem could be fuel-related so, as they entered the engine room, they plugged the fuel transfer pump in. When they started the port generator, the fuel transfer pump started and began filling the new fuel oil day tank. When the tank was full, it overflowed through the vent and the spilled fuel ignited on the starboard generator's hot exhaust, engulfing the engine room in smoke and flames.

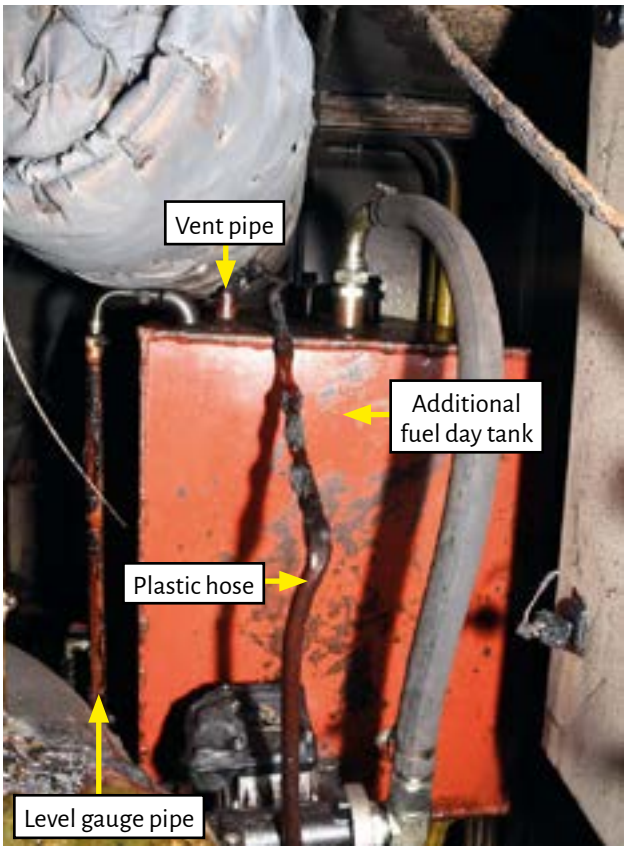


Figure 3: The installed fuel oil day tank

3. **Procedure →** Emergency escape hatches must be able to function as intended. In this case the deckhand knew where the emergency escape from the engine room was, and was able to escape through it. However, the escape hatch from the accommodation was routinely obstructed by the fruit and vegetable boxes. Thankfully the crew were able to escape safely this time, but it could have been worse.

4. **Qualified →** Despite regularly being tasked to carry out jobs in the engine room, the vessel's crew were neither trained in engineering nor had any engineering experience. The injured deckhand did not understand how the retrofitted fuel oil day tank operated, and was unaware that the system was not fully commissioned. Qualified crew who are familiar with the correct operation of a vessel foster a safer working environment for all on board.

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Why do the same marine accidents keep happening?





By Zella Compton

Zella Compton is the managing editor of Marine Industry News. Zella is a journalist and author specialising in marine news, maritime news, and marine business news.

info@marineindustrynews.co.uk
https://marineindustrynews.co.uk/

Despite years of investigations and countless safety recommendations, the same types of marine accidents continue to occur. **Why?**

According to Andrew Moll, chief inspector at the UK's Marine Accident Investigation Branch (MAIB), the answer lies in human behaviour, missed opportunities, and a lack of real cultural shift in the way boating safety is viewed. In this exclusive interview, Moll unpacks the challenges — and the changes the industry must embrace.

"No matter how hard we try to promote safety there will always be some that think 'it' will never happen to them," says Andrew Moll, chief inspector of marine accidents for MAIB – the UK's Marine Accident Investigation Branch.



Capt Andrew Moll, OBE,
Chief Inspector of Marine Accidents for MAIB

He's been with the organisation since 2005. "You would have thought I had seen it all by now," he says. "However, the marine industry is so diverse that there is always something new to learn, and even after 20 years, every day feels like a school day."

Horrific accidents get the message across

It must be frustrating to see accidents repeat themselves time and again. Moll (pictured left) reflects whether accidents repeat because the lessons are not being learned, or because MAIB is not being effective enough in promoting safety messages.

"MAIB is not into generating clickbait, but we do need to make our safety messages accessible for those that are unlikely to read a full investigation report," he says.

"Sad to say, it sometimes takes a really bad accident for it to resonate sufficiently to change behaviours. The rigid inflatable boat accident in May 2013 on the Camel Estuary when a family of six were ejected from their boat was a really horrible accident that resonated across the UK.

"The RIB kept circling over the family, causing death and injury until it could be brought under control. Following that accident, the need for RIB drivers to wear a kill cord, so the engine would stop if they left the helm, really got through, and the incidence of out-of-control RIBs and speed boats dropped right down.

"Even though that accident occurred 12 years ago, I know that some powerboat instructors still refer to it in their teaching, so the lessons are not lost."

But, having horrific outcomes from each accident is definitely not wanted by anyone, even if it is a proven way to get the message across.

Different perceptions of safety between sail and power boaters

Moll thinks that a person's route into boating may affect their perception of safety.

"As sailing boats tend to be more affected by the wind and tidal streams, sailors need to learn about the elements if they want to make progress," he says. "The risks of being set onto a lee shore or on to rocks or shallows can also be greater if your speed is limited.

> "On a calm day, roaring around in a powerboat can seem very easy, so complacency can be a risk."

One of the risks which power-boaters face is shock mitigation.

"Just this last summer, MAIB has been notified of eight spinal injuries to passengers travelling in small high-speed boats, including one crushed disc and four fractured vertebrae. The risks are very real, but they can be mitigated by awareness."

No requirements for boat drivers to be trained

Moll says most of the victims of leisure craft accidents that MAIB deals with are shocked that there are no requirements for boat drivers to be trained or to have insurance.

"I will always advocate training because you can get so much more pleasure out of boating and are less likely to have accidents if you know what you are doing," he says.

"We work with the sport national governing bodies (NGBs), such as the RYA, quite a lot, and they are always willing to reflect the lessons learned from accidents in their training to help improve future safety. However, I also recognise some of the challenges they face.

> "It can be hard to attract people to take up a 'fun' sport if the training is full of dire warnings about the perils involved."

"The NGBs can also face the challenge of having to cram a lot of training into reasonably short, accessible courses. Provided students understand the limits of the training they have received and are signposted towards future learning that can take them to the next level, they will, I hope, better understand their capabilities."

An MAIB inspector in action



The body's capability for survival is something that Moll wishes more people were aware of.

Boat owners need to understand cold-water shock

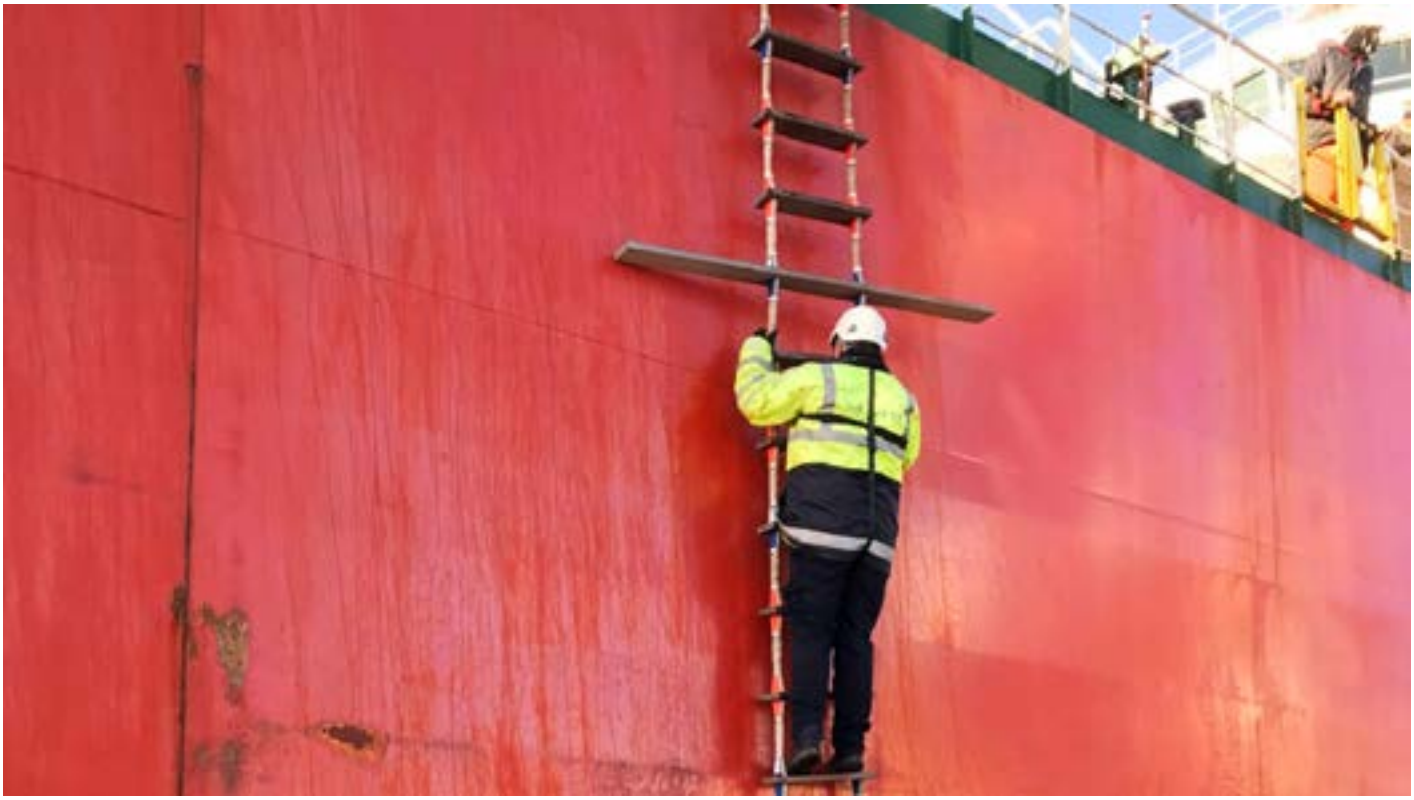
"I wish more people understood the dangers of being suddenly immersed in cold water (below 15C) — the waters around the UK are 'cold' almost all year round," he says. "I am afraid I could bore for Britain on 'cold shock', which is the sudden gasp reflex we experience on being suddenly immersed in cold water, and 'cold incapacitation', which reduces our ability to swim, tie knots, let off flares, or conduct other tasks that could help us survive and be rescued.

"Even on a hot day, the water can be very cold and wearing a lifejacket really will help you survive whether you are expecting to enter the water or not.'

Moll is ex-Royal Navy and classifies himself as fortunate that most of his military career was spent at sea, in small ships and large.

"The people were great, which was important as some of our deployments could be nine months long. The navy taught me to evaluate risks, to plan, and to always have a Plan B, so I suppose it set me up well to be an accident investigator, where my job has been looking into why other people's plans have not worked out as intended."

An MAIB inspector climbing aboard a vessel



The digital age affects safety at sea

Recently Moll spoke out about the role of human watchkeepers at sea. "Humans do not make good monitors, and if under-stimulated, they will find other things to occupy themselves," he said, and this means, there's "a need to radically rethink the role of human watchkeepers in the digital age."

But he's not pinning all his hopes on technology to solve maritime challenges.

While technology is a great enabler, it can also tempt boat owners into shortcuts and – sometimes – laziness. "A simple example is the car driver who ends up somewhere completely unexpected after blindly following their SatNav, simply because they did not check that the destination made sense before they set off.

"On most boats, the electronic navigation system will tell you exactly where you are, including if you are hard aground on a reef. The trick is to make sure it helps keep you safe as well."



Two of the images from MAIB's annual report 2024 front cover

"To use technology effectively we must ensure it attracts our attention when we need it too. You cannot expect your navigation system to alert to you an imminent grounding if you have not input a minimum depth setting and a look ahead zone."





Two more images from MAIB's annual report 2024 front cover

Timely reporting on accidents

And when it doesn't keep people safe, Moll says his biggest challenge is getting accident reports out the door fast enough.

"We will never keep up with the media, who move on so quickly to the next story," he says. MAIB is currently investigating the *Bayesian* disaster. "However, when we know the investigation report that tells the whole story is going to take time, we will not hesitate to issue safety bulletins when we identify urgent messages people need to hear."

Maritime safety isn't just a box-ticking exercise — it's a matter of life and death. From cold water shock to untrained boat operators, the risks are real and persistent. As Moll stresses, safety messaging must evolve, and training must not only inform but resonate. The sea may be unpredictable, but preparation for it shouldn't be. As MAIB continues its mission, lasting change can only come if the entire industry — and its recreational participants — take safety seriously, every time they set sail.

Andrew Moll (OBE) set to retire in February 2026



News has reached IIMS that Captain Andrew Moll has announced his retirement as Chief Inspector of Marine Accidents with the (Marine Accident Investigation Branch (MAIB) after nearly half a century of unbroken public service. He will formally leave the organisation in February 2026.

Andrew Moll joined the MAIB in 2005 as a Principal Inspector and was Deputy Chief Inspector from 2010 until he took up post as the Chief Inspector in 2018. He obtained a bachelor's degree in psychology through distance learning while working at the Branch in order to improve his understanding of human factors in marine accidents.

Prior to joining the MAIB, Andrew served 27 years as a deck officer in the Royal Navy. His career was largely sea-going, spent on destroyers and aircraft carriers. His commands included: the fast patrol boat SNV AL FULK, while on loan to the Omani Navy during the later stages of the Iran-Iraq war; the Type 42 destroyer, HMS YORK; and, the Type 22 frigate, HMS CHATHAM.

Andrew is one of the Younger Brethren of Trinity House, a Member of the Nautical Institute, and he is the Chairman of Trustees for Southampton Sea Cadets.

In a personal statement posted on LinkedIn, Andrew said, "After nearly 49 years of unbroken public service, 21 of those at the MAIB, I have decided it is time to retire. It has been a hard decision to take as I firmly believe that my job is one of the best and most rewarding in the marine industry. Further, it has been a real pleasure to work with so many talented people over the years, and I will definitely miss that. With every door that closes, another opens, and my plan for retirement is to commence a 40-week course at the Boat Building Academy in Lyme Regis learning, unsurprisingly, to build boats!"

Andrew is regarded as a friend of IIMS, and we are grateful for the help he has given us and the interest he has shown in the Institute over many years. He will be a hard act to follow.

CHIRP Maritime FEEDBACK Newsletters

Confidential Human Factors Incident Reporting Programme

CHIRP's independent, confidential incident and near-miss reporting programme improves safety at sea for mariners worldwide. The team investigates every report and publishes their anonymised findings to raise awareness of safety issues.

CHIRP welcomes safety-related reports from anywhere in the world and from all parts of the maritime industry including commercial seafarers, fishers, recreational and leisure mariners, and anyone who works in a port or harbour. The organisation also welcomes reports from members of the public who use ports, harbours or maritime transport (e.g. ferry and cruise vessel passengers).

CHIRP never reveals the identities of their reporters, and as soon as their investigations are complete, they permanently delete their personal details from their database. This means that you can raise safety concerns without fear of your identity being revealed to your peer group, line managers or the company you work for. However, CHIRP does not normally act upon anonymous reports.

Please note that CHIRP's incident reporting programme is a voluntary scheme. Sending a report to CHIRP does not alleviate any legal obligation that may be placed upon you to submit a report to the appropriate authorities.



General Maritime FEEDBACK Newsletters

DECEMBER 2024

MFB 77: 'Stop work' authority saves lives | Featured reports

- Unfinished maintenance creates hazard
- Life raft maintenance was ignored
- Close quarters situation
- Open Manhole Cover Creates Hazard
- Confined space carbon monoxide poisoning
- Unsafe Pilot ladders
- Fatal tank inspection
- Critical safety failures and crew fatigue on cruise ship during passenger excursions
- Collision Regulations and autonomous maritime vessels

Read in full at
https://chirp.co.uk/newsletter/stop-work-authority-saves-lives/

MARCH 2025

MFB 78: Safety takes time | Featured reports

- Non-compliant pilot ladder
- Eye injury
- Unacceptable living conditions
- Container fire
- Corroded walkways over deck pipes
- Fire on a large motor yacht
- Near miss: poor configuration of CO2 firefighting system
- Lifeboat capsize during a capability demonstration

Read in full at
https://chirp.co.uk/newsletter/safety-takes-time/

MAY 2025

MFB 79: Recurring safety culture – we're not there yet | Featured reports

- Fatalities during heavy weather
- Voyage Data Recorder (VDR) issues
- Entanglement and fall from height during lifting operations
- Pilot falls into the water while boarding
- Safety equipment obstructed by cargo gear
- Chemical exposure in the engine room

Read in full at
https://chirp.co.uk/newsletter/recurring-risks-missed-chances/

AUGUST 2025

MFP 80: Built to break? | Featured reports

- Pest infestation
- Near miss – escape route blocked
- Aerial errors: ships plans mislabelled
- Pilot welfare when boarding
- Design flaws jeopardize Pilot boarding and crew access
- Unmanned survey vessel (USV) capsizes
- Enclosed space inspection leads to crew injury

Read in full at
https://chirp.co.uk/newsletter/built-to-break/



Superyacht FEEDBACK Newsletters

DECEMBER 2024

SY 08: Building a safer and more inclusive superyacht sector | Featured reports

- Harassment on board
- Unsafe pilot transfer arrangements
- Battery explosion on superyacht
- A 'bitt' of a hazard!
- Working aloft without proper PPE (again!)
- Collision at anchor
- Life raft maintenance was ignored

Read in full at
https://chirp.co.uk/newsletter/building-a-safer-and-more-inclusive-superyacht-sector/

MAY 2025

SY 09: Drugs, design and dry-docks! | Featured reports

- Fire on a large motor yacht
- MLC living conditions
- Drug use on board superyachts
- Working aloft: unsafe by design?
- Near Miss- fatality avoided
- Anchor operations compromised by unfamiliarity and tiredness create a hazardous situation
- Identification of Enclosed spaces on a Super Yacht

Read in full at
https://chirp.co.uk/newsletter/drugs-design-and-dry-docks/

JULY 2025

SY 10: Say what you do; Do what you say! | Featured reports

- Safety Concerns Dismissed
- Working aloft without proper fall protection
- Look After Your Pilot – They're Looking After You!
- Crew Abandonment
- Crew Injury while Mooring
- Chemical injury to the crew

Read in full at
https://chirp.co.uk/newsletter/say-what-you-do-do-what-you-say/



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Accidents and incidents 2025 Calendar of Tragedies

Each year IIMS keeps a monthly log of maritime accidents and incidents reported during the year, collated from websites, newspapers, TV reports and social media platforms.

In total, we recorded 555 incidents from December 2024 through to November 2025. December 2024 was the deadliest with 56 incidents. This year, we have, out of necessity, included a reduced Accident Calendar highlighting some of maritime accidents of throughout the year in this publication. A separate Accident Calendar Supplement with all the incidents recorded is available to download at **https://bit.ly/4pP9Xjp**.

Reported in December 2024

Container ship and autonomous vessel collide near Rotterdam

A container ship and an autonomous vessel collided on the river Scheur near Rotterdam, leading to four containers being knocked into the water. According to reports, although River Drone 5 is capable of fully autonomous operations, it was under human operation at the time of the incident.

Blaze rips through Staten Island marina, damaging 12 boats

Twelve boats docked at a marina in Staten Island went up in flames on Wednesday morning, injuring two firefighters. The boats were badly damaged.

Seven dead, one missing after fishing boat capsizes off South Korea

Seven people were confirmed dead after a fishing vessel capsized in the waters off the southeastern city of Gyeongju. The 29-tonne fishing vessel Geungwang collided with a 456-tonne barge carrying a cargo of sand. The fishing vessel then overturned with its crew of eight still on board six kilometres off the coast.

At least 10 people die in Nigeria ferry accident

At least 10 people died when a boat capsized on the Benue River in central Nigeria. Agatu local government chairman, Melvin Ejeh, told Reuters, that around 70 mostly women traders were on board the boat, which had no manifest. "50 people have been rescued alive so far. Search and rescue operation still ongoing," Ejeh added.

Russian tanker pair in serious accident in Kerch Strait

A Russian oil tanker carrying thousands of tonnes of oil products split apart during a heavy storm, spilling oil into the Kerch Strait, while another tanker was also in distress after sustaining damage. Russian investigators opened two criminal cases to investigate possible safety violations after at least one person was killed in the incident.



Brand new bulker suffers cargo fire at Gran Canaria

After two days of firefighting, a cargo fire in the holds of a bulker at a port in the Canary Islands has finally been brought under control as first responders covered the bulk cargo with foam to prevent a reflash. An investigation into the cause of the blaze is under way, but local authorities suspect that the cargo self-ignited during loading, as it had been carrying bulk scrap metal.

Tanker splits in half in Kerch Strait

Russian oil tanker Volgoneft 212 snapped in half during a severe storm while traveling through the Kerch Strait. The ship reportedly had 15 crewmembers - 12 of whom were rescued. At least one crew member died, with two still missing. No detailed report had been released on the environmental damage initially.

13 dead after Indian naval vessel collides with ferry

An Indian Navy fast response boat collided with a ferry off the coast of Mumbai. Thirteen people died as a result, including one naval personnel. Reports say the incident occurred while the naval vessel was out on speed trials after undergoing an engine replacement. However, the engine became stuck on full throttle and struck the ferry. There were more than 100 people on the ferry, which sank afterwards.

Hole in ferry hull after colliding with UK port

Irish Ferries' Isle of Innisfree was damaged after it collided with Fishguard port in Wales. The incident took place as the ferry attempted to dock but struck a port structure instead. No one was hurt but the ship ended up with a hole in its hull above the waterline. The inaugural Dublin-Fishguard vessel route was created after two vessels collided with Holyhead Port in Wales during a storm in separate incidents. The damage done to Holyhead Port shut down the port for repairs planned until 15 January.

Two missing after ship sinks in Mediterranean

Russian merchant vessel Ursa Major sank after an engine room explosion in the Mediterranean between Spain and Algeria. Two crewmembers were missing and 14 others were rescued and taken to the Spanish port of Cartegena.

Cargo ship sinks after colliding with tanker in Indonesia

General cargo ship Kuala Mas collided with the product tanker Maritim Khatulistiwa at Kupang. Initial reports suggested the cargo ship had drifted with the current before striking the anchored tanker. The incident caused a hole in the cargo ship's hull, and crew worked to seal the leak unsuccessfully. However, the captain made the decision to intentionally ground the ship in shallow waters. Some of its containers sank and others drifted to shore. No crewmembers were injured.

Reported in January 2025

Major fire damages yachts in France

A fire broke out on board 26.88-metre Leopard yacht Naisca IV at Port de la Lave in France. The blaze destroyed the vessel and the 17-metre yacht moored on its port side, which were partially sunk in the incident. Another yacht, moored to starboard, was severely damaged by the fire. No casualties were reported.

Vessel loses cargo at sea

Cargo vessel Sun Ray lost its cargo while transiting a deepwater shipping lane off the coast of Texel, Netherlands. The coastguard and Rijkswaterstaat, an executive division of the Dutch Ministry of Infrastructure and Water Management, successfully recovered 14 objects. A virtual buoy was deployed in the area to mark off the search location.

Two dead, one hospitalised after lobster boat capsizes

Two people are confirmed dead while a third has been hospitalised after a fishing vessel capsized off the tourist town of Beachport in South Australia.

Container vessel runs aground in Kiel Canal

Container ship Eco Levant ran aground on the embankment of the Kiel Canal, Germany. An issue with the hydraulic system that led to machine failure was the cause of the incident. The canal had to fully close for hours until the vessel was refloated.

Timber goes overboard as vessel tilts in Russian port

Cargo ship Stepan Geyts lost most of its timber cargo after the vessel tilted at Plastun Port in Russia. The ship managed to regain its stability and no casualties were reported.

Reported in February 2025

Five dead, five others missing after South Korean fishing vessel capsizes

Five people were confirmed dead while another five reported missing after a fishing vessel capsized and sank in the East China Sea off the South Korean city of Yeosu. The SAR effort led to the recovery of four survivors and five deceased victims.

Cargo vessels hit each other at Turkish port

General cargo vessel Friends RS 1 was manoeuvring to leave Gemlik Port when it collided with docked Jessica B. Jessica B's above waterline outer section was punctured in the incident, which lead to a discharge of ballast water into the sea under pressure.

Explosion at Barcelona port kills one, injures three

One person has died and three were injured in the Port of Barcelona following a tank explosion. The incident occurred in a tanker filled with methyl acetate while undergoing maintenance. The fire was quickly contained and extinguished 40 minutes after it started.

Freighter trapped in ice at Lake Erie

Canadian freighter Manitoulin got stuck in thick ice on Lake Erie after leaving Buffalo, New York. All crew were safe, and the ship was not damaged.

Chemical fire on board vessel docked in Netherlands

Smoke was seen coming from batteries on wind turbine vessel Les Alizes while docked at Wagenborg Terminal, Eeemshaven. Around 100 hundred crew were evacuated and were reported to be safe. Reports say damage was limited to the battery cabinet of the ship.

Fire aboard vessel lasts days outside Scottish port

A fire broke out in the cargo hold of bulk carrier Lowlands Diamond and continued to burn for at least four days afterwards. The vessel had berthed at the port of Aberdeen when the fire started but firefighting efforts had isolated the blaze to one of the ship's cargo holds. The crew, the local community and the vessel itself were reportedly safe.

Container vessel collides with another in Hong Kong

Container ship One Columbia hit another container vessel, Clifford Maersk, which was docked at Hong Kong's Kwai Chung No. 9 Terminal. The collision occurred as One Columbia arrived into the port, and both ships sustained minor damage. Clifford Maersk lost three containers in the incident, which were recovered later.

Reported in March 2025

Tanker and cargo vessel ablaze after colliding in North Sea

Oil tanker Stena Immaculate and cargo vessel Solong went up in flames after the cargo ship crashed into the tanker near the Humber Estuary off the East Yorkshire coast in the UK. The fire forced all 23 crew of the Stena Immaculate to abandon ship. Of the 14 crewmembers of the Solong, only 13 made it back to shore with the search for the final sailor called off on the assumption he was killed in the incident.

Three yachts destroyed after fire in Florida

Three yachts were destroyed in a fire in Miami River, Florida. Reports said one of the yachts was completely submerged, another was partially submerged and the third was afloat but significantly damaged. No injuries were reported.

25 dead after boat capsizes in DR Congo

A boat carrying passengers capsized Maï-Ndombe province in the southwestern Democratic Republic of the Congo killing 25 people. 30 other people were safely rescued, but it is unknown how many people were on the boat at the time.

Tanker damages Brazilian port in collision

A person was injured after crude oil tanker Olavo Bilac collided with three docked navy patrol boats at the port of Santos in Brazil. The ship lost rudder control while it was manoeuvring in the port and collided into one boat which pushed it into two others. One navy officer received minor injuries, and he was taken to a local hospital but was treated and released. The three boats also suffered minor damage while there is a large scrape on the tanker.

Tourist dies after boat catches fire in Thailand

A fire spread rapidly from the engine room of diving boat, the Davy Jones Locker, while off the coast of Koh Tai, Thailand. There were 21 other people on board, including 15 tourists, two crewmembers and four diving instructors and assistants. They were evacuated when the fire broke out. A search was launched to find the missing passenger, however local news agencies reported the tourist had died in the fire.

Peruvian fisherman survives 95 days at sea

A Peruvian fisherman was rescued after he had spent 95 days off the coast of Ecador. The 61-year-old had been left adrift after a storm blew him off course and his boat's engine failed. He was unable to send a distress signal as he had no EPIRB. He survived by eating insects, birds and sea turtles before an Ecuadorian patrol vessel came across him and saved him.

One dead after tour boat capsizes off Bali

A person died after tour boat Sea Dragon 2 capsized off Bali, Indonesia. Two others had non-life-threatening injuries. The boat, which was carrying 16 people, overturned after it was hit by large waves. A nearby boat pulled all 16 people out of the water. Three were taken to hospital, but one was later pronounced dead.

Vessel loses containers in stormy weather

MSC Houston V had to make an emergency stop at the Port of Vigo, Spain after it lost at least 15 containers due to severe weather. The container ship was off the southern coast of Portugal when it hit rough seas and high winds. Container bays experienced cargo collapse with some containers dangling over the side of the ship damaging the deck. The port authority said none of the cargo on board was hazardous.



One dead and one missing after tugboat and bulk carrier collide

Tugboat M/TUG Sadong 33 and bulk carrier Universe Kaisa collided near Maasim, Sarangani Province, Philippines. The Philippine Coast Guard rescued six of the eight tugboat's crew. However, the captain of the boat was found dead, and another crewmember was missing. Search and rescue continued looking for the missing crew.

Six dead after tourist submarine sinks in Red Sea

A tourist boat, Sindbad, sank in the Red Sea near the harbour of Hurghada, killing six. The 39 other passengers and five crew were rescued. Many were injured – four of them critically.

One dead after cargo ships collide off Chinese coast

One person died and three others were injured after cargo vessel Ning Yuan Bei Lun collided with Jiang Hai Zhi Da 66 off Ningbo, China. The latter vessel sank with 13 crew on board. All were recovered; however, one was found dead while three others had to be taken to hospital.

Search for missing fishermen after boat capsizes

A fishing vessel, the Bruma, capsized and sank off the coast of Coronel, Chile. Seven of the fishing vessel's crew are missing and a search and rescue operation was launched to find them. The vessel's lifeboat was also missing.

Reported in April 2025

Four fatalities after cargo ship and fishing vessel collide off Vietnam

Four died after cargo ship Hosei Crown collided with fishing boat TH 92686 TS in the Gulf of Bắc Bộ, Vietnam causing the boat to sink. The Vietnam Maritime Search and Rescue Coordination Centre launched an operation to search for the fishing boat's 12 crewmembers. Eight of the fishermen were safely rescued, and the bodies of the vessel's other four crewmembers were recovered.

One dead and 14 injured in boat collision off Brazil

Two boats, the Lipe Lara and Safira, collided off the northeastern coat of Brazil killing one person and injuring 14 others. One boat was partially submerged but was later refloated. The Brazilian Navy and local police have launched an investigation.

One dead, five missing after boat capsizes off US coast

One person died and another five are missing after a boat capsized of southeastern Florida. Of the 10 people on board, four were rescued by the U.S. Coast Guard, a fifth was pulled from the water and later declared dead, and five were confirmed missing. Three of the survivors had non-life-threatening injuries, but the fourth was in a serious condition.

Fire destroys four boats at Turkish port

A fire broke out in the port of Fethiye on the west coast of Turkey. According to local news, the fire started on a boat and spread to three other boats. The local coastguard pulled the four burning boats out to sea to launch a cooling operation. The cause of the fire was unknown. The fire was brought under control within a couple of hours. Four people were treated for smoke inhalation.



Four dead, eight missing after vessel capsizes off Philippines

Four crewmembers have died after sand carrier Hong Hai 16 capsized and partially sank off Occindental Mindoro province in the Philippines. Search and rescue were deployed to the area and safely rescued 14 crew. Four were found dead with another eight missing. The local coastguard continued their search for the missing crewmembers.

Nearly 150 dead in boat fire and capsizing

At least 148 passengers died after a boat caught fire and capsized in the Democratic Republic of Congo. The motorised wooden boat was carrying more than 400 people when it sank in the Congo River.

Two dead in boat accident off Panama coast

Two people have died and one missing following an incident off Panama's Pacific coast. The vessel suffered mechanical trouble as it travelled between Perico and San Miguel with 23 passengers. Search and rescue rescued 20 people and recovered two dead victims. Search and rescue operations continued their search for the final missing passenger.

Supply vessel collides with wind turbine in the North Sea

Offshore supply vessel Glomar Venture collided with a wind turbine in the North Sea off the coast of North Holland in the Netherlands. Two crewmembers were injured in the incident.

Offshore platform fire injures 14

An explosion on offshore platform Petrobras' Cherne 1 130km off Brazil's southeast region injured 14 people. The fire was successfully extinguished four hours after it had started. All injured personnel were taken to a hospital in Macaé.

Fire breaks out on bulk carrier in Amsterdam Port

A blaze broke out on board bulk carrier Federal Tweed while it was berthed in Amsterdam's Western Port Area in the Netherlands. The incident started in the cargo hold storing scrap metal. Nearby residents were advised to keep windows and doors closed as a precaution. A crane was used to lift the smouldering scrap onto the quay.

Explosion kills 70, injures 1,200 in Iranian port

An explosion at the port of Bandar Abbas in Iran killed at least 40 people and injured at least 1,200 others. The force of the explosion damaged the windows of buildings several kilometres away and was reportedly heard as far as 20 kilometres away. Further explosions occurred hours after the first one.

Two dead after falling overboard in Malaysia

Two fishermen died after the fell overboard from their boat in Selangor state in Malaysia. The Malaysian Maritime Enforcement Agency recovered the bodies a day after they had been scheduled to return after family members reported them missing.

One dead after boat hits ferry in Florida

A boat carrying collided with Clearwater Ferry near the Memorial Causeway Bridge in Florida. One person died and others were injured in the incident. The boat had been carrying six people, and the ferry had 45 passengers. The boat fled the scene but was later identified by another law enforcement agency.



Reported in May 2025

Ten dead after two boats sink in China

Ten passengers died and others are missing after two boats capsized in severe weather conditions in the Liuchong River in Guizhou Province, China. More than 80 people fell into the water of which 10 have been found dead and another 70 injured.

Three dead, seven missing off US coast

Three people have died and another seven are missing after a boat capsized off Del Mar Beach in San Diego. Four people were found and needed medical of the estimated 16 people aboard the panga-style vessel. The U.S. Coast Guard suspended its search for the missing others after searching for nearly 28 hours.

Two dead after Mexican sail training ship hits Brooklyn Bridge

Two people were killed and at least 19 others injured as Mexican training vessel Cuauhtémoc crashed into the Brooklyn Bridge, USA. All three of its mast hit the underside of the bridge, but the bridge was not damaged in the event. Preliminary reports indicate the Mexican Navy training vessel suffered some sort of mechanical issue that may have caused it to go in the wrong direction instead of heading out to sea.

Three die in fire aboard Chevron's BBLT Platform

A fire started on board Chevron's Benguela Belize Lobito Tomboco (BBLT) oil platform approximately 97 kilometres offshore from the Cabinda coast. Seventeen crew were injured, four of them seriously, in the incident with another reported missing. Two workers who had been transferred to specialist units died from their injuries, and the body of a third worker was yet to be recovered from the ocean and identified.



Boat capsizes off Kenya, one missing

One person was missing after a passenger vessel capsized off Lamu East Constituency in northern Kenya. The boat had been carrying four people before it sank.

Ferry capsizes off Indonesia killing two crewmembers

Two people died after Ro-Pax ferry Muchlisa sank in Indonesia's East Kalimantan province. The vessel suffered engine failure and water ingress, which the crew unsuccessfully tried to resolve. They then intentionally beached the ferry, but it went adrift before capsizing and sinking. All 23 passengers and all but two crewmembers were safely evacuated. They missing crew were later found by a Basarnas dive team.

One missing after fishing vessel sinks off US coast

The U.S. Coast Guard suspended its search for a missing captain of fishing vessel Captain Raleigh after it sank near Westport, Washington. The vessel master issued a distress call stating they were taking on water and the onboard pumps could not keep up. Three crew were rescued from the water.

Seven people died, 34 injured after boat capsizes in Indonesia

Seven people were killed and another 34 injured after tour boat capsized and sank off Indonesia's Bengkulu province. The wooden-hulled boat had 98 passengers and six crewmembers when it capsized in bad weather. It had suffered engine failure as it returned before it struck a coral reef, causing a water leak.

Tugboat destroyed in fire in Paraguay

A fire that began in the engine room of tugboat Julie completely destroyed the vessel near the Remanso Bridge over the Paraguay River. All 10 crewmembers were safely evacuated from the vessel. The push tugboat had oil drums, electronic equipment and around 250,000 litres of fuel, but firefighters was able to bring the fire under control.

Accident during launch of new North Korean warship

North Korea's newest warship was left lying sideways in the water after it was launched during a ceremony at a shipyard in the port city of Chongjin. Some sections of the destroyer's hull were "crushed" after the 5,000-tonne ship lost balance.

Container ship runs aground metres away from residence in Norway

Container ship NCL Salten ran aground in the Trondheimsfjord near Lauvset in Norway. The ship missed houses on the shoreline – one residence by mere metres. No injuries were reported, and the Norwegian Coastal Administration was supporting the ship in attempts to refloat the vessel.

Cargo ship capsizes at Norwegian port

General cargo vessel Torvang capsized as it was moored at the Hendvågen quay in Averøy, Norway. The vessel listed and fell over to its side after it had loaded gravel. Its cargo hold was half-filled with water. All five crew safely made it ashore without injury.

"Disaster" as container ship sinks off Indian coast

A container ship carrying hazardous containers capsized around 38 nautical miles off the coast of Kerala, India. Local newspaper Deccan Chronicle reported the Kerala State Government of India declared it "a state-specific disaster". Fortunately, all 24 crew of MSC ELSA 3 were safely rescued by the Indian Coast Guard. However, many containers fell overboard during the incident. The vessel had 640 containers, 13 of which had hazardous cargo and 12 were carrying calcium carbide. It is thought to have sunk due to flooding of its cargo holds.

Explosion on bulker in New Zealand

An explosion in the engine room on board bulk carrier Olivia while docked at a port in New Zealand killed one crewmember and injured two others. The cause of the incident is unknown. A small fire was extinguished before fire and rescue services arrived.

Employee dies in explosion on board waste disposal vessel

An explosion on board a waste disposal vessel killed one person and injured another two while the ship was docked at a Hudson River pier near the North River Wastewater Treatment Plant. The explosion had thrown the wastewater treatment plant employee into the water and died after being trapped between the vessel and the dock.

Two bodies recovered after shrimp boat sinks off US coast

The bodies of two people have been recovered after a shrimp boat sank near the city of Everett, Washington. One person, the sole survivor, was rescued soon after the boat sank, but another person is still missing following the incident.

Reported in June 2025

Vehicle carrier sinks after 20 days on fire off US coast

A fire broke out on a vehicle carrier as it was carrying 3,048 vehicles 300 nautical miles southwest of Adak, Alaska. The Morning Midas crew were forced to evacuate into a lifeboat after failing to contain the fire. They were later transferred to container vessel Cosco Hellas. Salvors went to the vessel but after 20 days, the Morning Midas sank.

Five die after boat capsizes in Malaysia

Five people died after a boat capsized while conducting sea trials near Port Klang, Malaysia. A preliminary probe suggested the boat had hit large waves before capsizing. There was only one survivor in the incident.

One person killed in boat collision in U.S. river

One person has died and another two were injured after two boats collided on the Bayou Sara in southern Alabama, USA.

Crude oil tanker leaks 20 tons of oil off Thailand

Crude oil tanker Phoenix Jamnagar discharged 20 tons of crude oil off the coast of Sriracha in Chonburi Province in Thailand. The incident occurred following a pipeline rupture and oil leak for 30 minutes during offloading operations. The crude oil leak was successfully contained by the end of the next day.

Four missing after container ship explosion off Kerala coast

Four crewmembers were missing following an explosion on board container ship Wan Hai 503 while it was 130 nautical miles northwest of the Kerala coast in India. The ship had 22 crew—six of whom were injured and four were missing. Two weeks later, pockets of fire remained with reignition in one area according to Indian authorities. It took three months for the vessel to secure a port of refuge in the United Arab Emirates.

Tug runs aground and spills 30 tons of fuel in Russia

Tug OT 2439 ran aground on the Kazachinsky rapids of the Yenisei River in central Siberia, Russia. Its hull was damaged in the incident causing it to spill approximately 30 tons of diesel fuel. A state of emergency has been called in Kazachinsky district as despite efforts to contain the oil, some drifted downstream and is affecting riverbanks.

Several missing after boat sinks in Indian river

Several passengers have been reported missing after a boat broke apart and sank in the Brahmaputra River in India. The vessel had been carrying more than 100 passengers with inland waterways officials saying the vessel had no manifest and no lifejackets had been provided to passengers.

Four dead in fire at Indonesian shipyard

Four people have died and another five injured after a fire broke out on floating storage vessel Federal II at ASL Shipyard in Batam, Indonesia. The fire started while workers were cutting steel plates on the vessel, according to local police. A preliminary report suggests a leak of flammable gas or vapour might have started the incident.

Cargo ship partially submerges off Trinidad coast

General cargo vessel Hein grounded off the southern coast of Monas Island in Chaguaramas, Trinidad and Tobago. The vessel was carrying bricks and after a cargo shift, its crew intentionally grounded the ship, which resulted in the ship partially submerging instead of capsizing. The hull remained intact; however, hydrocarbons leaked from the bilge.

Two killed after fishing boat sinks off U.S. coast

Two people died after fishing boat Seahorse sank off Cape Cod, Massachusetts in the USA. The pair were the only occupants of the boat who sailed out to catch clams.

45 dead after three motorised canoes capsize

At least 45 people have died after three motorised canoes capsized in Lake Tumba, Democratic Republic of Congo. Others were still missing with 100 people confirmed as alive.

Two killed in cargo unloading accident in Rotterdam

Two people have died and another two were injured following an accident in the cargo hold of inland cargo ship Ronny-O in Rotterdam's Waalhaven harbour. The exact circumstances of the incident were unclear, but the captain of the vessel suspected some steel plates had fallen onto the two who were killed, according to Baird Maritime.

Tourists die after boat capsizes in U.S. lake

Eight tourists died after an 8-metre-long vessel capsized in Lake Tahoe near D.L. Bliss State Park, California, USA. The boat had been carrying 10 passengers when it was caught in a severe thunderstorm suddenly.

Two fishing vessel incidents leave two dead, one missing

Two people died and another is missing following two fishing vessel incidents in Sri Lanka. The first vessel sailed out of Dondra Fisheries Harbour with five crewmembers. Authorities suspect it collided with a commercial ship and all were thrown into the water. Four were pulled out of the water and the last has been reported missing. The following day another fishing boat capsized with two people on board who were later found washed up ashore on a beach in Bentota.

Three killed after boat capsizes off Malaysia's Perhentian Islands

Three people died after a boat capsized in bad weather off Malaysia's Perhentian Islands. The vessel had been carrying 15 passengers, and a preliminary investigation revealed they had not been provided with lifejackets. The vessel's captain had tested positive for drug use, and it was discovered they had prior drug-related offences. He was taken by police for further questioning.

Reported in July 2025

Four dead after jackup barge sinks in Gulf of Suez

Four crewmembers have died after jackup barge Adam Marine 12 capsized around 300km south of the Suez Canal. The incident occurred as it was being towed to a new location. Of the 30 personnel on board, 23 were safely rescued, three were missing and four have died.

18 dead after Ro-Pax ferry sinks off Bali

At least 18 people have died after a ferry sank near Bali, Indonesia. KMP Tunu Pratama Jaya had been carrying 65 people. Thirty people were rescued, and the other 17 were unaccounted for. Adverse weather conditions, waves reaching up to 2.5 metres, hindered initial rescue efforts.

11 found alive after boat capsizes in Indonesia

Rescuers found 11 people who were missing at sea after a boat capsized in bad weather in Indonesia. The survivors swam for at least six hours to reach the nearest island. The other seven had been saved earlier.

Minor oil spill in Uruguay

A minor oil spill took place at the Punta Pereira Port Terminal, Uruguay. The incident occurred during unloading operations by crude oil tanker Capella when backpressure in one of the vessel's tanks caused fuel to overflow onto the deck. It was estimated 50 to 70 litres entered the water. The cleanup and recovery operations were conducted by the Oil Spill Response Organization team with help from the Punta Pereira Port Terminal response team.

Fishing vessel capsizes in USA, captain feared dead

The captain of a shrimp trawler is feared dead after it capsized near the Port of Brownsville in Texas. One crewmember was rescued while the only other person on board, the vessel's captain, was still missing when the search was suspended 14 hours later.

25 dead after boat capsizes in Nigeria

25 people have died after a boat carrying more than 100 passengers capsized in north-central Nigeria.



Dozens dead after tourist boat capsizes off Vietnam

Most of the people aboard a tourist boat died after the vessel capsized in Ha Long Bay in Vietnam. The Wonder Sea boat had been carrying 49 people, including about 20 children, when it hit a sudden storm – 39 bodies were recovered during search and rescue efforts.

Five die in ferry fire off Indonesia

A fire broke out aboard passenger ferry KM Barcelona VA int the Celebes Sea off Sulawesi Island in Indonesia. Crew and passengers were forced to abandon the vessel after the fire spread. Of the nearly 300 people on board, 284 were rescued, five bodies were recovered with others still missing. The fire was extinguished and according to reports, the vessel was towed.

Three die in explosion on dredger

Three people were killed and others were injured in an explosion on board a dredger at the mouth of the Danube River in Ukraine's Odesa region. It occurred as the 11 crewmembers were about to carry out scheduled work.

40 containers damaged during storm off Brazil

A storm of the coast of Rio Grande, Brazil damaged 30-40 containers on board container ship Ever Feat as it was berthed at the port of Montevideo, Uruguay. Containers on one part of the vessel were shown stacked unevenly with some damaged and dented.

20 gallons of hydraulic oil spill into USA river

An estimated 20 gallons of hydraulic oil was discharged into the St. Marys River near Neebish Island in Michigan. The incident took place after the Presque Isle tug suffered a steering malfunction. Containment booms were deployed to prevent the spread of pollution.

Four dead after tour boat capsizes

Four people died after a tour boat capsized in bad weather near Sulina, Romania. The vessel had been carrying 14 passengers, although a preliminary investigation showed the boat's maximum capacity was only 12. It had also sailed despite warnings of bad weather conditions. The boat's captain had tested negative for alcohol consumption.

Reported in August 2025

50 containers lost off Peru

Around 50 containers were lost from the Ever Lunar while it was anchored Callao Bay in Peru. Severe rolling caused the containers to go overboard, yet authorities confirmed they did not contain hazardous materials.

Two killed and another missing after boat capsizes in Indonesia

Two people died and another missing after a tourist vessel Dolphin II capsized off Bali. The boat was crewed by two and carried 78 passengers – some of whom were injured in the incident.

Coastguard suspends search for missing fisherman

The U.S. Coast Guard suspended its search for a missing fisherman after a boat capsized near Newport, Oregon. The fishing vessel had been carrying four people when it took on water and capsized. Rescue crews saved three from the water but had to call off the search and rescue mission after eight hours of searching.



One dead after vessels collide off Japan

One person was killed after aggregate carrier Sada Maru No 38 and a yacht collided off southern Japan. Search and rescue initially found one person in the water who was later pronounced dead at hospital. Authorities said the exact number of those on the yacht at the time of the incident was unknown.

One dead after vessel sinks off U.S. coast

One person has died after a fishing vessel sank near Point Roberts, Washington, USA. Both US and Canadian authorities responded to the incident. A Good Samaritan vessel recovered one of the two fishermen and assisted in finding the second fisherman.

Narrowboat explosion in UK marina

Firefighters were called to tackle a fire on a canal boat following an explosion at Gayton Marina in Northampton, UK. It is believed that lithium-ion batteries were the cause of the explosion on the vessel.

Three dead, 22 missing after capsizes in Nigeria

Three people were killed and another 22 were missing after a wooden boat capsized in a river in the northwestern province of Sokoto, Nigeria. Initially only 10 of the more than 50 people on board were safely rescued. However, another 15 were confirmed to have been rescued by Nigerian authorities.

One dead and two injured in fires off South Korea

One person has died and another two were injured after two vessels caught fire at the port of Sinbuk in South Korea. Reports said the blaze started on a chemical tanker before spreading to a small cargo vessel moored nearby. All 14 crewmembers of the tanker and the four crewmembers on the cargo vessel were rescued. However, the captain of the cargo vessel's captain was later declared dead. Two of the tanker's crewmembers were also injured in the incident.

Inland vessel spills 10,000 litres oil into Belgian canal

Inland motor freighter River Drone 4 spilled around 10,000 litres of fuel oil into Olen Lock in Albert Canal, Belgium. The barge ended up with 15cm diameter hole above the waterline in its hull, but it's unknown how the barge was damaged as it passed through the lock. The oil spread over a few kilometres, and a specialised company was called in to contain the spill.

Boat capsizes in Nigeria, three die

Three people were killed after an overloaded passenger boat capsized in a river in Borno state in Nigeria. Of the 27 people believed to be on board, 17 were safely rescued while three other people were already dead when their remains were pulled from the river hours later.

Yacht wreck found of missing co-founder of Mazu Yachts

The body of missing co-founder of Turkey's Mazu Yachts, Halit Yukay, was located near the wreck of his yacht in the Marmara Sea. After 19 days, his body was found at a depth of 68 metres on the seabed near his boat, Graywolf. Authorities were investigating allegations that his yacht and dry cargo vessel Arel 7 had collided. The ship's captain had been arrested earlier on.

Boat capsizes in Nigerian river, kills 16

Sixteen people were killed after an overloaded boat overturned in a river in the northwestern state of Zamfara, Nigeria. Reports say it overturned after two women jumped on board after the boat was already underway. The vessel had around 50 people. Officials said the boat had only been permitted to carry 16 people.



Reported in September 2025

Cabin boy dies after falling from naval tall ship rigging

A sailor serving on board Colombian Navy training ship ARC Gloria died after falling from the rigging. The seaman apprentice had been serving as the tall ship's cabin boy when they fell from the mainmast as part of an arrival ritual at Barranquilla.

Yacht capsizes minutes after launching

A new 24-metre luxury yacht capsized and sank minutes after it was launched in the Ereğli district of Zonguldak, Turkey. The Dolce Vento had just started its maiden voyage when it developed stabilisation issues and took on water 15 minutes after launching. All four people on board leapt into the water and safely swam to shore.

At least 60 dead after boat capsizes in Nigeria

At least 60 people have died after a boat struck a submerged tree stump and capsized near Gausawa community in Borgu Local Government Area in Nigeria. The vessel had been carrying more than 100 passengers – 10 had been found in a serious condition.

Fishing vessel grounds in Alaska

The U.S. Coast Guard received a distress call after fishing vessel Sea Ern hit a rock and was taking on water in Alaska. An estimated 3,500 gallons of diesel spilled into the water. A Good Samaritan vessel rescued the vessel's three crewmembers who were uninjured in the incident.

Over 70 containers fall off ship at U.S. port

Around 75 containers fell off cargo ship Mississippi into the water at the Port of Long Beach, California, USA. A smaller emissions capture barge connected to the cargo vessel was damaged by some of the containers.

Five dead after boat capsizes in Pakistan

Five people died after a rescue boat capsized in Chenab River, Punjab, Pakistan. The emergency response vessel had been evacuating people due to flooding from monsoon rains. It struck a submerged object in strong currents and low visibility. Ten were rescued and five bodies were recovered. Search and rescue were continuing efforts to locate any others that may have been on board.

Fishing boat catches fire off Malaysia

A wooden fishing vessel caught fire off the coast of Perak state, Malaysia. All 25 crewmembers jumped into the water to escape the blaze but were rescued. There were no serious injuries reported. The fire was extinguished, and the owner said there was a loss of MYR1 million (USD240,000) which included the value of the vessel on fishing equipment on board.

Second boat capsizes in Pakistan

Three people died after a boat capsized in a river near Jalalpur Pirwala, Punjab, Pakistan. It had been carrying 28 residents who were leaving their homes due to heavy flooding when the incident occurred. Nineteen people were rescued and at least eight were missing.

Over 100 dead in boat fire in Congo river

At least 107 people died after a whaleboat caught ablaze in the west of the Democratic Republic of Congo. 209 people were saved, several with injuries, but all the cargo was destroyed and 15 riverside homes caught fire.

Five missing after vessels collide off Mauritania

Five people went missing after two fishing boats, trawler Tafra 3 and another vessel the Grey Whale, collided off the coast of Mauritania. Tafra 3 sank soon after the incident occurred with 21 of its 26 crewmembers were safely rescued. Mauritanian authorities continued their search for the missing five fishermen.

Seven dead after boat capsizes off the Philippines

Seven fishermen died after their boat Jobhenz capsized in bad weather off Cagayan province in the northern Philippines. The fishing boat had dropped anchor to shelter from Typhoon Ragasa when strong winds made it capsize. Of the 13 crewmembers, six were rescued and seven bodies were recovered.

20 dead in boat accident in Nigerian river

Twenty people have died after a boat capsized in Kogi state, Nigeria. The vessel had been transporting people along the Niger River when the accident occurred. Eyewitnesses said only five people were rescued and 20 bodies have been recovered. An unknown number of people were reported to remain trapped beneath the capsized vessel.

Two missing after cargo ship capsizes off Chinese coast

Chinese authorities have called off the search for two missing crewmembers of a cargo ship that capsized. The incident took place off the province of Jiangsu in China after the vessel started flooding in severe weather. The captain ordered the crew to abandon ship, and four were able to evacuate on a waiting liferaft. However, the remaining two were swept away and could not be found.

Crewmember dies on Greek ferry

An engine room cleaner died after becoming trapped in one of the watertight sliding doors on the vehicle deck of Ro-Pax ferry Blue Star Chios. The crewmember was taken to hospital from the Port of Piraeus but was later pronounced dead.

Reported in October 2025

At least 26 dead after boat capsizes in Nigeria

A boat carrying traders capsized in the River Niger, Kogi State, Nigeria killing at least 26 people.

Tanker drifts towards wind farm off Dutch coast

A tanker was left adrift after it experienced engine failure in the North Sea and drifted close to Hollandse Kust Zuid wind farm - about 37 kilometres west of Ijmuiden. The Netherlands Coastguard responded to Eva Schulte's distress call after the vessel unsuccessfully tried to stop its drift by dropping anchor. A tow was secured, and it was manoeuvred to a safe position where the ship's crew managed to repair the main engine.

Fisherman dead after boat capsizes in U.S. river

A fishing vessel capsized in the Mississippi River in east central Minnesota, USA. Of the three crew, two were able to swim to shore but the third was found unresponsive.

Fisherman missing after tanker collides with boat off Vietnam

A fisherman has gone missing after fishing vessel BD 83019-TS and an oil tanker MS Favor collided off Ca Na estuary, Vietnam. The fishing boat sank and 10 of its crew were rescued by another fishing vessel. Only the owner/captain of the boat remains missing – believed to have been trapped in the cabin as the vessel sank. Reportedly, the tanker continued its journey without stopping following the incident.

One dead after fishing boat capsizes near Danish port

A Danish news outlet reported a person died after fishing vessel Flipper capsized near the Port of Hanstholm, Denmark. The boat's crew decided to return to port after the vessel showed issues with its steering gear. However, bad weather and large waves flooded and capsized the vessel as it tried to enter the harbour. All four crew were recovered, but one was shortly declared dead.

Two die after Ro-Ro cargo vessel tips over in Turkish shipyard

Two workers died after Ro-Ro cargo vessel Elmes tipped over at Yıldız Shipyard in Turkey. The ship was undergoing repairs when it fell over on its port side. Several others were injured in the incident.

15 dead after boat capsizes in Ghana

Fifteen people were killed after a boat capsized in Lake Volta in the Oti region of Ghana. Only four people survived the incident. Authorities have launched an investigation - preliminary findings suggested the boat had been overloaded.

Barge snaps power lines in Germany

A crane on barge Inn accidentally hit overhead powerlines on the River Main near Viereth-Trunstadt, Germany. While there were no injuries reported, the incident caused a local power outage. The barge had been offloading a car from its deck using the onboard crane. Repairs restored power the same day.

Race ends in tragedy as four die in Indian Ocean

Four people have died after a race boat capsized off Mombasa, Kenya. The vessel had been participating in a race at Tudor Creek as part of the East Africa Ocean Festival. Local authorities launched a search and rescue operation, but all four missing people were recovered dead.

13 dead, 18 injured in tanker fire at Indonesian shipyard

Thirteen people were killed and another 18 were injured after oil tanker Federal II caught fire at a shipyard in Batam, Indonesia. The vessel had been undergoing repairs when the fire broke out.

Cruise crewmember dies on cruise ship

A crewmember died following an accident on board P&O Cruises ship Arvia. The vessel was en route to Tenerife when the incident occurred.

One dead, four injured in explosion at Turkish yard

One person died and another four were injured by an explosion on a ship at a private maintenance yard, Torlak Shipyard, in Istanbul. The explosion was reportedly caused by a ruptured CO^2 cylinder in the engine compartment of the vessel.

Three dead, four missing after boat capsizes off Mozambique

Seven crewmembers were reported missing after a service boat capsized off the coast of Mozambique. Of the 21 people being transported to chemical tanker Sea Quest, only 14 people were rescued from the water after the service boat capsized. Indian news outlet The Daily Jagran reported the bodies of three Indian nationals were later recovered.

Two crewmembers killed after LPG tanker catches fire

LPG tanker Falcon was deemed an explosion risk and was still on fire two days after the blaze began. The vessel, approximately 113 nautical miles southeast of Aden, was reportedly fully loaded with LPG. A search and rescue operation was launched after only 24 of the vessel's 26 crewmembers were evacuated. The Indian Navy later recovered the remains of the two missing crewmembers.

Tanker leaks 2000 litres of phosphoric acid at French port

Product tanker NQ Rosa leaked approximately 2000 litres of phosphoric acid as it was docked at the Port of Sant-Malo in France. The vessel had been unloading the phosphoric acid when a ruptured hose leaked the acid into the retention tank. Splashes of acid hit the quayside - fortunately there was no runoff into the port waters. A security guard was taken to hospital for acid exposure.

Two missing after ships collide in China

Bulk carrier Haili 5 and inbound container vessel Wan Hai A17 collided in the Lingding Channel, Pearl River Estuary, China. The bulk carrier sank and only 13 of its 15 crew were rescued.

One dead, eight missing after vessel capsizes in India

One person was killed and another eight were reported missing after a river boat capsized in Uttar Pradesh in northern India. The vessel had hit a partially submerged log and had been carrying 22 passengers. Only 13 were safely rescued while the body of one person was recovered. Search and rescue continued their effort to find the remaining eight occupants.

One killed on board vessel in Norway

A crewmember was killed in a crush accident on board fish feed vessel Eidsvaag Marin in Stravanger, Norway.

Crane vessel capsizes in Crimea killing two

Two people were killed and another 20 were injured after crane vessel Gregory Prosyankin capsized in Sevastopol, Crimea. The vessel had been undergoing testing when it suddenly overturned.

Two missing after vessels collide in Amsterdam

Two people were missing after a small workboat and an inland vessel hit each other in the Port of Amsterdam. The work boat sank after the incident, and a search and rescue effort was launched to recover its two occupants.

Reported in November 2025

4,000 litres of oil spills off Norwegian coast

Landing craft Soroysund ran aground off Fjelldal in Norway. A salvage operation revealed a leak in one of the vessel's fuel tanks and an estimated 4,000 litres spilled into the sea. Containment booms and cleanup crews were deployed to contain and deal with the incident.

Two dead, 12 missing in two capsize incidents off South Korea

Two people have died and another 12 were missing after two Chinese fishing vessels capsized off southwestern South Korea. The first incident involved a 98-tonne Chinese fishing vessel around 80 kilometres off Gageo Island. Six crewmembers were rescued by Good Samaritan vessels while authorities recovered two others suffering from cardiac arrest who later died. Three were still missing. In the second incident, a 99-tonne vessel capsized around 150 kilometres off Eocheong Island. Good Samaritan vessels rescued two people and authorities continued their search for nine others.

Toxic exposure aboard chemical tanker kills crewman

A sailor died and another two were reportedly critical due to possible toxic exposure on board chemical tanker Swanlake off the Turkish coast. The exact substance has not been disclosed.

Three dead in explosion at Malaysian port

Three people were killed and another three injured in a fire on board container ship Kyparissia at the Port of Tanjung Pelepas in Malaysia. The vessel had been unloading cargo when the fire started in a cargo hold following an explosion. The cause of the explosion was unknown at the time.

Eight die after overloaded ferry sinks in Indonesian river

A ferry with 28 passengers and sacks of cement sank in the Mahakam River, Indonesia. Strong currents and a suspected overload caused it to capsize. Only 20 passengers were rescued, and the remaining eight bodies were recovered.

At least 19 die after boat capsizes in Congo

At least 19 people have died after heavy winds caused a boat to capsize on Lake Mai-Ndombe in the Democratic Republic of Congo. At the time of the report, there were 82 survivors and 19 bodies had been recovered. An unknown number of people were missing but there were an estimated 200 plus passengers on the vessel.

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What happens in the aftermath of a serious marine accident



The Marchioness. Image: John Sturrock / Alamy Stock Photo



By Mike Schwarz

Maritime accidents and incidents involving deaths and the loss of valuable assets are a daily occurrence, sadly. News of a major shipping or boating accident is rarely deemed of suitable importance by newsrooms to make international media headlines. In recent times, I can think of the Ever Given blocking the Suez Canal, the extraordinary collapse of the Baltimore Bridge when it was hit by MV Dali, and the sinking of The Bayesian off the coast of Sicily, plus a few others only.

These tragedies were thought to be important enough by news teams to make international headlines, but these disasters quickly fade from the media pages after a few days and, for most, the incidents are forgotten. But have you ever wondered what happens in the following months and years in the aftermath of a major incident, the time involved and the sheer cost, which is inestimable?

I stumbled across an old Hansard report online about the tragic Marchioness disaster on the River Thames in London that happened in the early hours of 20 August 1989, resulting in the deaths of 51 people.

Hansard is the name given to the official, substantially verbatim report of the proceedings of the UK Parliament. It includes transcripts of debates in both the House of Commons and the House of Lords, as well as records of votes, written ministerial statements, and written answers to parliamentary questions. Essentially, it's a comprehensive record of what is said and done in Parliament.

I have slimmed down the original version to make it easier to digest. But it gives us an insight into some of what happens following a maritime tragedy, in this case the debate that was held in the House of Commons on Tuesday 14 December 1993. As one reads the text, it becomes clear that years after such a tragic event, there remain questions to debate and answer. There are investigations to undertake, reports to produce, legal challenges to organise, coroner's reports to review and finally, many years later, regulation changes.

Here's an extract from the full Hansard entry.

12.23 am Tuesday 14 December 1993.

Mr. Nigel Spearing

Member of Parliament (Newham, South)



I have no pleasure in raising the subject of the Marchioness disaster. We should not be here; it should not have happened; and it should have been cleared up by a public inquiry.

In my Adjournment debate on 10 July last year, we were given an answer by one of the Ministers who is now present. I suspect that neither he nor a colleague will reply to the debate. I understand why two are present. I asked at least 10 questions which were not answered.



One of the singular issues was that had the Marchioness disaster happened in June or July with the House in session, there would have been a statement within a day or two. There would have been an enormous furore, and I think that there would have been a public inquiry. Anything less would not have been, and I do not believe has ever been, acceptable.

Fifty people died unexpectedly and tragically in the centre of London. It is the only disaster we have had on the Thames in over a century, since the Princess Alice went down off Beckton. That illustrates the relative safety of the Thames and makes it all the more important that something should have been done.



I have no commercial interest in the river, but I am a vice-president of the River Thames Society and a member of the Inland Waterways Association, Transport on Water, the Thames Traditional Boat Society and the Thames Wherry Trust.

Usually, I tend to be rather detailed and legalistic. I hope that the House will forgive me if I become more colloquial in recounting the complex and horrific story of the events that took place after the disaster. I do not want to give way, except to Front-Bench spokesmen if they really wish to intervene.

This has been a story of inaction. After King's Cross and the incident at Clapham, there were, quite rightly, big inquiries. An inquiry asks questions and reveals and the Government and all of us should assist that process. Unfortunately, in this instance, as I will demonstrate, the reverse has been the case.

After the refusal by the then Secretary of State for Transport to grant a public inquiry a former Director of Public Prosecutions brought a case. People thought that there would be action at last. It was a case about not keeping a proper lookout. In the courts, that meant that matters of liability, blame and factors other than failing to keep a lookout were not germane to the proceedings. I understand that the maximum fine for that offence was £2,000 or two years imprisonment. It meant that all other comments were sub judice. That went on for a long time. Unfortunately, the jury did not agree on the first case, and it had to be retried.



Time went on and the matter died down to an extent. It progressed only at an inquest by the Westminster coroner. I expressed concern about that at the previous debate on the matter, but I have had no satisfaction. Some of the hands of those who were drowned were removed by order of the coroner, who prevented, by some form of order, some of the next of kin from even identifying their loved ones and family.

When the case on keeping a look-out arose, the matter went sub judice and, when it was concluded sometime later, despite requests from more than 30 families, the inquest was adjourned and has not been resumed.

So cutting off the inquiry was the second block. I understand why that may have been justified. In answer to a written question, the Under-Secretary of State at the Home Office told me:

"Under section 16(3) of the Act, the coroner may resume the adjourned inquest after the conclusion of the criminal proceedings if, in his opinion, there is sufficient cause to do so." - [Official Report, 13 December 1993; Vol. 234, c. 439.]

That is usually when some other circumstances are connected with the death, but the coroner has an option to reconvene the case. In this case, he used the right not to do so, despite the clear need to take the matter further through the inquest.



Next, a private prosecution was brought by a relative of one of the deceased. Mr. Glogg's wife was drowned, and he brought a private prosecution against the owners of the Bowbelle, Ready Mixed Concrete.

The corporate case against RMC was against individual members of its management, but things went wrong. It would take too long for me to go into the complication, but the difficulty arose because the DPP intervened again. He has the power to take over a private prosecution if he thinks that it is wise to do so but, having taken it over, he can drop it.



There was an argument between him and the Marchioness action group about what was to happen. I understand that he said that he wanted to see all the group's evidence before taking a view on the matter. Members of the group thought it so outrageous that the DPP wanted to see the evidence before it was tried in court that they made the matter public and he then dropped it.

The prosecution went ahead, but further difficulties arose when the firm involved understandably applied for a judicial review and tried to stop the case going ahead. Although it went ahead, the magistrate said that, if it was a matter of corporate liability, the condition of the craft and how it was managed would not necessarily count. He questioned whether it could be proved that the Marchioness had turned to port, as the inquiry had showed.

In the same way, one might have an accident with a motor car that comes across one's front. He said that it was impossible to tell whether that had happened. If it had, it would have made no difference how well the ship was managed or how responsible the company was. That is my understanding of that matter.



That took us, after two years, to the report of the Marine Accident Investigation Branch (MAIB). Although that report was completed and some of the material that it contained, including the recommendations, were published, the report itself - quite properly - was not due to be published.

If the Marchioness action group wanted to pursue the corporate matter, as it did, it had a problem with the report, because it was about to be published. The action group went to the Attorney-General and said, "If the report is published at this time, the case that we are about to pursue based on the course of the Marchioness will be prejudiced. Please ask the Government to hold back the MAIB report, so that the matter will be deemed sub judice, but this time on our terms, until that court case is finished." The Government did not agree.

The preface to the MAIB report is signed by Captain Marriott, who states:

"I submit my Report following the Inspector's inquiry into the collision between the passenger launch Marchioness and the aggregate dredger Bowebelle".

Although Captain Marriott was the senior man in the MAIB, it was not his inquiry. He refers to "the Inspector's inquiry". Who conducted the inquiry? That is not stated in the report. The inquiry was conducted by someone who may be known but who was not named and was sent by his superior officer to the Secretary of State for Transport. We do not know who formally conducted the inquiry, although we might have some guesses about it.



How did that arise? Unlike a proper inquiry, a maritime inquiry of that nature comes under the Merchant Shipping Act 1979 and Statutory Instrument 1172, the Merchant Shipping (Accident Investigation) Regulations 1989, which were published only a month or two before the Marchioness disaster, and which are highly relevant. Regulation 8(2), regarding the conduct of investigations, states:

"An investigation may extend to cover all events and circumstances preceding the accident which in the opinion of the inspector may have been relevant to its cause or outcome, and also to cover the consequences of the accident and the inspector's powers shall apply accordingly."

Regulation 8(4) states:

"Upon completion of an investigation the inspector shall submit to the Chief Inspector his findings as to the facts of the accident and, where the facts cannot be certainly established, his opinion as to the most probable facts. He shall clearly distinguish between established facts and conjecture. He shall also submit his analysis and his conclusions together with such observations and recommendations as he thinks fit to make."



The personality of the inspector who submitted his report to the Chief Inspector, Captain Marriott, is therefore most important. We are getting further and further away from what one would expect from a public inquiry in the form that one would expect, at which members of the public can volunteer information, and so on.

The MAIB report was well publicised at the time of its publication. Full summaries were sent to the press in August 1991, and it is true that it said some hard things about the way that Department of

Transport officials and possibly Ministers handled safety on the Thames for a number of years.

I am told that many of those who survived the traumatic incident gave statements to the police, and that was all they heard about it. One person of whom I know had to make great efforts to give evidence to the MAIB inquiry. Other people did not know that they had the opportunity to do so. Advertisements were placed in newspapers. Does that mean that the survivors' addresses were unknown? It was an extraordinary way to go about things.



I knew that the Bowbelle had been involved in several accidents before that disaster -neither the Bowbelle nor its sister ship was unknown on the river. As soon as the report was published, I looked to see what it could tell me about the accidents that I had seen in Lloyd's List. Out of seven or eight accidents of which I knew, only one was included in the report. I immediately wrote to the Secretary of State for Transport. In my letter I stated that the Bowbelle had been involved in six accidents that were not mentioned in the report, and that there must be something wrong.

I found that many factors were wrong. I read the report and found that it raised as many questions as it answered. I wanted to know so many facts that were not included in the report. There were so many omissions and massive gaps that I could not regard it as a thorough or complete report. It was necessary to know the river to be able to identify them. I concentrated on the six accidents that were not reported. I corresponded with the hon. Member for Derbyshire, West, who was then a junior Transport Minister.



On 12 December 1991, the Minister eventually told me that he had received no representations about omissions of relevant facts from the investigation. I said that I had sent him a letter asked questions only to be told that they were not relevant. The Minister's reply continued:

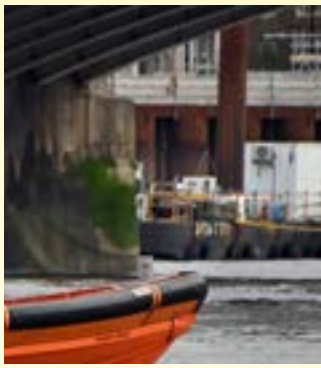
"The letter of 19 August from the hon. Member was received on 20 August: I replied on 19 September. That letter from the hon. Member was not considered to be a representation about relevant facts in the context of the Marchioness report. The MAIB inspectors were aware of the number of incidents involving vessels, including Bowbelle, which had occurred prior to the tragic accident that they were investigating. Section 15 of the report discussed the reaction of the owners, PLA and the Department at some length. To have gone into detail on each incident would have greatly lengthened that section without adding to its value; the reason for singling out the incidents described in annex 11 of the report is that they had particular similarities to the Marchioness case."-[Official Report, 12 December 1991; Vol. 200, c. 511.]

Eventually, on 21 January 1992, the subject was placed on the record when I asked the Secretary of State for Transport whether he would draw the accidents to the attention of the Hayes inquiry established by him. The gaps in the report included the fact that it contained no account of the career or experience of both masters. There was no real investigation of the intensity of illumination - at least of the Bowbelle's lights. The inspector said that, if Captain Faldo had turned and the boat was in the line of vision, it was possible that he did not see it.



The report contained no description of the tidal sets - streams that run sideways across the river - which are important, or the depth of the water at that time. Speed tests were not carried out on the Bowbelle. There was no transcript of the Thames navigation service radio, which transmitted messages from various boats at that time. The transcript that is now in the library has the phrase "unknown vessel" against one of the key transmissions.

Later the report states that both boats went through the centre arches of Southwark bridge. That is what the report says, and everybody agrees with it. There was no discussion about convergence speeds or line of sight at that point.



Most important of all, because rumour was rampant on the river at that time, there was no reference to when police took statements from those who were mainly concerned. I do not repeat rumour, but I can ask questions. There was a rumour, not mentioned in the report or denied, that a representative of Ready Mixed Concrete was aboard Bowbelle before the police. That may not be true; I do not know. All I am saying is that that was believed by some people. I ask the question: was that true or not true? Why was not it dealt with in the report as a matter of routine description?

We move to the next phase, when the Marchioness action group met the Secretary of State and asked for an inquiry. He had to do something about that, did he not? He then produced the Hayes report into river safety. That was trumpeted around and resulted in headlines in the press. I shall quote the Department of Transport press release dated 19 December 1991. It was headed:

"Marchioness: river safety inquiry announced",

and said:

"An independent investigation is to take place of the Department of Transport's past and present handling of river safety, Secretary of State for Transport announced today."

In fact, the Hayes inquiry was not into the Marchioness disaster. Its terms of reference stated:

"In the light of the Marchioness/Bowbelle disaster to examine the handling since 1980 by the Department of Transport of its responsibility for the safety of vessels on rivers and inland waters and to report on the effectiveness of the present approach. The enquiry should take account of developments in the field of marine safety at the international level."

In correspondence, Mr. Hayes made it quite clear that, while he could consider that disaster and take some lessons from it, he was not entitled either to investigate the disaster itself or still less to make an evaluation of the MAIB report.



A remarkable statement was made in paragraph 1.7 of the report, when Mr. Hayes said:

"When the disaster occurred, I understand that the decision not to order a public inquiry was taken at No. 10 Downing Street on advice from the Department."

I do not suppose that the Minister can tell us why that was the advice. I should very much like to know. The only reason that I have heard was that, as in the case of an air disaster, the technical people could deal with it rather better than a public inquiry.

One of the principal recommendations of the Hayes report was:

"There should be an early review of the rescue arrangements and equipment on the Thames which should take account of the Marchioness/ Bowbelle disaster."

As the Hayes committee would not have been set up but for that disaster, we automatically expected that that would be accepted by the Department, because it was surely one of the principal recommendations.

I have lost count of the blockages that occurred in this sad story, but I shall cite another involving the present Secretary of State, the right hon. Member for Norfolk, South. In his reply to the Hayes report, he said:

"The Government has given careful consideration to the recommendation but have concluded that a further review of this kind would not be justified. Action is, however, being taken to ensure that the lessons...have been fully assimilated." - [Official Report, 7 July 1992; Vol. 211, c. 101.]



One of the prime reasons for setting up the Hayes committee, even if, contrary to public expectation, it did not consider the Marchioness disaster, as that misleading headline suggested it might, was not accepted. But it gets worse, if one can imagine that.

On 19 July, a year later, the hon. Member for Romford asked the Secretary of State for Transport:

"Which recommendations in the MAIB report into the collision between the Marchioness and the Bowbelle have now been implemented and what action has been taken on the recommendations in the report of the inquiry into river safety, the Hayes report."

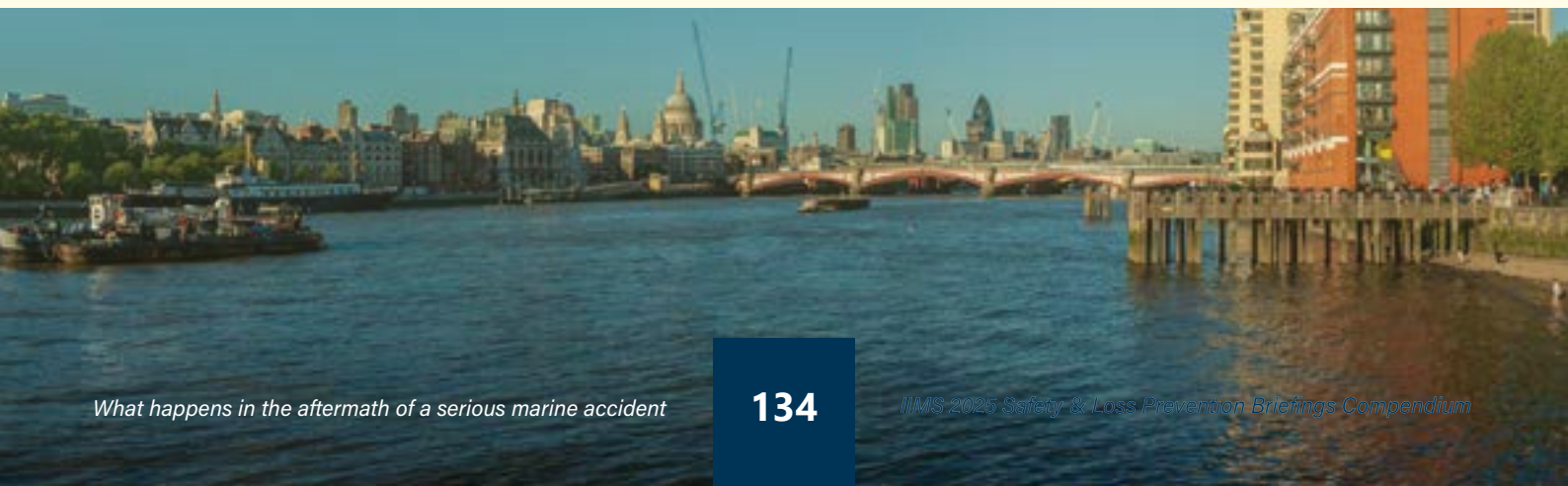
I am sorry to say that the Minister for Transport in London, who is present in the Chamber, answered thus:

"The MAIB report into the loss of the Marchioness contained 27 recommendations. All have now been implemented. The Hayes report contained 22 recommendations, and action is in hand on all." - [Official Report, 19 July 1993; Vol. 229, c. 78.]

That is the nearest thing that I have seen to a falsehood in Hansard in my career.

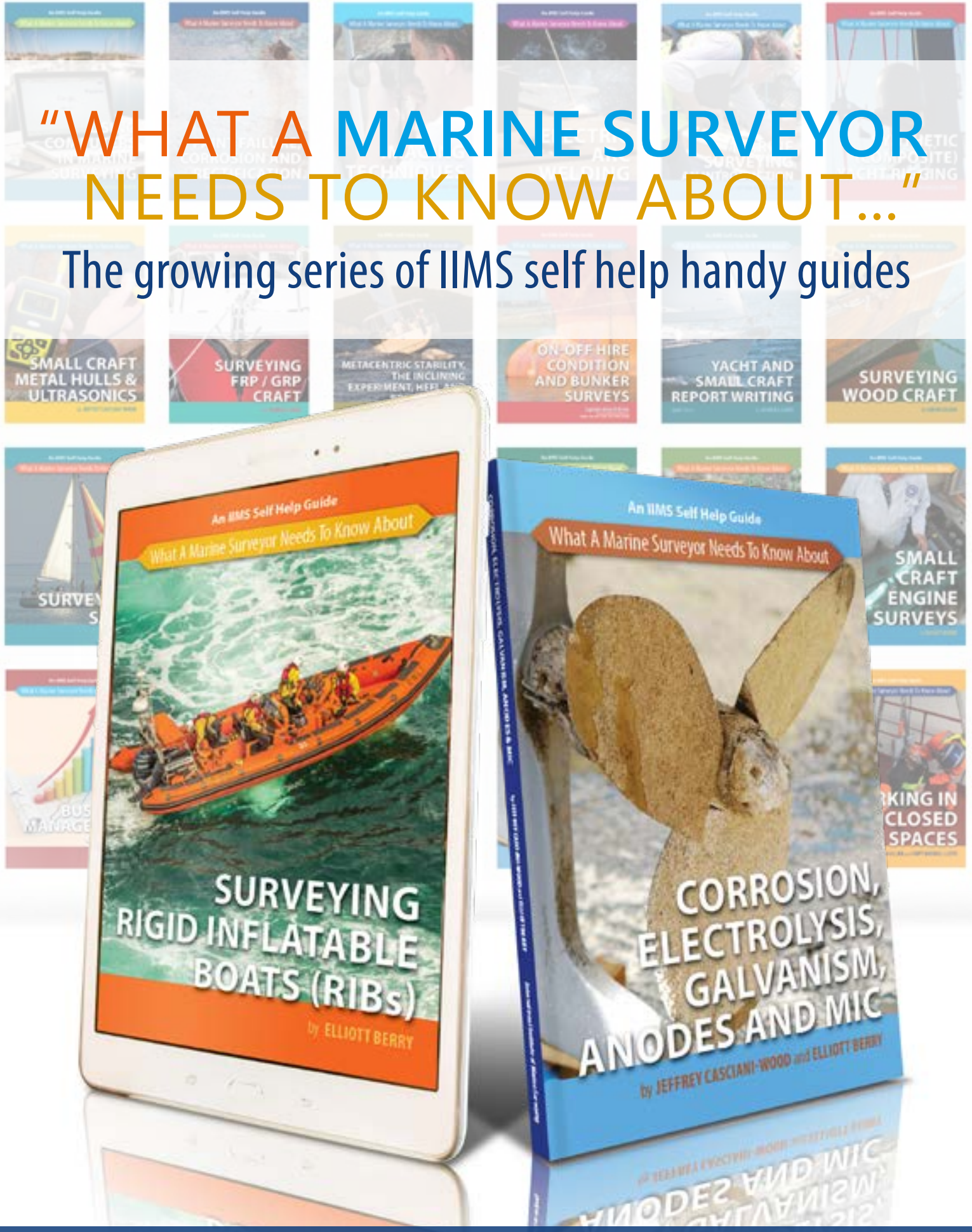
Hansard end.

Personally, I found this an extraordinary and revelatory read. So once those media headlines surrounding a fatal accident have faded and gone, in reality it is just the start of a lengthy process that will run and run, in some cases, for many years and at huge expense.



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What's behind the latest spate of boat fires?

IIMS CEO, Mike Schwarz, has been alarmed at what seems to be a growing number of destructive boat and yacht fire incidents reaching his desk since the start of 2025. Mike has been motivated to write this article so he can set out and catalogue some of the higher profile fire incidents, as well as some of the less well publicised ones.

This is an expanded article following the introduction I wrote for the IIMS June News Bulletin on this subject. It may have passed you by, but there seems to have been a string of eye-catching large yacht and boat fires erupting around the world since the start of 2025 with devastating consequences. So, what is behind this surge in yacht and boat fires? Is there a common thread? Not sure yet, is the simple answer.

So, what we do know is that boat fires are nothing new. I have no idea who records the number of yacht and boat fires across the world from one year to the next - someone must - but it seems to me that 2025 has been an appalling year so far, although how it compares in reality with previous years, I cannot be sure. Remarkably the death toll has been low, but the instances of catastrophic fires have become too frequent. And of even greater concern, are the fires affecting tour and dive boats.

In some cases, we must wait for the results of ensuing investigations. Some causes, tragically, will never be known. And what about the impact for insurers in what is already a tight market? How often can they keep paying out sometimes extraordinary sums of money?



Marseille yacht fire. Image credit: Tom Moreau/Marine Nationale

Whilst the reason of a boat fire is not always known instantly, lithium-ion batteries are said to have been the cause of one devastating fire in Marseille in January which kick started this unwelcome run of boat fires.

This fire destroyed Naisca IV and spread to two nearby yachts. The second yacht was also destroyed, while the third sustained severe damage to her port side. Dubtless there was damage to the marina infrastructure too. Oil booms were deployed to mitigate the environmental harm. Who knows what the final cost to insurers will be, once the dust settles.



Image credit: CBS Miami



Remains of Ramonda.
Image credit: prlainovic_m_13_



Miami river fire.
Image credit: Fire Engineering

Also in January, a 29-metre Princess Yacht was destroyed in a blazing inferno. The vessel was allegedly being chartered by the renowned hip-hop producer Metro Boomin, who was not on board at the time. The Miami-Dade Fire Department mobilised more than 30 units, including ground crews and rescue boats, to contain the growing fire. However, the yacht eventually took on too much water and capsized into the river.

Three further major fires occurred during March. The 29.63-metre Azimut motor yacht Ramonda was destroyed in the Portonovi resort marina in Montenegro. The images are horrific and very little remains of the vessel - just a charred and burnt-out hulk from what I can see. The local police force managed crowd control and supported the operation, whilst firefighter units worked to extinguish the fire. However, according to reports, the fire could not be contained on site.

That same month, three yachts were destroyed following a marina fire in northwest Miami-Dade County, Florida, on the Miami River. According to local reports, authorities arrived at the scene to discover all three yachts ablaze. Firefighting efforts ensued from both shore and sea, with the fire extinguished three hours later by “foam techniques”. Two of the affected vessels were below 24 metres, with the other confirmed to be the 30.8-metre Rodman yacht Nirvana.

The other fire to catch my attention involved a Colombian catamaran tour boat. The incident forced 89 tourists to abandon ship. The Daily Mail reported that “all 92 passengers and crew in the Caribbean Sea off the city of Santa Marta in northern Colombia were forced to abandon ship after their vessel caught fire”.

An initial investigation revealed that the blaze on the tour boat Katamaran Tayrona I ignited after one of its engines suffered an electrical short. Taximarino, operator of Katamaran Tayrona I, has since issued a statement, which is of little comfort, saying that the engines fitted on the vessel were rebuilt approximately two months prior to the incident. Does that make it OK? Of course not!

Moving on to April, a massive fire erupted on a yacht in Fethiye's Karagozler Marina in Türkiye. Firefighting teams from Fethiye and Seydikemer initially responded but were unable to contain the flames. Arriving swiftly at the marina, emergency crews worked intensively to control the fire, but it seems they could not prevent it from spreading to other nearby boats. Actual facts about the incident are sketchy. Eyewitnesses stated that one of the burning yachts had recently been launched and was a relatively new vessel.

And then bizarrely by coincidence in April, two dive-boat engine fires occurred on successive days in southern Thailand. All passengers and crew involved were able to be rescued.

In the second incident, 18 tourists and Thai passengers and 8 crew had to take to a life-raft in the Andaman Sea in the early hours. The vessel, the 35m steel DiveRACE Class E, had brought divers to Khao Lak National Park, and anchored for the night ready to visit the 1980s wreck of the tin-mining dredger Boonsung and surrounding coral reef the next day.

Just the previous day, fire had broken out in the stern of a smaller commercial boat, the Aor Subpiti, as its engine burst into flames. Sixteen-year-old helmsman Manawat Bialy sustained significant burns to his arms and face when the engine exploded close to where he had been working, but he was still said to gone on to help get the family safely into the water before trying to put out the fire.

These two incidents happened less than a month after 26-year-old London backpacker Alexandra Clarke went missing when the charter dive-boat David John caught fire and sank. Clarke had been one of 22 tourists and crew on the vessel when the fire broke out some 10km off the coast of Ko Tao on the western side of the Gulf of Thailand.

According to police the boat's fuel tank overflowed while being refilled, with the vapour ignited by a spark when the engine was started. Fire spread quickly through the engine-room, as the divers and crew jumped into the sea. They were rescued by the crews of private boats alerted by an emergency call. The vessel eventually sank and the captain and the crewmember who had been filling the tank have been charged with negligence.



Karagozler Marina, Fethiye, Türkiye fire. Image credit: Patronlar Dunyası



The burnt-out dive boat. Photo credit: Phuket Info Centre



Fire on the David John: Photo credit: Surat Thani Provincial PR Office



Emperor Seven Seas ablaze



Boat fire at Imperial Yacht Club

More problems for Egyptian maritime authorities

Egypt's liveaboard industry received another blow with the news that the Emperor Seven Seas had been burned out by a fire while docked in Port Ghalib marina. Thankfully, no crew or passengers were injured, and while the vessel was declared a total loss, everyone was safely evacuated as the fire took hold and could not be dealt with.

A statement from Emperor said: 'In the early hours of Thursday, 13 March, Emperor Seven Seas was moored in Port Ghalib when a fire broke out that could unfortunately not be contained.

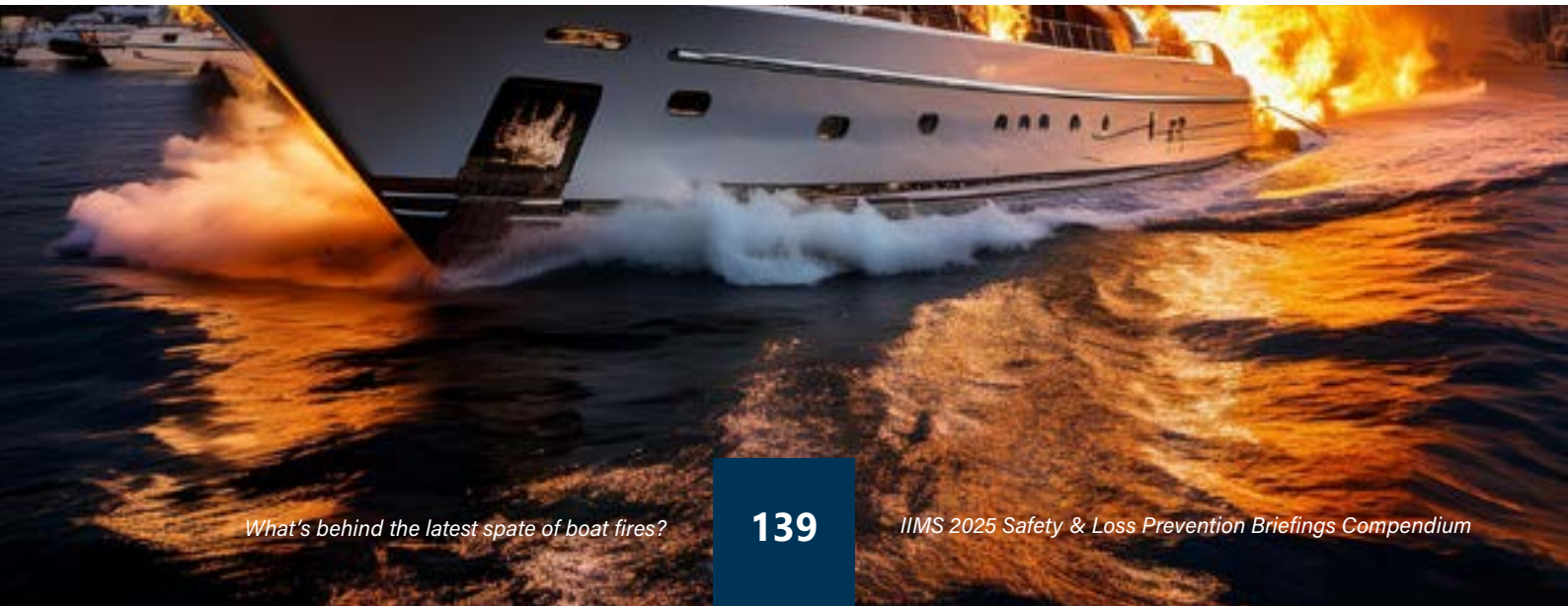
On the other side of the world, two separate boat fires in New York and New Jersey on the same night killed 2 women, with a further 3 hospitalised.

The newspaper report said, "Raging fires engulfed boats in New Jersey and Westchester in separate incidents overnight that saw two people dead and three hospitalised, according to officials. The two females were taken to University Hospital, where they were pronounced dead." Bet that story passed you by?

Then just four hours later, a larger blaze broke out at Imperial Yacht Club, a marina on the Isle of San Souci in New Rochelle. A total of seven boats were destroyed as it took firefighters two hours to get the blaze under control.

There have been other serious yacht fires too in recent months. What I have shared with you is the tip of the iceberg. So, what are we to make of this situation, which seems to be setting a rather worrying trend? The intensity and severity of these fires are also of concern. It is remarkable that more people were not killed.

Once again, these cases highlight the continuing spate of fires affecting the boating and tour boat industries. While it could certainly be argued that these fires are disproportionately reported due to the sensational and excessive use social media, the rate of total losses caused by such incidents would seem to be increasing. Until the industry identifies and addresses the root causes of yacht and tour boat fires, it seems inevitable that such incidents will likely persist and only grow in volume and severity.





Surviving the M/S Estonia disaster and the journey of resilience and recovery



On the night of 28 September 1994, the M/S Estonia, a passenger ferry travelling from Tallinn to Stockholm, sank in the Baltic Sea. The incident resulted in significant loss of life; of the 989 crew and passengers aboard, only 137 survived, making it one of the deadliest maritime disasters in modern history.

Sara Hedrenius, published author and Senior Advisor in Mental Health and Psychosocial Support at the Swedish Red Cross, was one of the survivors, and the memories of that fateful night remain clear in her memory. Severe weather conditions, with high waves and strong winds, made the mass rescue operation (MRO) more difficult.

"A loud bang was the first indication that something was wrong. I remember making my way up and out onto the deck. Once there, I felt uncertain about what to do, so I clung to the highest point I could reach, the railing. Looking down at the black water below felt utterly surreal.

"When the ship capsized, we climbed over the railing and stood on the vessel's side. The moon was shining, and I had never been so scared in my entire life – my heart was pounding, and I felt sick.

"When the captain signalled, we knew it was time to leave the ship. There was nothing to hold on to, nothing to keep us afloat, so we moved toward the water and let a wave sweep us into the sea," says Sara.

The time between the first banging heard and the moment the ship finally sank was approximately one hour. Surviving a disaster of this magnitude comes with long-term effects. Sara, who was 20 years old then, could not fully grasp what had happened.

Support from fellow survivors played a key role in validating her memories and understanding her reactions. "It was helpful to see that other survivors struggled with similar reactions and thoughts. It made it easier to understand that my responses were a result of what I had been through, not a sign that I had fundamentally changed as a person."

Trauma therapy provided practical tools for managing the psychological impact and helped her move forward. The Estonia disaster led her to focus on crisis response and mental health support. "My studies in psychology and psychotraumatology eventually guided me to work with the Red Cross, specialising in disaster and crisis management."

Maritime disasters can highlight gaps in rescue operations. She interviewed several rescue swimmers afterwards and learned that equipment failures hindered efforts that night.

"Torbjörn Olsen, one of the rescue swimmers that night, developed a new product after the disaster to make helicopter hoists safer. Tragic events can sometimes lead to innovations in safety procedures, such as Torbjörn's helicopter hoist technology," she adds.

Following the Estonia disaster, changes were implemented, including adopting neon-green rescue suits and helmets for swimmers. The disaster raised awareness of the importance of structured crisis support for maritime personnel.

Maritime disasters impact survivors differently based on several factors. One crucial aspect is whether the accident was caused by human error or intentional actions, which can lead to more significant psychological injuries.

Survivors' personal experiences during the event, such as feeling their lives were in danger and the length of the period of uncertainty, also play an important role in their recovery. A major challenge is the transition from immediate crisis support to long-term care, as follow-up assistance is often neglected, leaving individuals without the support they need.

She believes having a basic understanding of human reactions and needs is helpful. Organisations must be prepared to provide Psychological First Aid. This reduces stress, provides reassurance, fosters connection, and enhances feelings of control during chaotic situations. Assessing needs and offering practical support are essential for recovery.

Sara spoke at the G6 MRO conference organised by the IMRF in Sweden. Her message to the SAR community emphasises the importance of crisis support and the need to integrate it within organisations.

She believes that learning the basics of crisis management is essential, as it helps individuals recognise what they may need during difficult situations and how they can support friends or colleagues – especially since knowing how to respond isn't always straightforward.

She says organisations and responders have to be prepared for the mental and emotional toll of MROs on both survivors and rescue personnel.

Preparedness requires thorough training exercises that include mental health considerations. Post-disaster evaluations should incorporate feedback from both survivors and personnel.

Insights from those directly affected contribute to meaningful operational improvements, ensuring that future responses are more effective.

"Despite growing awareness, stigma around mental health persists. Encouraging open discussions and normalising psychological support within SAR communities can help address this issue. Keep the conversation going and share experiences with one another. This will help your organisation grow, improve, and stay engaged in continuous learning.

"Adopting evidence-based international guidelines ensures consistency in post-rescue care. Additionally, research and data collection contribute to refining intervention strategies for both survivors and rescuers," Sara adds.

The role of SAR teams extends beyond rescue operations. Providing proper support during and after missions strengthens both individual resilience and organisational effectiveness.

"Mental health considerations should be a core aspect of emergency response strategies, ensuring that both survivors and rescuers are better prepared for future challenges," Sara concludes.

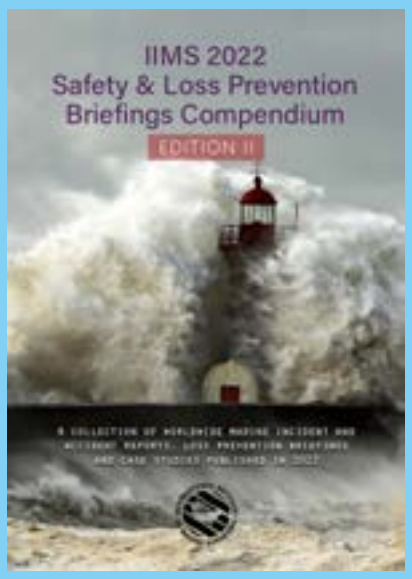


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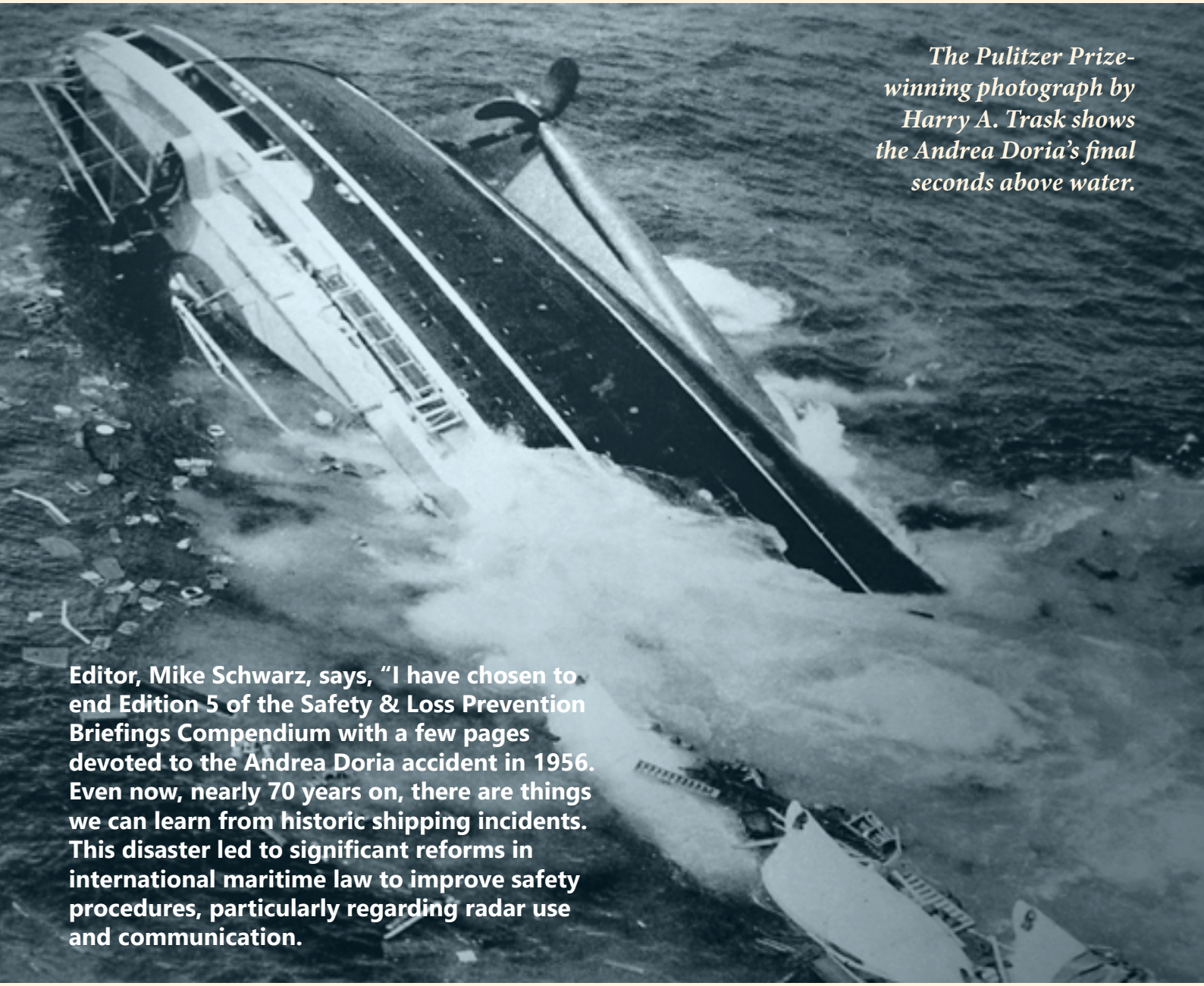
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Stories of the SS Andrea Doria Disaster



The Pulitzer Prize-winning photograph by Harry A. Trask shows the Andrea Doria's final seconds above water.

Editor, Mike Schwarz, says, "I have chosen to end Edition 5 of the Safety & Loss Prevention Briefings Compendium with a few pages devoted to the Andrea Doria accident in 1956. Even now, nearly 70 years on, there are things we can learn from historic shipping incidents. This disaster led to significant reforms in international maritime law to improve safety procedures, particularly regarding radar use and communication.

"The first article is an account written by Pierette Domenica Simpson, who was a young girl aged 9 at the time. She escaped and was safely rescued.

"The second article is a first hand, personal account from a young messman/ seafarer who became involved in the rescue of the last passenger from the sinking Andrea Doria.

"The emotional turmoil both experienced is plain to see as you read their accounts, both from entirely different perspectives.

"When you read the reasons from the report that led to the accident, once again you realise this was a wholly avoidable incident."



Background to the accident

The Italian luxury liner Andrea Doria collided with the Swedish liner MS Stockholm in dense fog off Nantucket, Massachusetts. The Andrea Doria, a top-heavy vessel, began to list severely, disabling half its lifeboats, but a swift rescue operation, aided by other ships including the Stockholm, saved most of the 1,706 passengers and crew. However, 46 people on the Andrea Doria and 5 on the Stockholm died in the collision, and the Andrea Doria sank early the next morning.

The accident was a result of human error, particularly a misunderstanding of radar readings and a miscalculation of distances by the Stockholm's bridge team. The captains of both ships made decisions that contributed to the crash, including the Stockholm taking a path that put it on a direct collision course with the Andrea Doria.

The Night I Survived the Andrea Doria Shipwreck

By Pierette Domenica Simpson, La Nostra Voce



Pierette Domenica Simpson holds her childhood photo snapped after the fateful collision.

On the evening of July 25, 1956, a collision between the ocean liners SS Andrea Doria and MS Stockholm killed 51 people and prompted one of the largest civilian maritime rescues in history.

"It was the longest day of my life. Words alone cannot convey the tortured moments of that morning of July 26, 1956, when I heard about the sinking of the Andrea Doria. Finally, the good news came: the telegram from the Ile de France read 'TUTTI SALVI.' I knew you were saved," Vivian Massa, Pierette's mother

My nonnis and I had survived the collision and thus became part of the "greatest sea rescue in peacetime history." But the loss of life and the crown jewel of the Italian Line shocked the world.

Ironically, upon her maiden voyage in 1953, the Andrea Doria impressed the maritime world for its modern technology with not only its peak speed of 23 knots, but by its two sets of steam turbines and two radars. It was designed for safety, meeting all requirements of the International Convention for the Safety of Life at Sea. Just as with the Titanic, some even dubbed the ship "unsinkable."

The Andrea Doria was designed by Italy's greatest artisans to exemplify the beauty of the Italian spirit inspired by centuries of artistic magnificence. In fact, it was called "a floating art museum" with works reflecting Italy's artistic heritage of painters, ceramists, sculptors, and designers. It was a prestigious choice of travel by the rich and famous, such as screen stars Anna Magnani, Ruth Roman, Betsy Drake, Cary Grant, Tyrone Power, Orson Wells, Spencer Tracy, Richard Widmark, and Joan Crawford.

At each of her ports — Genoa, Cannes, Naples, Gibraltar, and New York — the liner gracefully displayed its sleek lines. She was unquestionably the symbol of Italy's revival from the economic ruin of WWII. Her demise was devastating to the Italian soul!

My mother, Vivina, had emigrated from Piemonte eight years earlier (1949), when I was 15 months old. She would send letters from Detroit, Michigan, asking my grandparents who had adopted me, to bring me to America by ship or allow me to take a plane. But I would protest the latter, screaming that air travel was not safe! She kept promising us that we too would realize the American Dream. The final demand included three tickets for passage on the Andrea Doria. We travelled eight days in comfort and fun, especially since even Third Class had a swimming pool.

On July 25, 1956, the last full day on board the cherished Italian liner, our spirits were covered with a gloomy blanket of fog that even permeated the corridors.

11:10 p.m. near the Nantucket Shoals "I know this song…Arrivederci Roma. Guess we're saying goodbye to Italy for good. I'm excited; I get to see my mother, new baby sister, and stepfather tomorrow. Nonna finally looks relaxed…wish Nonno hadn't gone to sleep early…he said, 'Tomorrow's going to be a big day'…What's that noise?!"

I cried and trembled, along with all the astonished passengers who instantly froze into statues of fright, swaying from an abrupt jolt and hearing a thunderous noise. Those who were on the outer deck stood witness to startling fireworks created by grinding steel from another ship that had slammed into our hull at full speed. They watched in horror as the perpetrator tried to withdraw from the hole it had created, slicing through thick walls of steel that had once protected passengers from the dangers of the Atlantic Ocean. The gruesome spectacle was magnified by the crash of hundreds of bottles that landed on the bar floor, as if put there by the devil's rage. Every fibre in our spines reacted to the scraping, screeching, and crunching noises from some indefinable source.

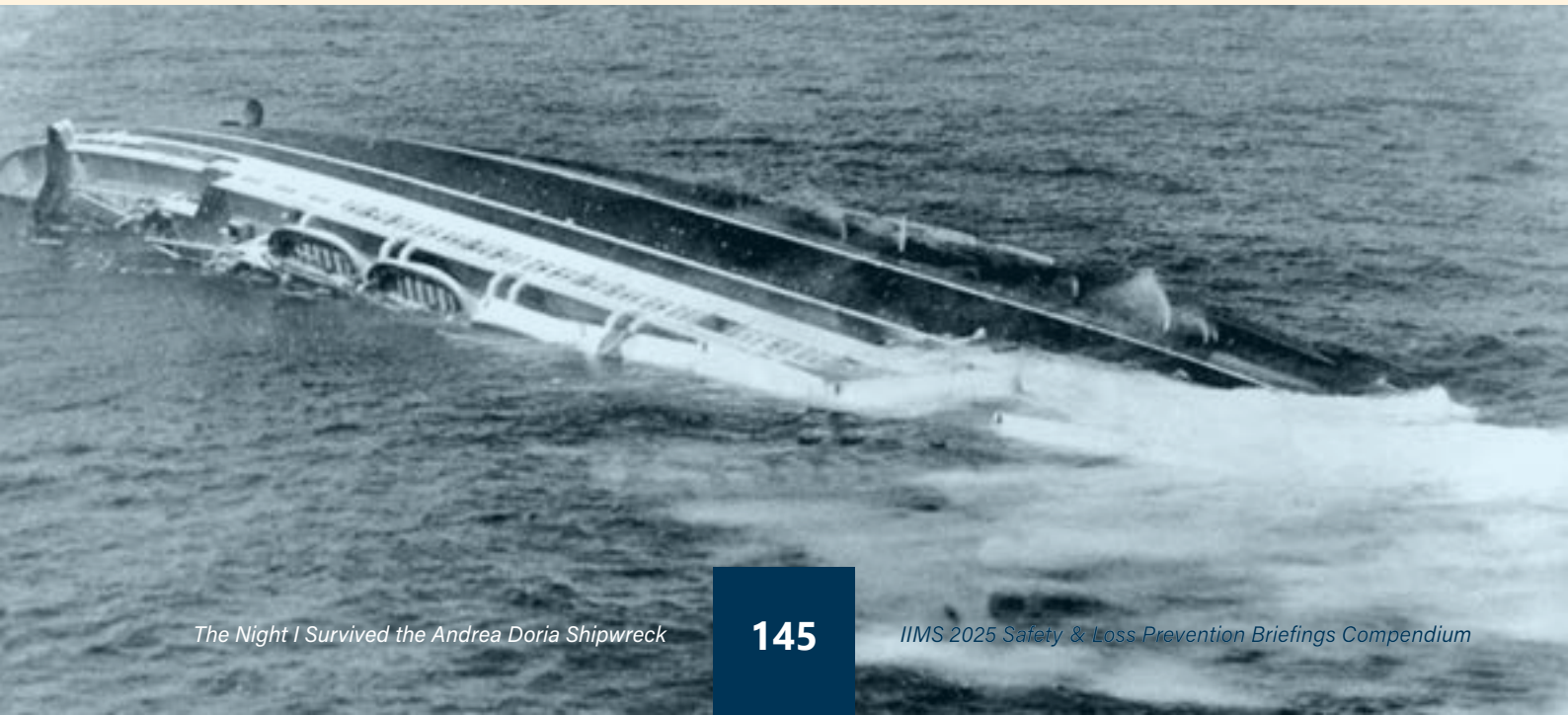
After what seemed like eternity, my nonnis and I sat on the floor in prayer circles of the already heavily inclined liner; the Ave Maria's last words, "….now and at the hour of our death" suddenly took on an eerie meaning. Afterall, we did not know that Captain Piero Calamai had sent out an SOS and rescue ships were on their way. For 1,640 passengers they were angels of mercy; tragically, 46 lives could not be spared on the Doria.

Even after 66 years, I quiver when I recall my frail, 9-year-old body dangling from a rope around my waist over the black ocean. Fortunately, I didn't understand the concept of drowning, but the intense screams from above and below signalled a great danger. As my life was literally in suspension, I screamed for my nonnis and they screamed something back. But the violent waves pounding against the ship's smashed hull created by the Stockholm's penetration muffled any words of confidence.

As I began to approach the black waters, I thought I was going to be dropped into the ocean! I could not see the Ile de France lifeboat below that was hidden under the steeply inclined liner (perhaps 40 degrees by now). A sailor's hands pulled me in to join people hysterically crying, screaming, and vomiting, many wearing only underwear or curtains on their backs.

Miraculously, my nonnis, in a desperate attempt to join me, grabbed ropes and lowered themselves into the swaying lifeboat. When I recall my nonna's lifelong paranoia of water, I marvel at her courage. And my nonno's sense of duty to the family managed to descend with his briefcase in hand, but his piercing blue eyes reflected unimaginable fright!

I admit that I worried about my First Communion dress and hoped it would be recovered somehow, but the quagmire of soggy suitcases, open trunks, and other debris was not reassuring. Moreover, during this ride from hell to the Ile de France, we were privy to a sight worse than in any disaster film: the Stockholm, a Swedish ship that had rammed us, stood crippled in the distance with its bow crumpled like tin foil. On the Doria, the area of impact was an enormous black hole, inviting in tons of water per hour. And its huge funnel was so inclined over the water that it reflected a red-hot glow on the calm sea.





27 July 1956: After colliding with Andrea Doria, Stockholm, with severely damaged bow, arrives at New York.

Undoubtedly, it could have been another Titanic; but thanks to an admirable captain and crew, the Stockholm rescuing around 500 passengers, and the many rescue ships that rushed to our aid from the New York area, the human loss - compared with many other large disasters - was miraculously low.

Yet, the Andrea Doria tragedy remained one of the most complicated and controversial collisions at sea. How could this happen on such a large ocean? My research, based on interviews with maritime experts in both Italy and the U.S. and with the scrutiny of a computer simulation at the U.S. Merchant Marine Academy in New York, revealed how the Stockholm's crew contributed to the collision:

- The captain assigned an inexperienced Third Officer and two other young men to the bridge in fog; he remained in his cabin even while in the most trafficked area near the Northeast coastline (approximately 50 miles from the Nantucket Shoals);
- The young men were overworked and overwhelmed;
- The Third Officer was directed to navigate in a lane designated for westbound traffic, thus in our lane as they travelled eastward;
- The Stockholm had an antiquated radar that had to be set by hand, with a flashlight to determine position of vessels;
- Its foghorn was silent, although prescribed by maritime law;
- The Third Officer misread his radar, thinking the Doria was approaching on his left; he mistakenly ordered two right turns which led to the shocking collision, at full speed.

These fatal errors were predicated on miscalculations in distance, position, weather, and timing. The result was Murphy's Law at its worst.

There should have been a trial, but Lloyds of London - the insurer for both the Stockholm and Andrea Doria - decided that there was not enough evidence to ascertain guilt. Hence the most complicated maritime disaster was settled swiftly with a no-fault verdict, even after four months of hearings. The terms of the agreement were to be kept secret. Passengers were compensated a meagre $6 million for loss of life and property, instead of the $115 million they had requested in 1956.

Nevertheless, Captain Calamai awaited the earlier promise to command the new sister ship of the Doria, the Cristoforo Colombo, but the request never arrived. Feeling abandoned and vilified, ashamed to have tarnished the name of the long line of Calamai men and their distinguished naval career, he exclaimed to the media, "I used to love the sea, and now I hate it." Calamai admitted himself to the hospital complaining of malaise. His last words were "Are the passengers saved?" His family and those who knew him well understood that he had died of "crepa cuore," a broken heart.

Captain Calamai's obituary of The New York Times in April of 1972, quoted maritime scientist, John Carrothers:

"The most tragic figure to come out of this disaster was Captain Piero Calamai, master of the Andrea Doria. A victim of circumstances, he was alone, brokenhearted, unable to defend himself... of all the principals involved, companies and individuals, Captain Calamai was the least responsible."

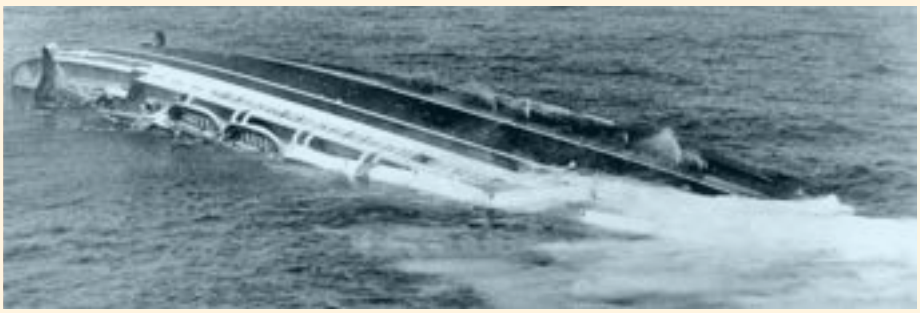
Through the years, books and documentaries unjustly assigned blame on the Italian captain and crew. Since the tragedy occurred not long after WWII, there was the stigma of Mussolini, droves of immigrants, and even our Catholicism; moreover, they were described as cowardly, emotional, illogical, and dishonest. It was easy, then, to find a scapegoat in Captain Calamai. He was guilty by the fact that he was Italian.

In my quest to ascertain the truth, I dedicated the last 19 years to learning how to write and publish, and later how to make a documentary. My works are intended to set the historical record straight and restore the honour due to Captain Piero Calamai, his crew, and the Ansaldo shipbuilders - all possessing Italian maritime brilliance that elicits names like Amerigo Vespucci, Marco Polo, and Christopher Columbus. Less famous in name, but not forgotten, is the tenacity of Admiral Andrea Doria, who in the 1500s crossed oceans on warships in the name of Genoa, to protect what was then an Italian republic. Ironically, the namesake of the Andrea Doria lived to be 94 years old while the Doria lived only three.
We acknowledge these courageous Italian seamen for centuries of navigation and for our privilege to enjoy sea travel.

About the author
Ms. Simpson lives near Detroit, MI. with her life companion Richard Haskin. She stays in touch with her family and friends in Italy, visiting whenever possible. After teaching foreign languages, she authored the non-fiction and fiction books, Alive on the Andrea Doria: The Greatest Sea Rescue in History, I Was Shipwrecked on the Andrea Doria, and produced the docufilm "Andrea Doria: Are the Passengers Saved?"

The Rescue of the Last Passenger from the Sinking Andrea Doria

By Don Persson



The final moments of the great liner

I was a crew messman onboard the T2 tanker Robert E. Hopkins of the Tidewater Associated Oil Co. of Delaware City, Delaware. I had just gone to bed around 9:30pm. I had to get up at 6:15am at the latest to set my tables and make the coffee for breakfast, so going to bed early was a routine.

On this particular night of 25th July 1956, I was really tired as we had just departed Fall River, Massachusetts after delivering about 125,000 barrels of gasoline. I had walked around Fall River for a couple of hours after dinner because it was quite warm with a nice breeze, but this walk really tired me out, so I was glad to get to bed.

Around 11:30pm I heard a lot of loud footsteps outside my cabin. I jumped up to see why so many men were running up the stairs across from my room. Were we sinking? Did I miss the alarm? I ran up to the mess hall in my underwear 12 steps above and saw the entire deck gang dressed in work clothes listening to Chief Officer, Eugene Swift. I heard them talking about launching our forward port side lifeboat #2 in 30 minutes.

I dashed below, put on my clothes, grabbed my wallet and gloves, and then woke up my drunk roommate. I then ran forward along the Main Deck passageway, out onto the Well Deck, up the steps to our fore and aft walkway, and forward to the forward deckhouse. Our 2nd Mate was just taking the cover off #2 lifeboat, a 36 passenger self-propelled boat. I told the 2nd Mate that I heard the boat was going to a rescue and told him, "I have a lifeboatman endorsement on my Z card (US Coast Guard Seaman's Document) so I can join the boat crew", and I showed him my Z card. He told me it was up to the Chief Officer, Eugene Swift. In minutes the deck guys were running up the stairs to the boat. The Chief Officer looked at me as if to say, "What is a 17 year old messman doing here?". The 2nd Officer explained to him that I had a lifeboatman endorsement and asked if it was okay for me to go along (usually a lifeboatman endorsement trumps a crewmember without it). The Chief Officer said, "Fine", and the deck guys just nodded their heads, probably because they knew how difficult it was to row that boat!

The deck gang finished removing the cover and began to check the boat to see if the oars were under the seats. Just then our captain, Renė Blanc, a man about 65 years old, appeared and said we needed to standby until the orders came. We were still underway all along, but I felt we were slowing down. I could see bright lights in the distance looking like something on land, a common sight for coastal tankers. But within minutes I could see that one source of the bright lights was a ship all lit up like at night in port! The other lights were clear, but I just couldn't understand what they were as we had a slight fog or mist, fairly common in early mornings in the North Atlantic.

I ran back to my room to get my Nikon binoculars and hurried back, my drunk roommate was still sleeping. Now I could see, and boy was I totally shocked! My heart started pounding as I studied the ships. I immediately recognized the unique funnel of the Swedish America Line (yellow, blue circle, and 3 crowns within the circle) and the Italian Line stripes. Was the Italian ship the Andrea Doria or the Cristoforo Columbo? Was the Swedish ship the Stockholm or Gripsholm? Then I realized it had to be the smaller Stockholm. I had visited both of these ships many times at dock on sailing day in New York.

Then the shock of my life. Out of the dark (about 2:00am) just to starboard was a magnificent sight lit up as I've never before seen, the 44,356 ton Ile de France of the French line. This 793 foot ship looked twice as large with all of its lights ablaze, especially the probably 100 foot by ten foot high, lighted sign on the boat deck with the name "Ile de France" in light bulbs. What a sight! The ship was black and looked like a projection on the water, a movie! It passed us and stopped very close to the sinking Andrea Doria, maybe only 1,500 feet away. All of its lifeboats were near the water level. Just amazing to me.



The beautiful 29,083grt Andrea Doria in her prime



The starboard boats had been launched as the vessel started to list

I kept thinking, "When are we going". We were ship #4 to arrive at the disaster.

As I scanned the Andrea Doria I saw a very strange sight. All five of the starboard boats had been lowered except for #1 boat which was still in the davit. But because of the degree of the Andrea Doria's list, maybe 35 degrees, the passengers couldn't jump into the boats from the boat deck because the boats were too far away from the hull. All along the side of the Andrea Doria were hawsers, nets, fire hoses, and rope ladders. Believe it or not, passengers were climbing down these ladders, nets, etc. into the lifeboats while being helped by crew members. Nearly all of the steward's department had fled the sinking ship in the first trip over to the Stockholm. Stockholm crew didn't want them onboard, but Capt. Nordensen told the crew to bring them onboard. Shockingly, I could see a few crew piggybacking a passenger. I assumed these were elderly people.

The Ile de France lifeboats were alongside the Andrea Doria in just minutes. Then I saw the Stockholm lower 3 lifeboats into the water, 6 altogether, at about 0230.

All the Andrea Doria lifeboats rowed/motored over to the Stockholm but just then they turned around and headed to other ships including the banana ship Cape Ann, which took on over 100 survivors. The Ile de France boats returned to their ship with about 750 passengers all together.

I frankly felt that we were being left out of the rescue because we were an oil tanker in ballast, a very dangerous ship for non-professionals to be on.

By about 4:00am most lifeboat activity had stopped. Many Andrea Doria lifeboats were tied alongside the Stockholm. A few floated loose and I saw two half-full boats about 2,000 feet away from the Andrea Doria just idle.

Suddenly from the bridge one deck above came the word, "Launch lifeboat". We lowered away just after 4:00am. Chief Officer Swift was in the bow, six of us rowed and the 3rd officer was on the tiller, and I was on the starboard side, last seat. The water appeared to be calm from the deck but, boy, it was rough! We pitched and rolled all the way until we saw someone right at the stern on a rope ladder waving. We pulled under him. He seemed either afraid or stuck. We yelled to him to jump but he continued down the ladder until Chief Officer Swift could grab him by his feet and guided him into the boat.

It turned out that this man, the very last passenger to leave the Andrea Doria, was an American Merchant Seaman, Robert Lee Hudson, being repatriated from Naples after injuring himself onboard the American Victory ship SS Ocean Victory.

He was wearing pyjamas, as I remember, but his top was missing. The press said he was naked, but I don't think he was. I think I would have remembered that! He appeared to be a little drunk, but he said he had been given sleeping pills and was in bed in the infirmary sleeping when he woke up to the 40 degree list.

We then rowed away from the sinking ship maybe 100 feet to avoid all the ropes, nets, etc. hanging down from the railings and headed to the bow. The ship was deserted but was really well lit. Below the wing of the bridge we yelled out, "Hello up there", thinking officers might still be onboard. No one answered although there were actually about 12 men on the bridge including the ship's Catholic priest. Our Chief Officer said, "Okay, guys, that's it. Back to the boat", and we turned toward the Hopkins. The two Andrea Doria boats we had seen were nearly gone! It seemed longer returning, perhaps because my gloved hands were totally sore. My oarlock was broken, and it took a lot of work to keep my oar straight up in the water.



The 44,346grt Ile de France of Compagnie Generale Transatlantique arriving at the scene of the disaster



Another ship on the scene was the 6,797grt C1 design Cape Ann of the United Fruit Company. She was built in 1941 by Consolidated Steel Corporation at Wilmington for the US Government. In 1947 she moved to Munargo Line before joining United Fruit Co. in 1957. In 1963 she was sold to American Union Transport Inc. and renamed Transunion. She was broken up by Chi Ho Fa Steel & Iron Co. at Kaohsiung during November 1968.

Back at the Hopkins the accommodation ladder was down so all except the Chief Officer walked up the ladder. The boat was walked forward with a line and stopped beneath the davit and the Chief Officer hooked it up to the falls.

Our passenger was escorted to the bridge and Capt. Blanc guided him to a sofa in the chart room and offered him a drink. Apparently, that suited Mr. Hudson because he never left the chart room until we arrived in New York City later that day.

Most of the crew were standing by the railings watching the disaster unfold except for my drunk roommate who refused to believe me when I woke him up for work! The sun was barely coming up and we could see many ships in the area, cargo ships, two troop transports, several USCG vessels, and a banana boat, who rescued many passengers. The Stockholm hadn't moved. Later I read that her anchors were caught on something and welders had to cut the anchor chains. By now the Andrea Doria was on her side and you could actually see inside the funnel.

At about 5:30am we saw the Ile de France get underway and it slowly steamed around the dying Andrea Doria, lowering its flag three times while its horn blew a tremendous 3 long blast salute as it steamed off. What an amazing sight to behold!

Just minutes after the Ile de France steamed off we got underway for the 180 mile trip to New York City. It was just about time for me to start work and I was exhausted. We didn't even slow down as we reached Ambrose Lightship (the pilot station) as Capt. Blanc had pilotage for New York Harbour on his Master's license.

I paid off the Robert E. Hopkins in November 1956 for a week vacation, then went on to another Tidewater tanker, the "supertanker" SS Flying "A" Delaware (26,000 tons, Newport News Shipbuilding) for one 2 week trip, then back to the Hopkins.

I haven't talked about the Andrea Doria sinking to many for 65 years because it was such an emotional experience for me. Since I had been 12 years old my mother would take me on sailing days to either Hoboken (Holland-America Line), Jersey City (APL and American Export Lines " Aces"), or to New York City's "Luxury Liner Row" and to piers along the Hudson. I lived in Jersey City, so it was only 30 minutes by bus to Times Square, 20 minutes to Harbourside Terminals in Jersey City, or 25 minutes on the trolley to Hoboken. We donated 50 cents and went onboard countless ships! I loved these ships and dreamed that someday I could sail on one. I had my favorite ships but the Andrea Doria and her sister Cristoforo Columbo were favorites because of their beautiful interiors. I loved the old Grace and Moore-McCormick liners but the Italians sure knew luxury! So, to see the Andrea Doria sinking was a huge shock to me, almost like a personal loss.

My first year on the Robert E. Hopkins was wild, sailing up the Hudson River in solid ice to deliver gas to Albany, causing us to damage our propeller



The Andrea Doria is started to list alarmingly

and hull plates, then the Andrea Doria rescue. Then, on the Flying "A" Delaware my Chief Steward dropped dead, apparently of a heart attack, in the galley while I was preparing salads in the pantry! I never experienced any other unusual events as crew, but as a passenger on the States Lines SS Oregon on 8th July 1970 when we were ready to dock in Saigon we were fired on. All passengers had been ordered to stay in their cabins for the Song Sai Don river transit. No one was hurt as the bridge was sand bagged! I had been in Saigon in January 1967 as Purser on board the USNS Croatan (the ship had anchored out) and I travelled around Saigon and Da Nang without incident.

Now I'm old with poor health, so I can't travel again. All I have are memories.

NOTES
I should mention at this point about the time these events occurred. Three time zones were in play here that caused some confusion amongst the press. We were on Eastern Daylight Savings Time. The Andrea Doria, I believe, was on Atlantic Daylight Savings Time. I've read about events occurring plus or minus from our time. There were messages in GMT (Greenwich Mean Time). This was about 5 hours later than Eastern Daylight Savings Time.

Some official reports say the collision occurred at 11:15pm but our radio officer Toney Grillo received his first message at 10:20pm from the Andrea Doria and the Stockholm radio officer stated the collision was at 11:01pm. The Andrea Doria Radio officer sent a message saying, "Collision at 03:20 GMT". An Andrea Doria officer's note that the collision was at "23:09". The Ile de France said its first SOS from the Andria Doria was at 11:30pm and the USCG cutter Evergreen signalled "The Andrea Doria sank at 261409 Zulu".

In a Swedish government report it noted that 3rd Officer Johan Ernst Carstens-Johannsen (the mate on watch on the Stockholm) said, "While the rescue was underway the cabins of all the officers were ransacked including the Captain's cabin". No one ever found out who did the crime. Was it Andrea Doria or Stockholm people?



TA view of the serious list from the port side

Who caused the disaster? Each company blamed the other. But a U.S. House of Representatives Committee Report, the Bonner Committee, investigated and presented a report primarily based on a report done by the Ansaldo Shipyard, in December 1956. It said, "The Andrea Doria just barely met the specifications of the SOLAS convention (Safety of Life at Sea)". It also said, "The ship could only meet the SOLAS requirement on condition that she was ballasted with rather large and specific amounts of liquid in its various tanks". Why she sank is not known except that on that occasion she was not properly ballasted in accordance with SOLAS and that there were errors in the ship design and construction. It was the committee judgement that at the time of the collision the Andrea Doria was only one third as stable as she should have been.

The legal settlement on 14th January 1957, in an informal meeting between all parties, agreed that each company would share its own damage expenses but then there was a problem about who would compensate the passengers and crew for baggage and cargo losses.

It was finally agreed that Swedish America Lines was responsible for 13% of the accident's miscellaneous expenses and that Italian Line was responsible for 87%. Insurance paid these losses. All other losses were paid for by each company. However, the underwriters agreed to pay Swedish America Lines $200,000 for "uninsured losses". The insurance paid out $16 million for the loss of the Andrea Doria, although Italian Line said it was worth between $25 million and $35 million.

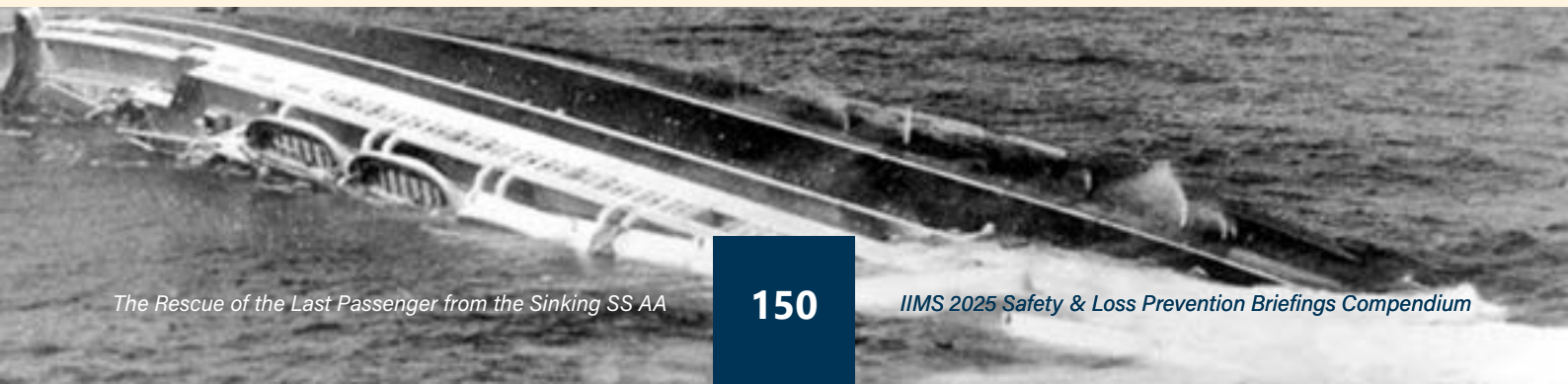
An Italian Newspaper, Italian Line Borghese stated, "The ship cost 16 billion Lira to build but was only insured for 10 billion Lira for loss".

But the battle over blame raged on. The above settlement was signed on 24th January 1957 but did not assess blame. "As of today, no official report of the cause of the accident exists" (Italian Line Borghese, 17th February 1957).

One last interesting note, an Italian Special Board of Inquiry report of July 1957, stated that, "The Ansaldo Co. in Genoa who built the Andrea Doria allegedly declared itself unwilling to accept any liability into the shortcomings of the ship and threatened, in order to protect its international reputation, to raise a BIG scandal and publish the entire dossier in its possession along with drawings for the vessel drawn and checked by the inexperienced and corrupt technicians at the Italian yard, in the Shipping Registry of the Merchant Marine Ministry".

The Italian Board's final conclusion of the collision was, "By reason of excessive speed during foggy weather".

One last strange fact, when the Italian Line drew up plans for a replacement ship for the Andrea Doria, which would become the Leonardo di Vinci, it contracted with a Swedish design firm in Stockholm to check over all the drawings!




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