Isle of Man Ship Registry

Summary of Casualties, Accidents and Incidents on Isle of Man Registered Vessels

2015

Isle of Man Government
Department of Economic Development

Isle of Man Government
Reiltys Ellan Vannin

INVESTORS IN PEOPLE | Gold

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Introduction

The Isle of Man Ship Registry (IOMSR) is committed to helping seafarers, managers, owners and operators concerned with all Manx vessels in achieving continued high standards of safety and pollution prevention. Occasionally things go wrong, when they do the master, skipper or technical manager is required by law to submit a report on what has occurred.

For ships to which the Maritime Labour Convention applies Standard A4.3.5 of the Maritime Labour Convention 2006 (MLC) requires that:

(a) Occupational accidents, injuries and diseases are adequately reported, taking into account the guidance provided by the International Labour Organization with respect to the reporting and recording of occupational accidents and diseases;

(b) Comprehensive statistics of such accidents and diseases are kept, analysed and published, and where appropriate, followed up by research into general trends and into the hazards identified; and

(c) Occupational accidents are investigated.

The reporting scheme is reliant upon masters, skippers or operators reporting as accurately and in as timely a manner as possible. From these reports we can alert the shipping industry about areas and activities where any additional safety controls may be necessary and hopefully prevent similar occurrences from happening again.

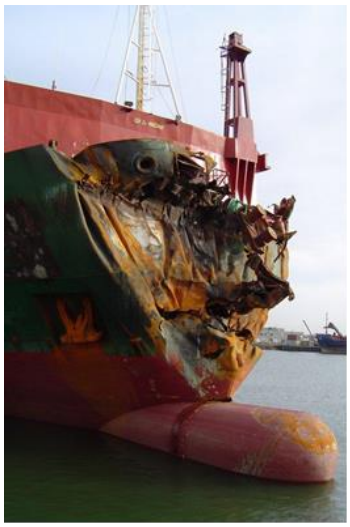
This report aims to provide statistics based on accident report findings. Where any trends are identified the Isle of Man Ship Registry aims to work closely with shipping companies and other organisations in an effort to reduce these occurrences on board Isle of Man vessels.

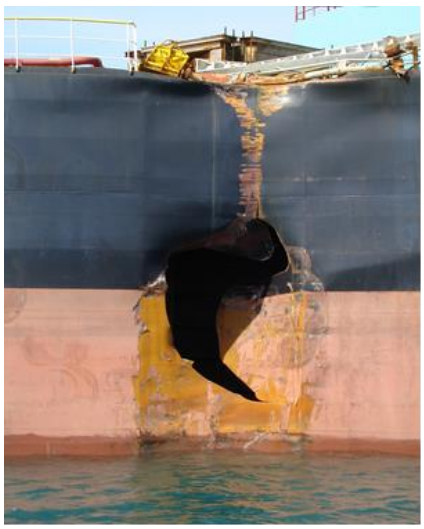
This report does not include statistics relating to deaths from natural causes.

To submit a report or if you have any questions please contact:

Isle of Man Ship Registry, Department of Economic Development,
St George's Court, Upper Church Street, Douglas, IM1 1EX, Isle of Man, British Isles

Tel +44 1624 688500 Fax +44 1624 688501 Email: marine.survey@gov.im





Contents

Chapter 1 – What is an occurrence?

An 'occurrence' is classed as either a **casualty**, **accident** or an **incident** in the Merchant Shipping Accident Reporting and Investigation Regulations (SD815/01). These are defined as follows:-

Casualty

This means "any contingency which results in:-

(a) loss of life or major injury to any person on board, or the loss of any person from, a ship or a ship's boat;
(b) the loss or presumed loss of any ship or the abandonment of any ship or a ship suffers material damage;
(c) a ship goes aground, is disabled or is in collision;
(d) any loss of life or major injury, or serious harm to the environment, is caused by a ship;
(e) any major damage to the environment brought about by damage to a ship and caused by, or in connection with, the operation of the ship."

Accident

This means "any occurrence of the following type provided that it caused material damage to any ship or structure, or damage to the health of any person, or serious injury:-

(a) the fall of any person overboard;
(b) any fire or explosion resulting in material damage to a ship;
(c) the collapse or bursting of any pressure vessel, pipeline or valve or the accidental ignition of anything in a pipeline;
(d) the collapse or failure of any lifting equipment, access equipment, hatch cover, staging or bosun's chair or any associated load-bearing parts;
(e) the uncontrolled release or escape of any harmful substance or agent;
(f) any collapse of cargo, unintended movement of cargo sufficient to cause a list, or loss of cargo overboard;
(g) any snagging of fishing gear which results in the vessel heeling to a dangerous angle; or
(h) any contact by a person with loose asbestos fibre except when full protective clothing is worn."

Incident

This means "any occurrence, not being a casualty or an accident as a consequence of which the safety of a ship or any person is imperilled, or as a result of which material damage to any ship or structure or damage to the environment might be caused."

Incidents can also be referred to as 'near misses' or 'near accidents'. Vessel inspections by the IOMSR have shown that the type of incidents reported to technical managers range from 'minor incidents', e.g. a person forgetting to wear a safety helmet on deck, to 'major incidents', e.g. narrowly avoiding a swung load suspended from a lifting appliance. The IOMSR encourages the master, skipper or technical managers to use their judgement in determining a 'minor incident' and a 'major incident'. All 'major incidents' should be reported to the IOMSR using the ARF Form. If there is any doubt then report to IOMSR.

IMO Classification

The International Maritime Organisation (IMO) Casualty Investigation Code (IMO Resolution MSC 255(84)) defines occurrences as a Marine Incident, Marine Casualty or Very Serious Marine Casualty. Refer to chapter 6 of this report for information concerning cases reported to IOMSR classified as per the IMO Casualty Investigation Code.

Chapter2 – Reporting occurrences

2.1 Who has to Report

The master, skipper or technical manager of any Manx registered vessel wherever they may be.
The master, skipper or technical manager of any foreign flagged vessel in Manx territorial waters.

A vessel means any description of watercraft ranging from pleasure vessels, fishing boats, commercial yachts, passenger ships and cargo vessels.

Occurrences on board ships in ports, with the exception of those involving stevedores or shore-based workers, are included and must be reported. Occurrences involving shore-based workers should also be reported to the country's Health and Safety Department or equivalent body.

2.2 When to report

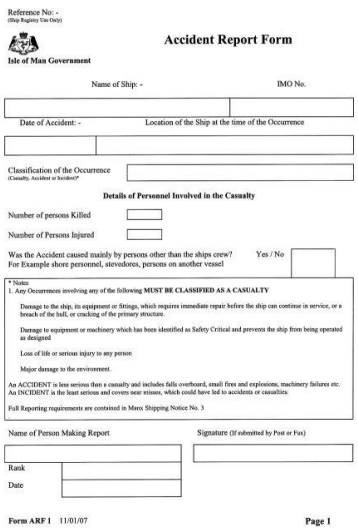
When a **CASUALTY** occurs the master, skipper or technical manager must inform the IOMSR as soon as possible after becoming aware of the casualty and the Master or Skipper must send a report to the IOMSR as soon as is practicable by the quickest means available.

When any **ACCIDENT** occurs the master, skipper or technical manager must inform the IOMSR as soon as is practicable and by the quickest means available. A report must be sent to the IOMSR no later than within 24 hours of the vessel's next arrival in port.

When an **INCIDENT** occurs the master, skipper or technical manager must report the incident to the IOMSR before the vessel departs from the next port.

2.3 How to report

Initial reports can be made directly by telephone, fax or email to the IOMSR. When the occurrence has been investigated on board the master, skipper or operator should complete the Accident Report Form (ARF – see right) and forward it to the IOMSR by fax, email or mail. Any additional report forms used on board to document the occurrence may also be submitted to the IOMSR along with the completed ARF. It is recommended that a copy of the ARF is kept on board as a record.



Reference No: -
(Ship Registry Use Only)

Accident Report Form

Isle of Man Government

Name of Ship: - IMO No.

Date of Accident: - Location of the Ship at the time of the Occurrence

Classification of the Occurrence
(Casualty, Accident or Incident)*

Details of Personnel Involved in the Casualty

Number of persons Killed

Number of Persons Injured

Was the Accident caused mainly by persons other than the ships crew? Yes / No
For Example shore personnel, stevedores, persons on another vessel

* Notes
1. Any Occurrences involving any of the following **MUST BE CLASSIFIED AS A CASUALTY**

Damage to the ship, its equipment or fittings, which requires immediate repair before the ship can continue in service, or a breach of the hull, or cracking of the primary structure.

Damage to equipment or machinery which has been identified as Safety Critical and prevents the ship from being operated as designed

Loss of life or serious injury to any person

Major damage to the environment.

An ACCIDENT is less serious than a casualty and includes falls overboard, small fires and explosions, machinery failures etc. An INCIDENT is the least serious and covers near misses, which could have led to accidents or casualties.

Full Reporting requirements are contained in Manx Shipping Notice No. 3

Name of Person Making Report Signature (If submitted by Post or Fax)

Rank

Date

Form ARF 1 11/01/07 Page 1

The ARF is available on request from the IOMSR or available for download from the IOMSR website.
http://www.iomshipregistry.com/formsdocs/forms/

A brief statement is also required in the Official Log Book Narrative Section.

All reports received that are "Very Serious Marine Casualties" as defined by the IMO Casualty Code (refer to Chapter 6) are investigated. For all other reports received a decision is made whether or not an investigation is warranted. Not all occurrences are investigated by IOMSR, this may be because:-

- it has been agreed that investigation is being conducted by another investigation authority; or
- the shipboard staff and/or technical managers have completed a thorough investigation and the underlying cause is clear.

Investigations are carried out in accordance with SOLAS ChI Reg 21 and the IMO Casualty Investigation Code. It is not the intention of these reports to apportion blame or economic liability.

The initial part of an investigation seeks to establish the causes and circumstances of what has happened, with a view to deciding whether or not any further investigation is warranted. Whenever an occurrence is investigated a report is made. A provision is made for any person likely to be affected by a report to see the draft and comment on the facts and analysis therein before it is finalised. Sometimes due to the circumstances surrounding the investigation it is not always possible to publish the reports.

Published reports are primarily for the benefit of all seafarers, managers and owners concerned with Manx vessels in the hope that lessons learnt may prevent similar occurrences from happening again. The names, addresses and any other details of anyone who has given evidence to an investigator are not disclosed unless a court determines otherwise. Any reports published are available on the IOMSR website.

2.4 ISM Code Vessels

Where vessels comply with the International Safety Management (ISM) Code the Safety Management Manual should include procedures for ensuring accidents and hazardous situations are reported (ISM9.1). The IOMSR will accept the vessel's reporting form in lieu of the ARF provided it contains at least all of the information required by the ARF.

If vessels have a safety officer on board as required by the Merchant Shipping Safety Officials, General Duties & Protective Equipment Regulations (SD816/01) then the safety officer should be involved in the investigation on board.

2.5 Investigations by IOMSR in 2015

Type of Ship	Nature of Casualty
Other cargo ship	Fire in cargo hold. Investigation ongoing.
Other cargo ship	Enclosed space deaths and near-asphyxiation. Sally Ann C – Report published in 2015.

2.6 Reports Published in 2015

Ship	Nature of Casualty
Sally Ann C	Death of the Chief Officer, Chief Engineer and serious injuries to the 2nd Officer when entering a cargo hold with a dangerous atmosphere.
Nordic Visby	Death of the Fourth Engineer in the engine room workshop.

Casualty investigation reports are published on the Isle of Man Ship Registry Website.
http://www.iomshipregistry.com/formsdocs/reports/casualty

2.7 Investigations by external investigation body on Isle of Man vessels in 2015

None.

Chapter 3 – ARF Reports Received in 2015

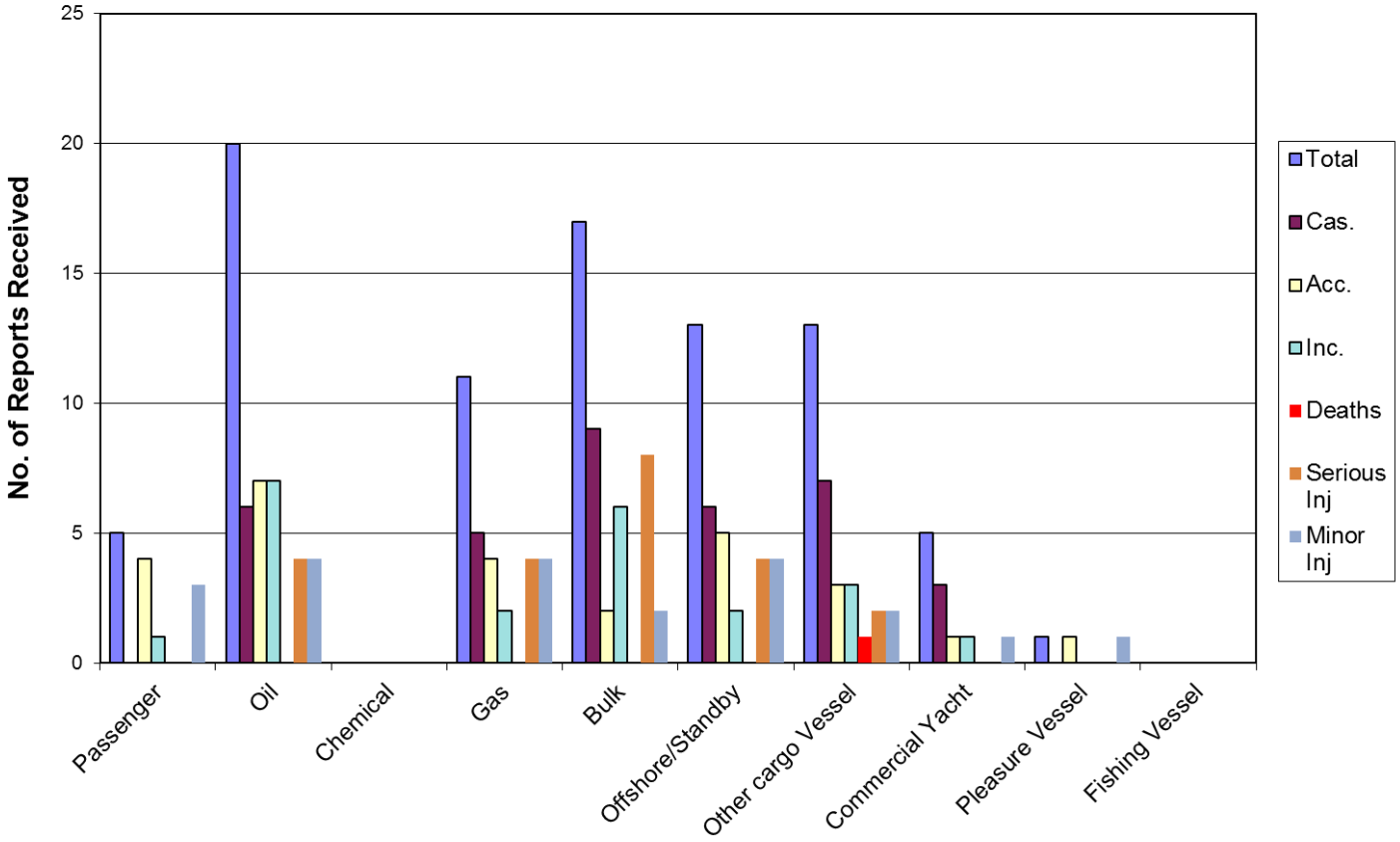
3.1 Reports from Isle of Man Registered Ships

In 2015 IOMSR received a total of 85 ARF reports from Isle of Man registered ships. The table below shows the number of reported occurrences by type in 2015 and the preceding 4 years including a breakdown per ship type for 2015.

Year	2011	2012	2013	2014	2015	2015										
Casualties	16	21	19	23	36											
Accidents	39	61	39	32	27											
Incidents	16	27	26	21	22											
Description of Occurrence by Type per Year	**71**	**109**	**84**	**76**	**85**	**Passenger**	**Oil Tanker**	**Chemical Tanker**	**Gas Carrier**	**Bulk Carrier**	**Offshore / Standby**	**Other cargo Vessel**	**Commercial Yacht**	**Pleasure Vessel**	**Fishing Vessel**	**0**
Collision/Allision - significant damage, foundering, stranding	6	4	4	6	9		2			1	1	3	2			5
Collision/Allision, touch sea bottom - no/minor damage	12	15	13	19	8		1		2	1	1	3				20
Fire	7	6	6	7	11	1	4		2		2	2				0
Explosion	1	1	1													11
Pressure vessel: explosion, collapse or bursting																17
Pipe systems: explosion collapse or bursting	1	2	1	1	1		1									13
Sudden uncontrolled release of any substance from a system or pressure vessel	1	7	3	7	6		2			2		1	1			13
Accidental ignition of flammable material					1		1									5
Electrical short circuit or overload			1	2	1								1			1
Failure of any lifting device	3	1	4	1	1					1						0
Failure of any access equipment		2		1												11
Involving access to or from the ship	2	2														17
Slips or falls (same level)	5	12	5	7	9	2	1		1		3	1		1		13
Slips or falls (different levels)	6	11	3	5	5		1		1	2	1					13
Involving mooring ropes or hawses	2	5	8	6	1		1									5
Involving lifting equipment	1	5	1	1	4		1			1	1	1				1
Exposure to hazardous or toxic substances	2	1	1													0
Man overboard	2		1		1					1						20
Electric shock	1			1	1						1					5
Violence to the person	1	2	1													0
Other	1			1												11
Moving about - no fall, no handling	7	8	3		2					1		1				17
Moving about - manual handling		1	4		2				1			1				13
Involving rescue boat/lifeboat/liferaft	1	2	3	2	2	1	1									13
Drill - other than survival craft																5
Cargo securing failure			2	1					4	3	2		1			1
Maintenance - machinery	2	2	5	1	10		1			3	1					0
Maintenance - other		5	1	3	4		2				1					11
Cargo hold cleaning					1					1						17
Navigation - COLREG infringement			1	1												13
Navigation - machinery/equipment failure	4	9	5	1	4	1				3						13
Navigation - other					1		1									5
Illness		4	2													1
Bunker operations		1	2													0
Cargo operations	3		1													0
Galley operations			2	1												0
Mooring/anchoring operations	1															0
Unauthorised boarding																0
Leisure activity on board		1		1												0
Total	71	109	84	76	85	5	20	0	11	17	13	13	5	1	0	

In this report a "*serious injury*" means an injury which is sustained by a person, resulting in incapacitation where the person is unable to function normally for more than 72 hours, commencing within seven days from the date when the injury was suffered. A "*minor injury*" means any lesser injury which is not a serious injury.

The graph below represents reports reported to IOMSR in 2015 - 36 casualty cases, 27 accident cases, 22 incident cases and includes 1 death case, 22 serious injury cases and 21 minor injury cases on different types of vessels.



Nb. More than one injury may have occurred in the same case. See Chapter 5 for information concerning seafarer injuries.

3.2 Reports From Foreign Flagged Ships in Isle of Man Territorial Waters

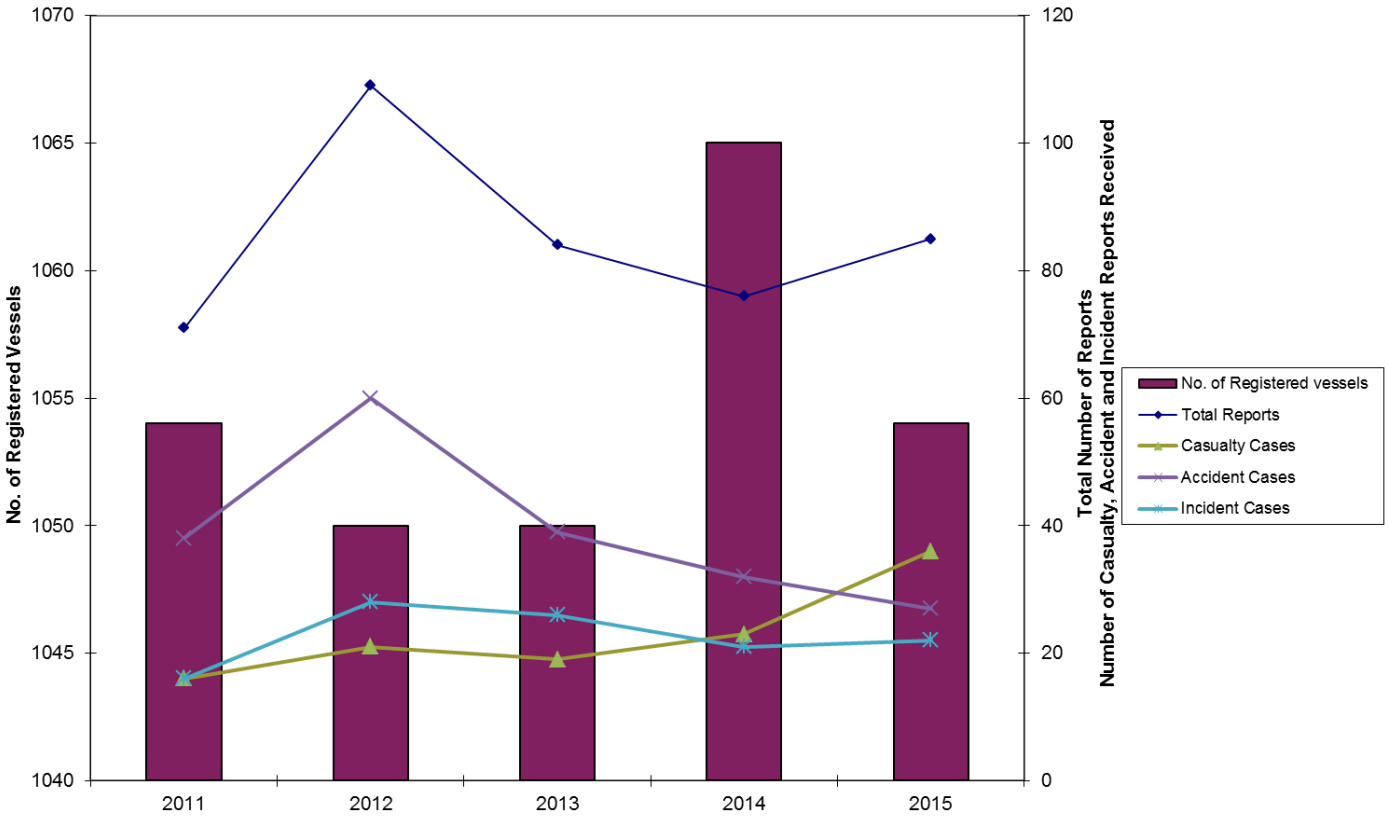
- none

3.3 ARF Fleet Comparison – Total Fleet

The table below shows occurrences as a percentage of the total Isle of Man registered fleet over 5 years. Isle of Man registered vessels include merchant ships, small ships, commercial yachts, pleasure vessels, fishing vessels, and demise ships.

Year	2011	2012	2013	2014	2015
Total Casualties / Fleet Size	1.5%	2.0%	1.9%	2.2%	3.4%
Casualties – death / Fleet Size	-	-	0.2%	0.1%	0.1%
Casualties – injury / Fleet Size	-	-	0.9%	0.9%	2.1%
Casualties – no injury / Fleet Size	-	-	0.8%	1.1%	1.2%
Total Accidents / Fleet Size	3.6%	5.7%	3.7%	3.0%	2.6%
Accidents – injury / Fleet Size	-	-	2.4%	1.5%	2.0%
Accidents – no injury / Fleet Size	-	-	1.3%	1.5%	0.6%
Incidents / Fleet Size	1.5%	2.7%	2.5%	2.0%	2.1%
Total Occurrences / Fleet Size	**6.6%**	**10.4%**	**8.0%**	**7.1%**	**8.1%**

The graph below shows a comparison between the number of reports received and the number of all Isle of Man registered vessels over the last 5 years. The total number of vessels on the Register each year is calculated as an average from the total number of vessels each month.

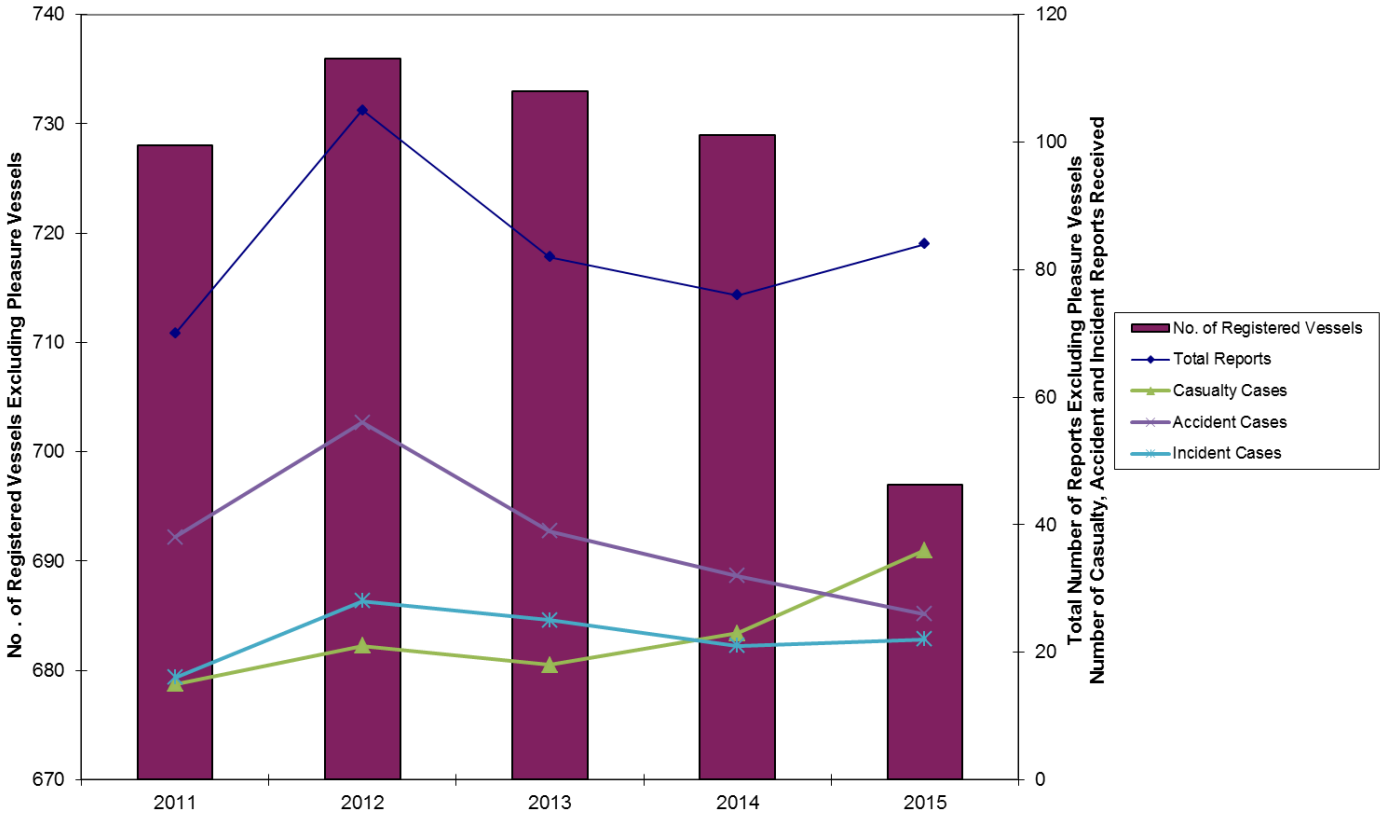


3.4 ARF Fleet Comparison – Total Fleet (Excluding Pleasure Vessels)

The table below shows occurrences with total Isle of Man registered fleet (excluding pleasure vessels) over 5 years.

Year	2011	2012	2013	2014	2015
Total Casualties / Fleet Size	2.1%	2.9%	2.5%	3.2%	5.2%
Casualties – death / Fleet Size	-	-	0.3%	0.1%	0.1%
Casualties – injury / Fleet Size	-	-	1.2%	1.4%	3.2%
Casualties – no injury / Fleet Size	-	-	1.0%	1.6%	1.9%
Total Accidents / Fleet Size	5.2%	7.6%	5.3%	4.4%	3.7%
Accidents – injury / Fleet Size	-	-	3.4%	2.2%	2.9%
Accidents – no injury / Fleet Size	-	-	1.9%	2.2%	0.8%
Incidents / Fleet Size	2.2%	3.8%	3.4%	2.9%	3.2%
Total Occurrences / Fleet Size	**9.5%**	**14.3%**	**11.2%**	**10.4%**	**12.1%**

The graph below compares the number of ARF Reports received with the number of registered vessels (excluding pleasure vessels) over a period of 5 years.



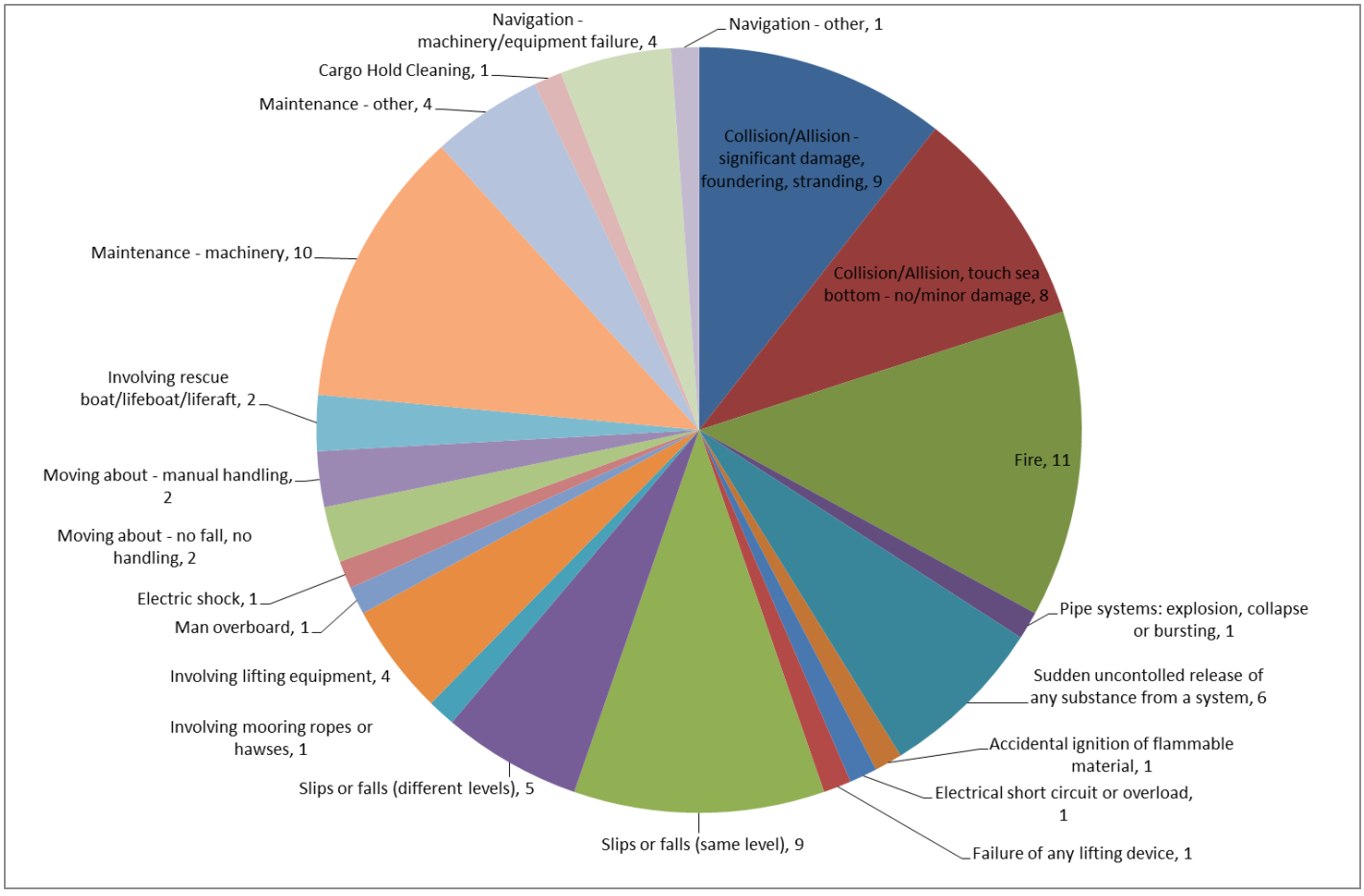
Chapter 4 – Analysis of ARF Reports Received in 2015

The table below summarises the condition the vessels were in at the time of the occurrence.

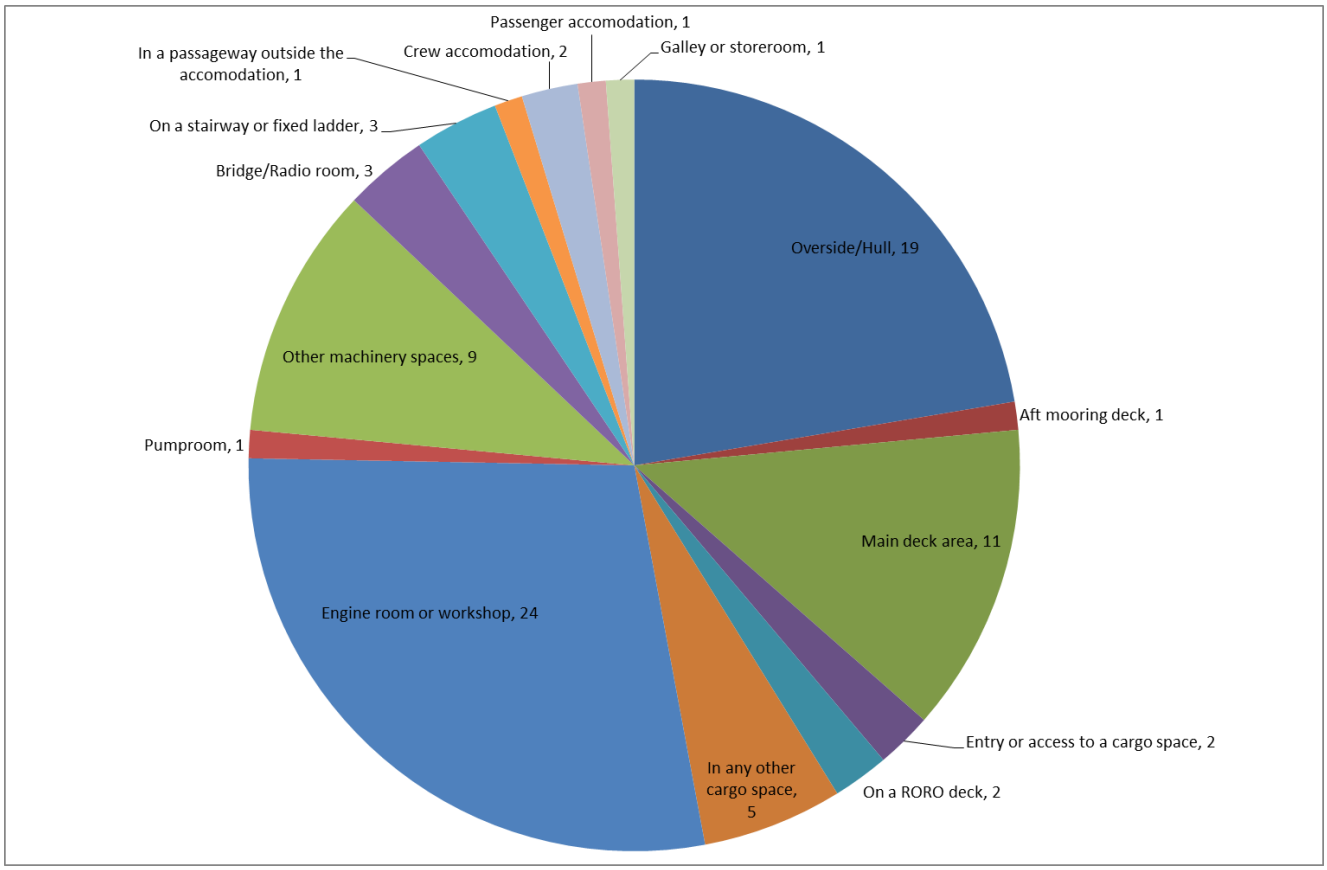
	Total Occurrences			Occurrences involving		
	Inc	Acc	Cas	Death	Serious Injury	Minor Injury
Berthed/Docked	4	12	7	0	5	10
At Anchor/Anchoring/Weighing Anchor	2	4	3	0	3	4
Mooring/Unmooring	5	1	3	0	0	0
Making Way in Port/Confined Waters	6	1	8	0	1	1
Making Way Open Sea	4	9	11	1	9	6
Stopped - Drifting/DP	1	0	4	0	4	0
Total	**22**	**27**	**36**	**1**	**22**	**21**

In some cases more than one person may have been injured in the same case. Where a case involves deaths and injuries, this is counted once under a death case.

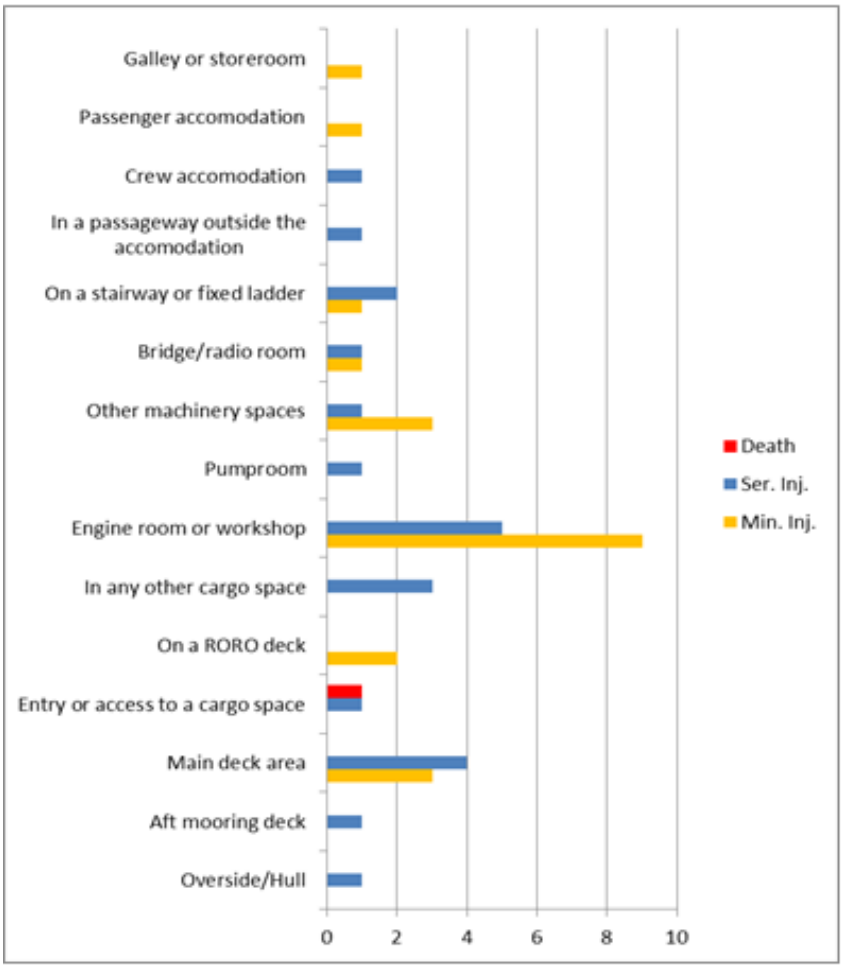
4.1 Type of Occurrences



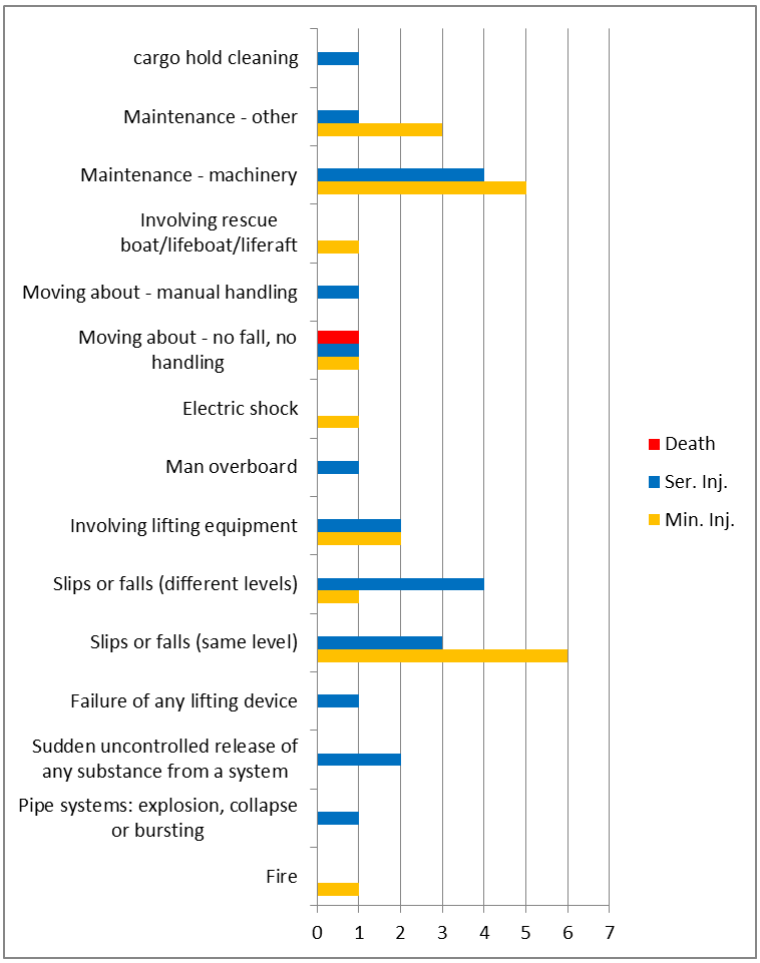
4.2 Place of Occurrences



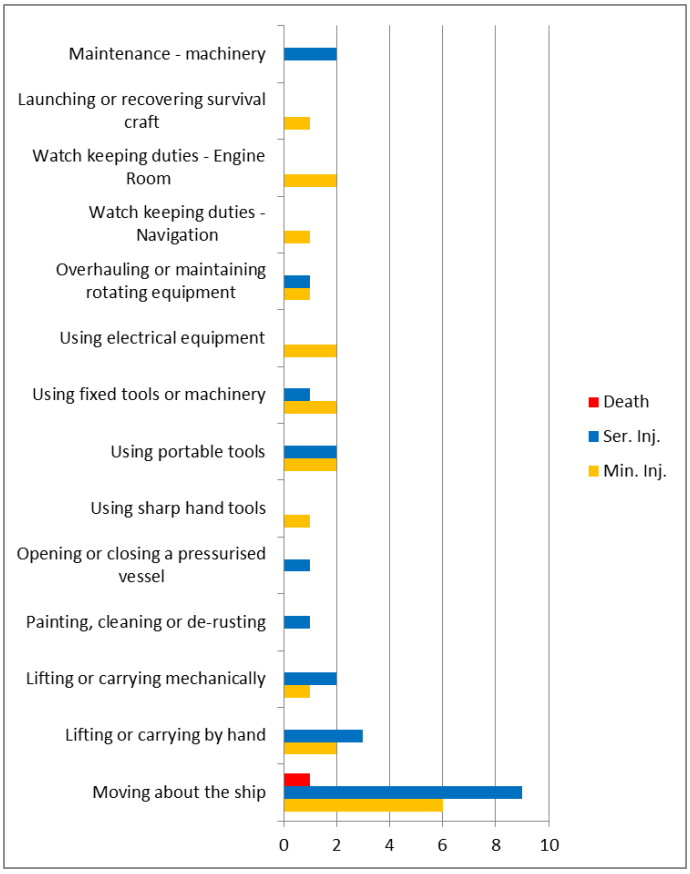
4.3 Places Where Injury or Death Cases Occurred



4.4 Type of Occurrence Leading to an Injury or Death Case



4.5 Type of Activity Leading to an Injury or Death Case



Chapter 5 – Reported Seafarer Injuries

5.1 Seafarer Injury Summary

	All Ships		MLC Ships		Non-MLC Ships	
No. of Seafarers	**Number**	**Rate**	**Number**	**Rate**	**Number**	**Rate**
Fleet estimate	13359		10173		3186	
Deaths	2	15	2	20	0	0
Serious injuries	22	172	22	216	0	0
Minor injuries	20	150	19	187	1	31

Rate per 100,000

Note:

1. The number of seafarers is estimated based on a seafarer average per ship type per ship size. Number of seafarers is based only on seafarers employed on board ships only and does not include seafarers at home on leave.
2. MLC Ship means any ship to which the Maritime Labour Convention 2006 applies.
3. Does not include passengers, yacht guests, visitors or contractors to the ship.

5.2 Number of Injuries and Deaths Reported by Rank

Rank	Total	Minor Injury	Serious Injury	Death
Master	**0**	0	0	0
Ch. Off	**7**	2	4	1
OOW Nav	**1**	0	1	0
Ch. Eng	**3**	1	1	1
2nd Eng	**5**	4	1	0
OOW Eng	**7**	5	2	0
Electrician	**2**	0	2	0
Deck/Dual Rating	**15**	6	9	0
Eng Rating	**3**	1	2	0
Deck/Eng Cadet	**0**	0	0	0
Cook/Steward/Purser	**1**	1	0	0
*Passenger/Yacht Guest	**2**	2	0	0
*Visitor/Contractor	**1**	0	1	0
Total	**47**	**22**	**23**	**2**

Nb The above table represents individual people. In some cases more than one injury may have occurred in the same case.

*Not included in Seafarer Injury Summary in Chapter 5.1.

Cases involving illness, suicide, missing or death due to natural causes are not included.

5.2.1 Place of Serious Injury or Death by Rank (number of people)

	Over side / Hull	Aft Mooring Deck	Main Deck Area	Entry or access to a cargo space	In any other Cargo Space	Engine Room or Workshop	Pump room	Other machinery spaces	Bridge / Radio Room	On a Stairway or Fixed Ladder	In a passageway outside the accommodation	Crew Accommodation	**Total***
Master													**0**
Ch. Off	1		1	2					1				**5**
OOW Nav				1									**1**
Ch. Eng				1		1							**2**
2nd Eng												1	**1**
OOW Eng						2							**2**
Electrician								1		1			**2**
Deck/Dual Rating		1	2		2	1	1			1	1		**9**
Eng Rating			1			1							**2**
Deck/Eng Cadet													**0**
Cook /Steward/Purser													**0**
Passenger / Yacht Guest													**0**
Visitor/Contractor					1								**1**
***Total**	**1**	**1**	**4**	**4**	**3**	**5**	**1**	**1**	**1**	**2**	**1**	**1**	**25**

5.2.2 Place of Minor Injury by Rank (number of people)

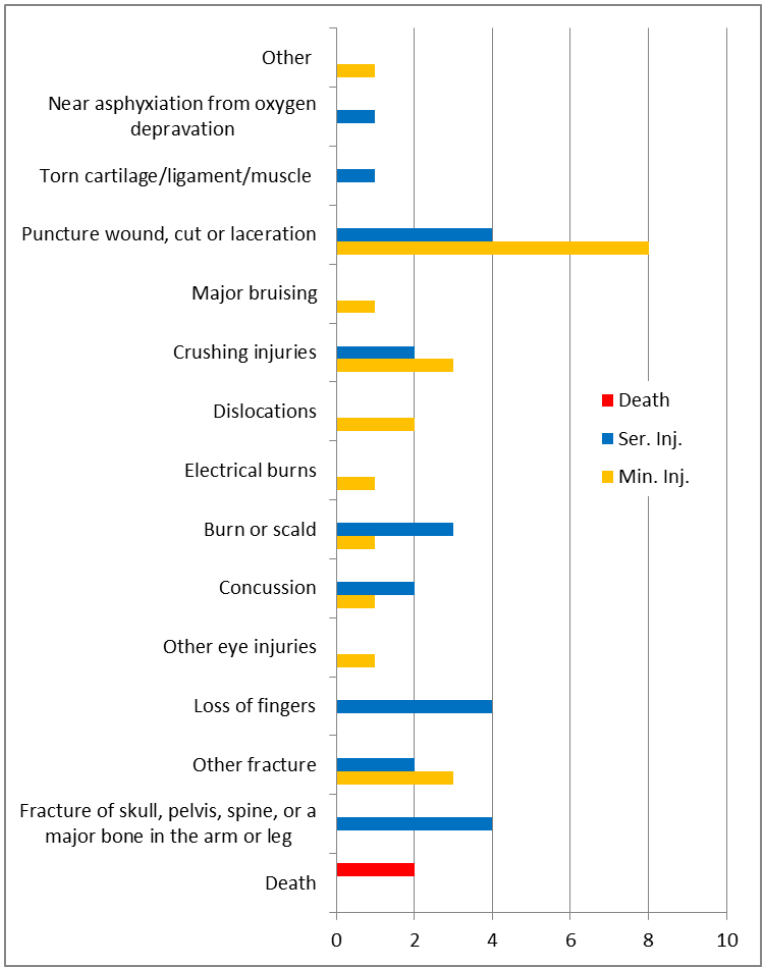
	Main Deck Area	On a RO RO deck	Engine Room or Workshop	Other machinery spaces	Bridge / Radio Room	On a Stairway or Fixed Ladder	Passenger Accommodation	Galley or Storeroom	**Total***
Master									**0**
Ch. Off			2						**2**
OOW Nav									**0**
Ch. Eng			1						**1**
2nd Eng			2	2					**4**
OOW Eng			3	1		1			**5**
Electrician									**0**
Deck/Dual Rating	3	1		1	1				**6**
Eng Rating			1						**1**
Deck/Eng Cadet									**0**
Cook /Steward/Purser								1	**1**
Passenger / Yacht Guest		1					1		**2**
Visitor/Contractor									**0**
Total	**3**	**2**	**9**	**4**	**1**	**1**	**1**	**1**	**22**

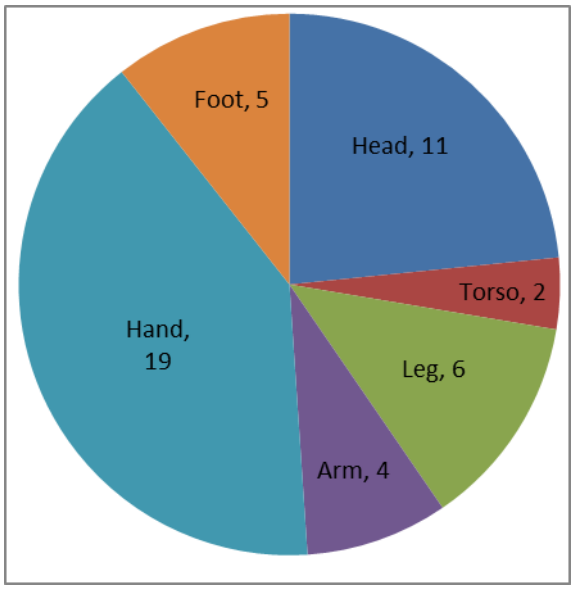
*In some cases more than person may have been injured in the same case.

5.3 Number of Injuries and Deaths reported by Age Range – all persons on board

Age Range	Total	Minor Injury	Serious Injury	Death
16-19	**1**	1		
20-29	**6**	3	3	
30-39	**15**	8	7	
40-49	**10**	3	6	1
50-59	**8**	5	3	
60+	**7**	2	4	1
Total	**47**	**22**	**23**	**2**

5.4 Reported Injuries and Areas of the Body Injured





Chapter 6 - IMO Casualty Investigation Code

Reports received by IOMSR in 2015 have been classified in this chapter according to the International Maritime Organisation (IMO) Casualty Investigation Code.

6.1 IMO Casualty Investigation Code Definitions

A **marine incident** means an event, or sequence of events, other than a marine casualty, which has occurred directly in connection with the operations of a ship that endangered, or, if not corrected, would endanger the safety of the ship, its occupants or any other person or the environment. However, a marine incident does not include a deliberate act or omission, with the intention to cause harm to the safety of a ship, an individual or the environment.

A **marine casualty** means an event, or a sequence of events, that has resulted in any of the following which has occurred directly in connection with the operations of a ship:

.1 the death of, or *serious injury* to, a person;
.2 the loss of a person from a ship;
.3 the loss, presumed loss or abandonment of a ship;
.4 *material damage* to a ship;
.5 the stranding or disabling of a ship, or the involvement of a ship in a collision;
.6 material damage to marine infrastructure external to a ship, that could seriously endanger the safety of the ship, another ship or an individual; or
.7 severe damage to the environment, or the potential for severe damage to the environment, brought about by the damage of a ship or ships.

However, a marine casualty does not include a deliberate act or omission, with the intention to cause harm to the safety of a ship, an individual or the environment.

Serious injury means an injury which is sustained by a person, resulting in incapacitation where the person is unable to function normally for more than 72 hours, commencing within seven days from the date when the injury was suffered.

Material damage in relation to a marine casualty means:

1. damage that:
    a. significantly affects the structural integrity, performance or operational characteristics of marine infrastructure or a ship; and
    b. requires major repair or replacement of a major component or components; or
2. destruction of the marine infrastructure or ship.

A **very serious marine casualty** means a marine casualty involving the total loss of the ship or a death or *severe damage* to the environment. (NB this does not include death by natural causes). A marine safety investigation shall be conducted into every very serious marine casualty.

Severe damage to the environment means damage to the environment which, as evaluated by the State(s) affected, or the flag State, as appropriate, produces a major deleterious effect upon the environment.

6.2 Reported Cases Classified as per IMO Casualty Investigation Code

The following table represents the cases reported to IOMSR in 2015 classified as per the IMO Casualty Investigation Code for different vessel types.

	Total	Passenger	Oil Tanker	Chem. Tanker	Gas Carrier	Bulk Carrier	Offshore/ Standby	Other Cargo	Comm. Yacht	Pleasure Vessel	Fishing Vessel
Very Serious Marine Casualty:	**1**							**1**			
Death	1							1			
Severe Damage to Environment	0										
Loss of Ship	0										

Marine Casualty:	**35**	**0**	**6**	**0**	**5**	**9**	**6**	**6**	**3**	**0**	**0**
Serious Injury	22		4		4	8	4	2			
Material Damage to Ship	7		2		1		1	2	1		
Stranding, Disabled, Collision	6					1	1	2	2		

Marine Incident:	**49**	**5**	**14**	**0**	**6**	**8**	**7**	**6**	**2**	**1**	**0**

The following table represents the cases reported to IOMSR in 2015 classified as per the IMO Casualty Investigation Code compared to the previous year.

Year		**2014**	**2015**	**2015 Cases**
Number of Reports Received		76	85	
Very Serious Marine Casualty	Death	1	1	See Chapter 5.2 – deaths by rank See Chapter 7.1 case 1
	Severe Damage to Environment			
	Loss of Ship			
	Total Cases	**1**	**1**	
Marine Casualty	Serious Injury	10	22	See Chapter 5.2 – injuries by rank See Chapter 7.1 cases 2-23
	Material Damage to Ship	6	7	See Chapter 7.1 cases 24-30
	Stranding, Disabled, Collision	6	6	See Chapter 7.1 cases 31-36
	Total Cases	**22**	**35**	
Marine Incident	**Total Cases**	**53**	**49**	See selected cases in Chapters 8 and 9

The numbers of Marine Incident, Marine Casualty and Very Serious Marine Casualty cases are reported by IOMSR to the International Maritime Organisation annually.

Chapter 7 – Casualties in 2015

A total of 36 casualty cases were reported in 2015 and are outlined below.

Casualties	Berthed/ Docked	At Anchor/ Anchoring/ Weighing Anchor	Mooring/ Unmooring	Making Way in Port/ Confined Waters	Making Way Open Sea	Drifting	Total
Passenger	0	0	0	0	0	0	**0**
Oil Tanker	0	1	0	3	2	0	**6**
Chem Tanker	0	0	0	0	0	0	**0**
Gas Carrier	3	0	0	0	2	0	**5**
Bulk Carrier	0	2	1	0	5	1	**9**
Offshore/Standby	1	0	0	1	1	3	**6**
Other cargo Vessel	2	0	2	2	1	0	**7**
Comm. Yacht	1	0	0	2	0	0	**3**
Pleasure Vessel	0	0	0	0	0	0	**0**
Fishing Vessel	0	0	0	0	0	0	**0**
Total	**7**	**3**	**3**	**8**	**11**	**4**	**36**
***Serious Injury cases**	5	3	0	1	9	4	**22**
***Death cases**	0	0	0	0	1	0	**1**

*In some cases more than person may have been injured in the same case.

7.1 Brief Summary of All 36 Casualty Cases in 2015

1 Other cargo ship – death case

Death of the Chief Officer, Chief Engineer and serious injury to the 2nd Officer when entering a cargo hold with a dangerous atmosphere.

- This case was the subject of an Isle of Man Ship Registry investigation. "Sally Ann C" report published on IOMSR website.

2 Offshore vessel – injury Case

Whilst the ship was making way in open water and heavy weather 2 ratings were asked to move some bags stored on an exposed area of the main deck to a more sheltered area. As the ratings were going down an external stairwell one rating slipped, fell down the stairs and broke his ankle.

3 Bulk carrier – injury Case

Whilst sliding down the rails of an Australian ladder in a cargo hold the chief officer fell 2m from the ladder to the platform and broke his leg.

4 Offshore vessel – injury Case

Whilst disembarking a helicopter a rating was walking along the anti-slip walkway where he felt dizzy. He stumbled off the anti-slip walkway, slipped over on the wet deck and broke his ankle.

5 Other cargo ship – injury case

Whilst in dry dock the attending superintendent was assisting the ship's crew with cutting in the cargo hold using oxy-acetylene. As the cutting started a defective oxy-acetylene hose caused burns to the superintendent's hand whilst he was using the equipment without wearing appropriate safety equipment.

6 Bulk carrier – injury case
When leaving the bridge the electrician slipped and fell down the stairs causing head injuries.

7 Oil tanker – injury case
After completing the required departure checklist the main engine was started. A steam leak emerged from a cooling system expansion joint. At this time OOW Engineer walked passed the leak and was burnt from the steam.

8 Oil tanker – injury case
Whilst the vessel was on passage the auxiliary boiler was due to be opened for maintenance. The maintenance work was due to be completed with a work permit under supervision of the 2nd Engineer. Prior to the work permit being issued an engine rating took it upon himself to start the work early. Whilst slacking the bolts excess steam was released and significantly burnt the engine rating.

9 Bulk Carrier – injury case
During installation of security razor wire whilst the ship was at anchor the chief officer fell 13m overboard to the water causing injuries. The seafarer was observed trying to free wire stuck behind the gangway without wearing appropriate safety equipment.

10 Bulk carrier – injury case
After departing port the ship was drifting and conducting hold cleaning in preparation for the next cargo. Some of the cargo had started to accumulate in the hold bilge. Whilst tying to remove the cargo a deck rating started to open the burlap on the bilge cover. Whilst trying to lift the cover he cut off the end of an index finger.

11 Gas carrier – Injury case
Whilst alongside conducting cargo operations the bosun noticed a leak from a strainer cover in the pump room. The bosun and pumpman were sent to fix the leak. As the bosun tightened the cover (stopping the leak) he lost sight of the pumpman and shortly after heard the pumpman's cries for help. The pumpman had entered the space below the gratings to investigate droplets of cargo in the vicinity of the turning pump shaft. The pumpman's clothing had become entangled on the spinning shaft causing severe lacerations to his back.

12 Bulk carrier – injury case
After making repairs to a leaking expansion valve on the ship's air conditioning system the secondary air conditioning system was shut down for inspection and gas collection. As the chief engineer explained the belt tensions to the engineers the electrician put his hand too close to a turning belt which became entangled in the belt and the guard severely injuring his fingers.

13 Bulk carrier – injury case
Whilst on passage the deck crew were cleaning the cargo holds. On completion the sludge crane was used to lift the cleaning equipment from the hold to the main deck. During this operation the crane wire parted and the load fell back into the cargo hold. The hook hit a deck rating who was working directly below the load as it was being hoisted. The seafarer sustained significant injuries to his head and leg and was flown to hospital.

14 Oil tanker – injury case
Whilst at anchor in favourable weather and sea conditions maintenance work was being conducted on the mooring winches on the aft mooring deck. As the winch was being operated a deck rating injured his hand when his hand became trapped between the storage reel securing bolts and the main winch shaft support connected to the warping drum.

15 Offshore vessel – injury case
During lifting operations on the main deck the hook became trapped on a roller fairlead. An integrated rating sees this and calls the crane operator stop. As lifting stops the hook becomes free and strikes an integrated rating on the head (whilst wearing a safety helmet) rendering him unconscious. The seafarer is later flown to a hospital ashore.

16 Bulk carrier – injury case
Whilst on watch on the bridge the chief officer went to the bridge toilet. On entering the toilet he slammed the door shut on his fingers causing the end of a finger to be cut off.

17 Gas carrier – Injury case
Whilst checking an apparent defect to an eductor the chief engineer and officer of the watch engineer went to the tank top in the engine room to check the eductor. As the chief engineer put his foot in the bilge he slipped and fell into the bilge breaking his ankle.

18 Gas carrier – Injury case
Whilst the ship was alongside the ship was preparing to start cargo operations. The shore foreman shouted to the chief officer concerning a condenser outlet with water flowing onto the jetty potentially damaging cargo equipment. The chief officer attempted to divert the water flow with a pallet and plastic sheeting with the help from a rating. Whilst rigging the pallet with lashings trapped the chief officer's hand between the lashing and ship's rail causing significant hand injuries.

19 Gas carrier – Injury case
The 2nd Engineer left his cabin and proceeded to walk down the corridor towards the stairwell. As the ship rolled the 2nd Engineer slipped over on some freshly applied wax stripper landed on the deck and broke his hip. No other seafarer was in in attendance on the deck neither were any warning signs in place.

20 Bulk carrier – injury case
When carrying out maintenance work on a main engine unit an officer of the watch engineering injured his fingers when a telescopic pipe fell onto his fingers causing significant injury.

21 Other cargo ship – injury case
Whilst conducting maintenance work on the gangway in port an engine rating injured his fingers when manually lifting the gangway motor. During the lift the engine rating's finger got caught between the motor and mounting.

22 Offshore vessel – injury case
During flexible pipe lay operations the pipe descended at an uncontrolled rate causing friction heat and shredded plastic. The plastic caused numerous spot fires while the pipe bunched up on the carousel and damaged machinery and hatch comings. During the firefighting and member of the firefighting team, a deck rating, slipped on the deck whilst preparing a hose and broke his leg.

23 Oil tanker – injury case
Whilst using a cutting disc in the engine room workshop the pumpman injured his hands when the cutting disc shattered causing severe lacerations.

24 Gas carrier – injury case
A fire broke out in the ship's incinerator room causing thick black smoke to enter the accommodation block. Some seafarers were trapped in the mess room by the smoke. Following a muster a rescue team wearing SCBA was despatched to rescue the missing seafarers. All missing seafarers were rescued effectively but two of the rescue party suffered minor burns to their faces and ears.

25 Oil tanker
Whilst transiting the Suez Canal close to a dredger the ship made contact with an underwater obstruction causing the ship to list and loose steerage.

26 Oil Tanker
Whilst manoeuvring in an anchorage area the vessel made contact with a buoy causing significant damage to the ship's propeller and the buoy.

27 Other cargo ship
Whilst entering a lock stern first in fog conditions the ship made heavy contact with the lock gate recess causing structural damage to the ship.

28 Offshore vessel
Whilst the ship was in a repair yard a fire occurred in the main switch board which resulted in severe damage. The busbar connected to a deck generator was observed to start the fire.

29 Commercial yacht
After completing a sea trial the yacht returned to the yard and was locked down and left unattended overnight. During the night the sewage treatment system malfunctioned and flooding the engine room and starting machinery by shorting the electrical control boxes.

30 Other cargo ship
A cargo container fire underdeck in the cargo hold caused significant damage to the cargo and the ship. No injuries or pollution.

- This case was the subject of an Isle of Man Ship Registry investigation.

31 Other cargo ship
Whilst the ship was berthing in port with a pilot on board the ship grounded. When the area surrounding the ship was sounded by the crew the water depths differed to the charted depths allowing for the tidal conditions. On inspection of the ship by the crew water ingress was discovered in the ship's ballast tanks.

32 Commercial yacht
Whilst slowly approaching a mooring buoy with guests on board being navigated solely by the skipper on the bridge the yacht grounded on a charted rock marked by buoyage. The bulbous bow was significantly damaged. The yacht remained on the rock until it refloated on the rising tide.

33 Bulk carrier

Whilst entering port with a pilot on board and tugs made fast and pilot on board the vessel grounded damaging forward tank sections causing water ingress to tanks. The ship did not have best scale chart on board for the port entry.

34 Other cargo ship

Whilst mooring with a pilot on board a turn was misjudged and the ship made heavy contact with another moored ship causing significant damage to both ships.

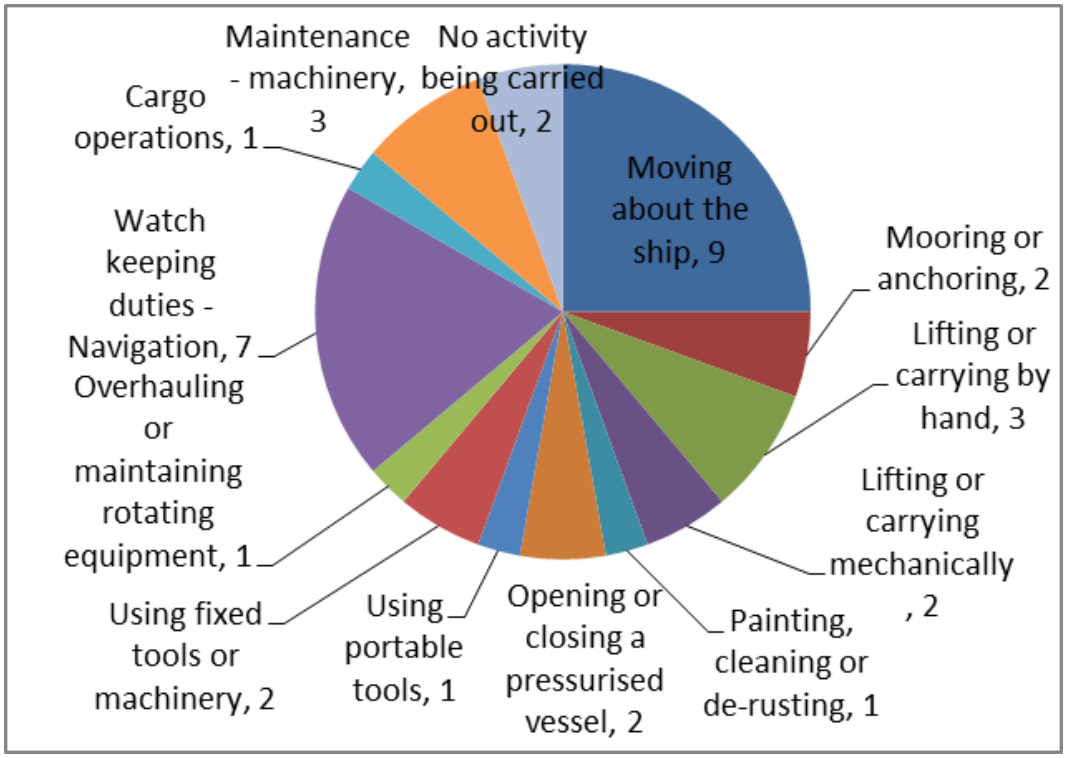
35 Commercial yacht

Whilst navigating a river at night a yacht instructor was instructing the crew on the use of navigation marks when the yacht grounded and remained fast until it was refloated on the rising tide.

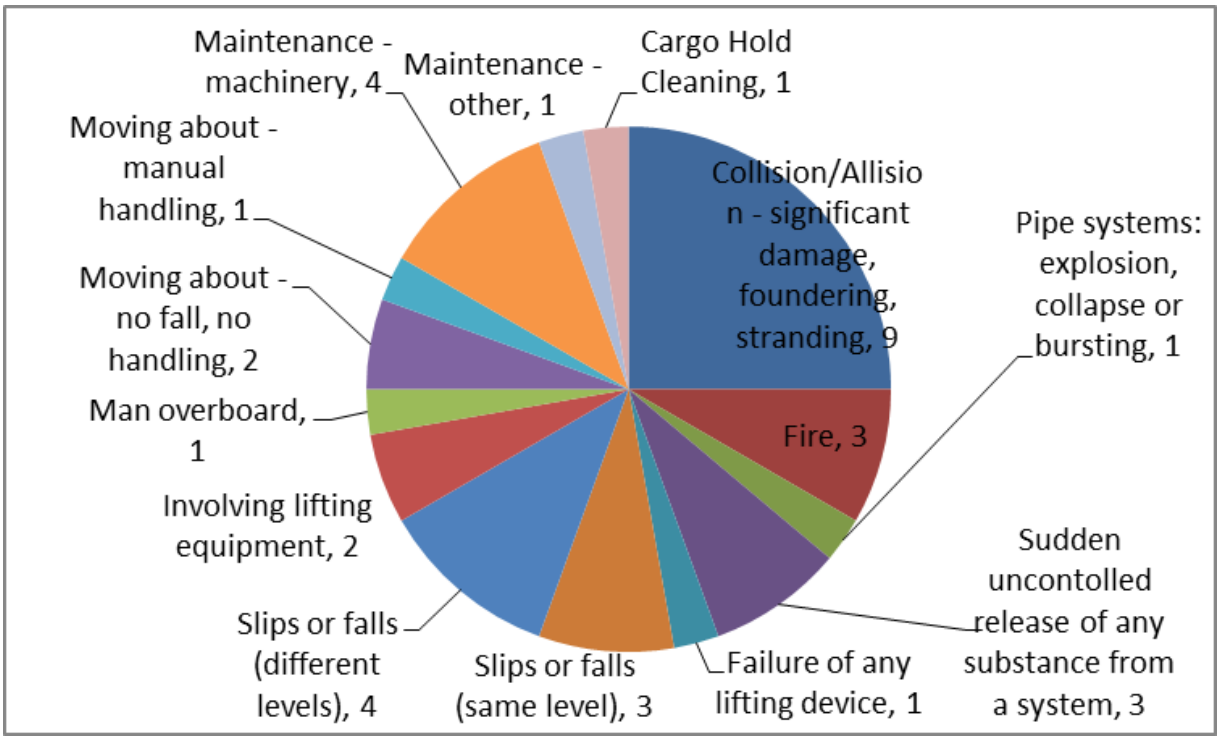
36 Offshore vessel

Whilst manoeuvring in port with a pilot on board the ship was slowing and commencing a swing. During the swing control of the engines and thrusters was transferred to another control console. It was then realised that there was a problem with the control console as the ship was not responding. Control was transferred and as the ship was thrusting and using engines to control the swing the ship collided with an unlit barge causing structural damage.

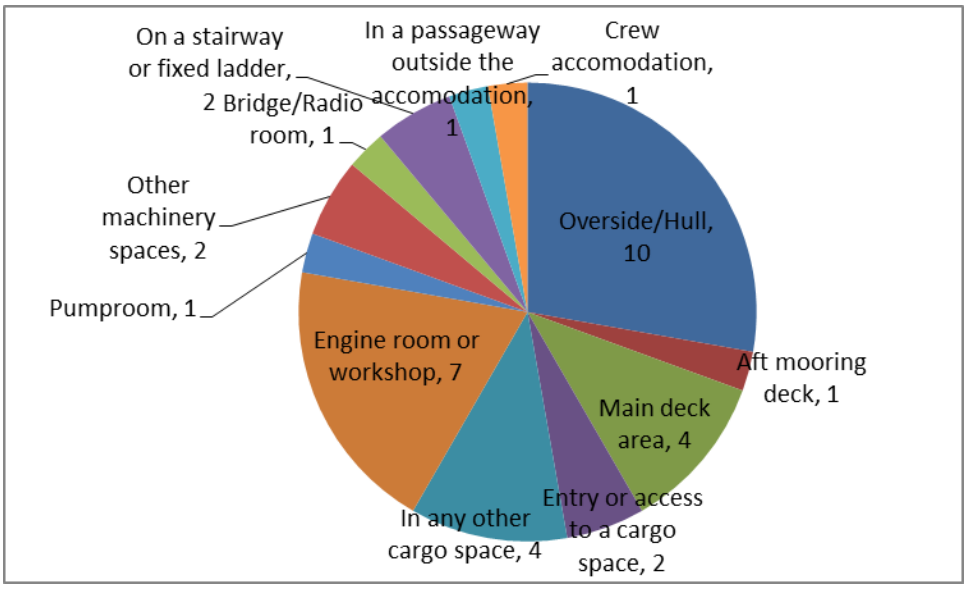
7.2 Casualty Chart Representations



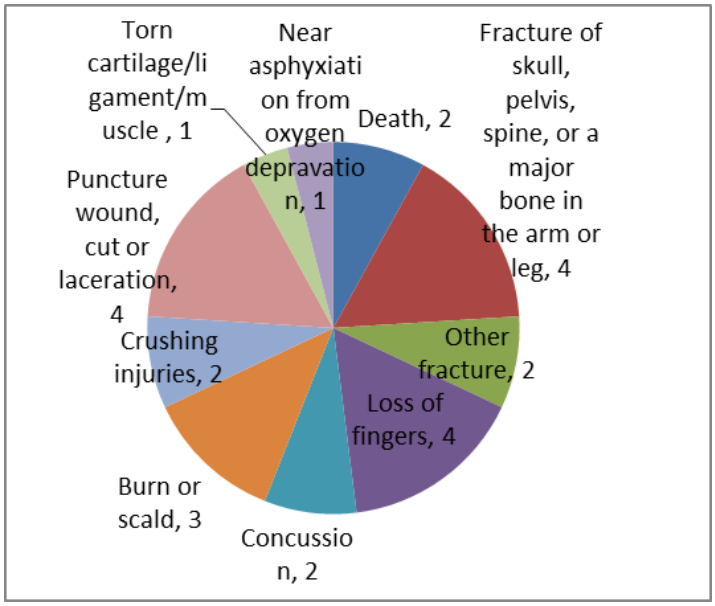
2015 Casualty Activities



2015 Casualty Types



2015 Casualty Places



2015 Casualty Injuries

Chapter 8 – Accidents in 2015

A total of 27 accident cases were reported in 2015 and are outlined below.

accidents	Berthed/ Docked	At Anchor/ Anchoring/ Weighing Anchor	Mooring/ Unmooring	Making Way in Port/ Confined Waters	Making Way Open Sea	Drifting	Total
Passenger	2	0	0	1	1	0	**4**
Oil Tanker	3	0	0	0	4	0	**7**
Chem Tanker	0	0	0	0	0	0	**0**
Gas Carrier	1	2	0	0	1	0	**4**
Bulk Carrier	0	1	0	0	1	0	**2**
Offshore/Standby	1	1	1	0	2	0	**5**
Other cargo Vessel	3	0	0	0	0	0	**3**
Comm Yacht	1	0	0	0	0	0	**1**
Pleasure Vessel	1	0	0	0	0	0	**1**
Fishing Vessel	0	0	0	0	0	0	**0**
Total	**12**	**4**	**1**	**1**	**9**	**0**	**27**
***Minor Injury cases**	10	4	0	1	6	0	**21**

*In some cases more than person may have been injured in the same case.

8.1 Brief Summary of Selected Accident Cases in 2015

1 Passenger ship – injury case

While recovering a lifeboat to its stowed position following a routine inspection a deck rating placed his hand on the davit roller as the davit was moving back to the stowed position. The deck rating suffered a minor injury to his finger.

2 Oil tanker – injury case

Whilst cleaning small bolts using a wire brush the Chief Officer cut his finger when the wire brush slipped and hit his hand.

3 Commercial yacht – injury case

Whilst cleaning some steel frames in the workshop the Chief Officer was also using a cutting tool at the same time. The Chief Officer cut his fingers using the cutter and was taken to the hospital for treatment.

4 Bulk carrier – injury case

Whilst removing cargo residue from a cargo hold using plastic buckets a deck rating attempted to lift a bucket using a rope passed through a block. As he heaved on the rope the deck rating felt a sharp pain in his shoulder and was taken ashore to the doctor.

5 Oil tanker – injury case

When arriving on the bridge for his evening watch the watch rating stepped though the doorway into the darkness of the bridge and slipped on the lino deck covering and sprained his ankle. The ship was rolling moderately and the deck matting had moved with the ship's rolling.

6 Other cargo ship – injury case
Whilst preparing lashing equipment for cargo operations a deck rating picked up a turnbuckle but it slipped and landed on the laced part of his safety shoe and injured his foot.

7 Offshore vessel – injury case
Whilst investigating why a heat recovery circulating pump was tripping the circuit breaker the chief engineer isolated the control boxes and junction boxes, tested them and found a zero reading. After disconnecting the supply cables the chief engineer re-instated the supply to run the pump. At this point the chief engineer became unbalanced and accidentally touched a supply cable giving him an electric shock.

8 Passenger ship
Whilst on passage the ships fire detection system was activated when a small fire was detected in the funnel space where some lagging had caught fire. Fire teams extinguished the fire quickly and boundary cooling continued until it was deemed safe. It was determined hot exhaust gas had escaped into the funnel space setting fire to the lagging.

9 Oil tanker
During routine use of the incinerator it was observed the incinerator trunking glowing red hot. On seeing this the officer of the watch engineer activated the fire alarm. All fuel to the incinerator was shut off and the incinerator shut down. A fire watch with charged hoses was posted until the incinerator cooled down.

10 Gas carrier
Whilst making way at sea the officer of the watch heard and saw a crack of lightning strike a mast riser. A small fire was then observed on the top of the mast riser. The crew were mustered and the fire was soon extinguished using the deck spray and nitrogen system.

11 Pleasure vessel – injury case
Whilst washing down the deck area with soapy water a deck rating slipped on the deck and fell over. As he landed on the deck he hit his head causing the arm of his sun glasses to brake and cut his head.

12 Bulk carrier – injury case
Whilst investigating a defective engine room mechanical blower flap the 2nd Engineer tried to manually operate the flap after draining the air from the system. As he operated the lever manually the weight of flaps caused to lever to move and the 2nd Engineer trapped his finger between the lever and a bar stopper.

13 Gas carrier – injury case
The 2nd Engineer was conducting maintenance on piston ring under tension in an expanded state. When removing the piston ring from the tool the piston ring slipped from the tool and injured the 2nd Engineer's hand.

14 Oil tanker – injury case
Whilst the ship was at anchor rolling moderately in rough weather the 4th Engineer was moving about the ship when he slipped over in an internal stairwell and landed awkwardly injuring his hip and head.

15 Other cargo ship
Whilst alongside in port discharging cargo the Officer of the watch noticed smoke emerging from the cargo hold and raised the fire alarm. Meanwhile a deck rating noticed a light was on fire and used a powder extinguisher to extinguish the fire. The fire team arrived with hoses whilst the power to the hold was isolated. Minor damage to the light fitting and cargo was incurred.

16 Offshore vessel – injury case
The chief cook slipped on some margarine on the galley deck, fell over and hit his head.

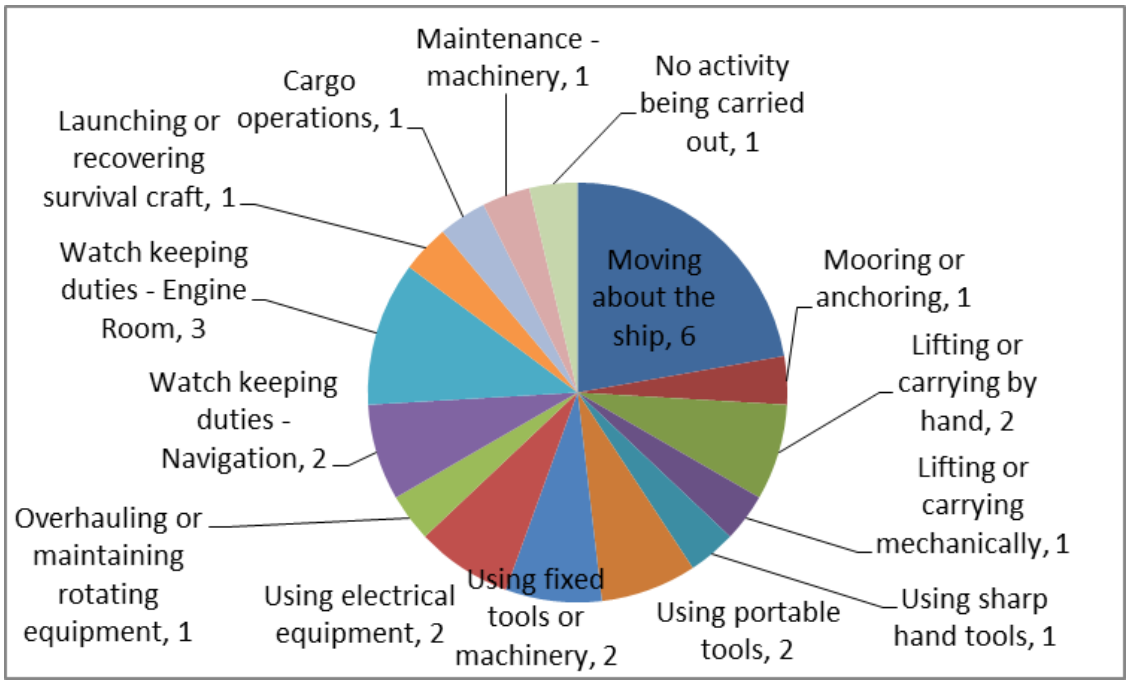
17 Other cargo ship – injury case
Whilst walking up the stairs in the engine room the oiler stumbled and fell on the stairs hitting his teeth on the steps as he fell. He broke a tooth.

18 Gas carrier – injury case
The 3rd Engineer went down to the engine room for a routine inspection before going to bed. Whilst spraying the compressor air belt he forgot to switch of the power to the compressor. During the spraying the compressor started automatically and he accidentally hit his hands on the impellor cutting his hand.

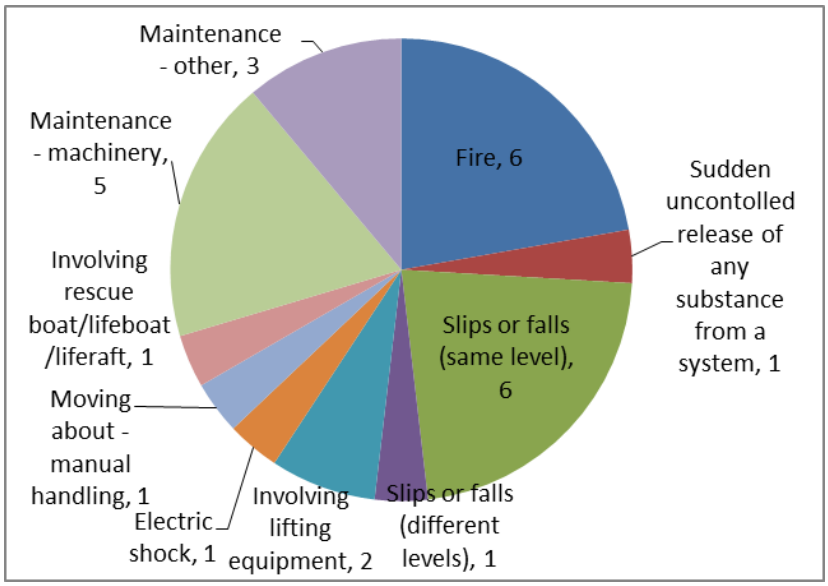
19 Offshore vessel – injury case
Whilst removing the shaft from the start air compressor the Officer of the Watch Engineering was hitting the shaft with a sledge hammer when he mishit the shaft and hit his fingers with the sledge hammer against the compressor casing.

20 Oil tanker – injury case
Whilst lifting a ballast pump in the engine room for maintenance the Chief Engineer incorrectly assumed a lifting eye pad above the pump would take the weight of the pump and a chain block. As the pump was being lifted with a chain block the lifting eye pad weld failed and the pump fell hitting the Officer of the Watch Engineer's hand causing injury.

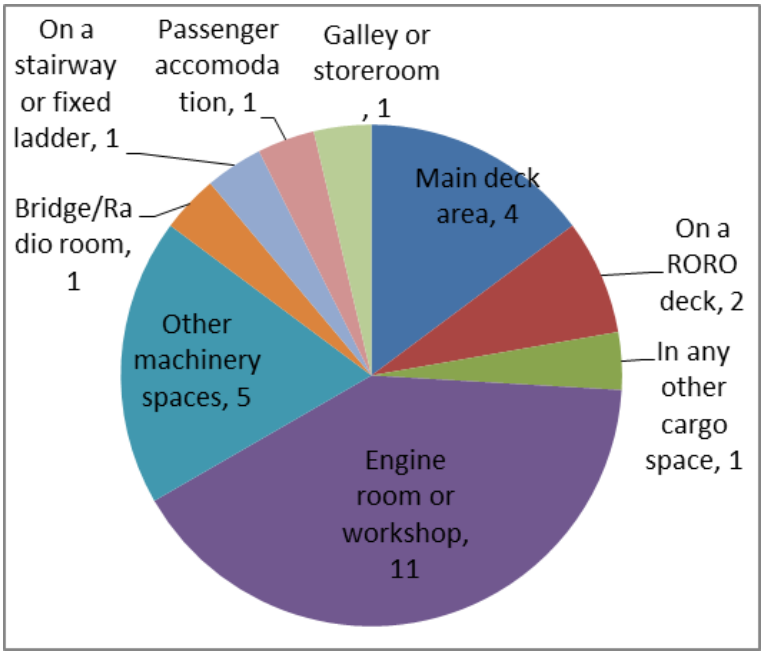
8.2 Accident Chart Representations



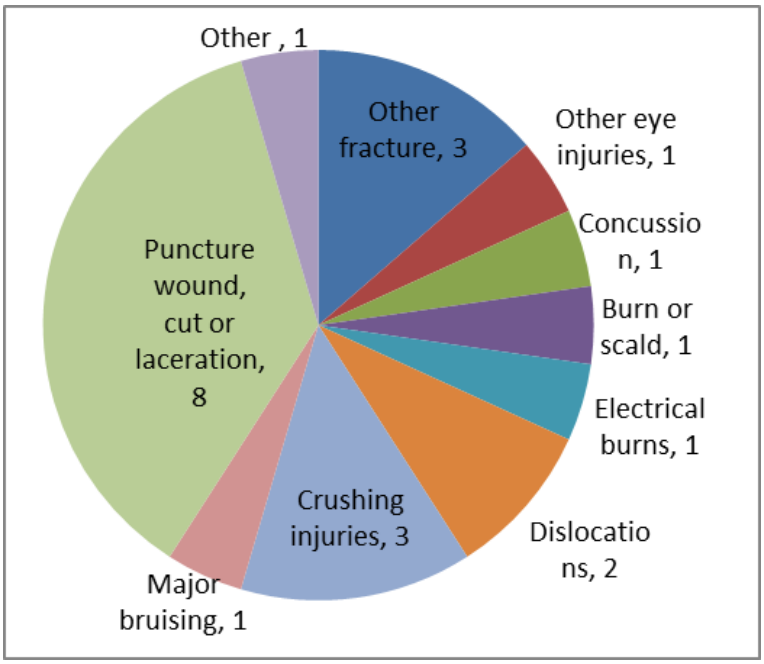
2015 Accident Activities



2015 Accident Types



2015 Accident Places



2015 Accident Injuries

Chapter 9 – Incidents in 2015

A total of 22 incident cases were reported in 2015 and are outlined below.

incidents	Berthed/ Docked	At Anchor/ Anchoring/ Weighing Anchor	Mooring/ Unmooring	Making Way in Port/ Confined Waters	Making Way Open Sea	Drifting	Total
Passenger	0	0	1	0	0	0	**1**
Oil Tanker	2	0	0	1	4	0	**7**
Chem Tanker	0	0	0	0	0	0	**0**
Gas Carrier	0	0	0	2	0	0	**2**
Bulk Carrier	1	1	2	2	0	0	**6**
Offshore/Standby	1	0	0	0	0	1	**2**
Other cargo Vessel	0	0	2	1	0	0	**3**
Comm Yacht	0	1	0	0	0	0	**1**
Pleasure Vessel	0	0	0	0	0	0	**0**
Fishing Vessel	0	0	0	0	0	0	**0**
Total	**4**	**2**	**5**	**6**	**4**	**1**	**22**

9.1 Brief Summary of Selected Incident Cases in 2015

1 Oil tanker

Whilst alongside in port conducting cargo operations a seafarer activated the fire alarm when he noticed a box stored on the funnel deck containing flammable materials was on fire. The crew mustered and a fire team extinguished the fire.

2 Bulk carrier

Whilst mooring to the quayside with a pilot on board and tugs attached a strong bump was felt by the ship's crew were it was suspected the vessel had touched the bottom. The vessel continued to moor without further incident. The vessel's hull was inspected by divers where no apparent damage was found.

3 Commercial yacht

While at anchor in a thunderstorm the yacht was struck by lightning. The yacht blacked out and power was restored shortly after. An initial check of the electrical equipment on board the following day indicated no damage.

4 Oil tanker

Whilst alongside discharging cargo a sudden gust of wind caused the SPM hawser to part and the vessel to drift. The ship was soon brought under control using the ship's engine.

5 Gas carrier

Whilst deporting port with a pilot on board in a narrow channel in poor weather conditions with reduced visibility the pilot ordered a big change of course. In order to check the vessel's swing the pilot ordered counter-rudder however due to the strong winds the counter-rudder had reduced effect and the ship continued to swing. As the intended course was being established the ship touched the bottom. The ship continued to an anchorage where a diver inspection could be conducted. The inspection indicated no damage to the ship.

6 Bulk carrier

Whilst approaching the planned anchorage position the fire alarm was activated by a seafarer who saw smoke emerging from the steering gear room. After the crew mustered the fire team entered the steering gear room after isolating the power closing vent and activating the hypermist system. The fire team discovered no apparent fire but some chemicals stored in the chemical store had leaked in the high ambient temperature and reacted causing the smoke.

7 Oil tanker

Whilst on passage an engineer officer responded to an alarm concerning the incinerator and noticed an oil leak. After stopping the incinerator the engineer left the incinerator room and returned with another rating to assess the incinerator and clean up the oil. Upon return they noticed more oil had leaked and the incinerator getting hotter. At this point fumes from the incinerator activated the fire alarm. After stopping the incinerator fan foam extinguisher was injected in the combustion chamber before boundary cooling. The uncontrolled combustion in the incinerator then ceased.

8 Other cargo ship

Whilst approaching a lock system with a pilot on board control of the main engine and thruster was transferred to a bridge wing control console. When attempting to manoeuvre the ship the control console was unresponsive. Control was transferred back to the central bridge console. At this time the ship's bulbous bow touched the muddy bottom. The ship later moored and a diver's inspection of hull indicated no apparent damage to the hull.

9 Offshore vessel

An electrical cadet was instructed to clean the carbon brushes on the shaft generator after conducting tests. The instruction was given with work permit or isolation certificate in place. As the cadet was working the ship had to change berth where the shaft generator was clutched in and ran. The cadet was lucky not to be injured.

10 Oil tanker

Whilst on passage in favourable weather a lifeboat drill was planned. After removing the gripes and harbour pins the lifeboat moved from the stowed position in an uncontrolled release. The disc brake proved ineffective and the lifeboat continued to the water where it was dragged by the ship. Fortunately no one was in the lifeboat. The ship was manoeuvred and the lifeboat was retrieved with the aid of the rescue boat. The lifeboat was not damaged during the incident.

11 Oil tanker

A faulty electrical dimmer switch for the lights in the officer's bar caught fire and was immediately extinguished.

12 Passenger Ship

Whilst arriving in port the ship experienced main engine failure on one of the main engines. Due to the confined waters within the port the master executed an emergency berthing on a smaller pier which caused minor damage to the berthing arrangements of the pier and minor damage to a fishing boat moored nearby.

13 Bulk carrier

Whilst approaching the berth with a pilot on board and tugs attached the ship suffered a main engine failure following a few main engine start/stops while approaching the berth. The ship continued to moor with the assistance of the tugs without further incident. The cause was determined to be a faulty pneumatic system preventing the main engine to start.

14 Bulk carrier

During bunker operations of two simultaneous tanks alongside in port the general alarm was sounded when a bunker tank overflow was observed spilling on the main deck of the ship. Bunkering was immediately stopped. The fuel oil was contained on the deck of the ship and cleaned up by the ship's crew.

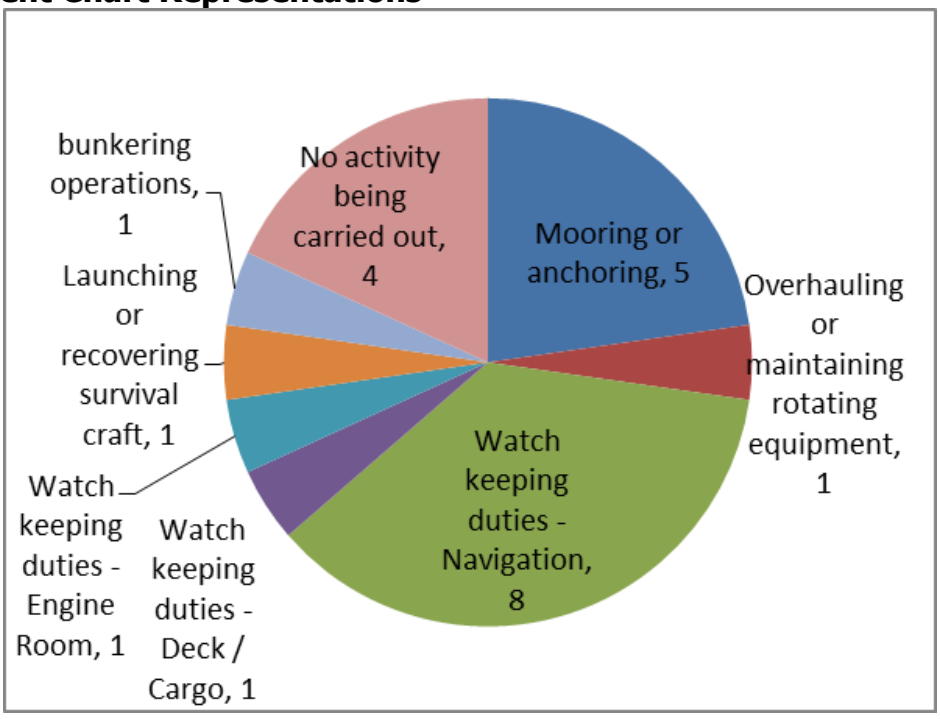
15 Offshore vessel

Whilst in the vicinity of the rig within the 500m zone using dynamic positioning the vessel made contact with the rig while deck cargo operations were being conducted. The master manoeuvred the vessel away from the rig and engaged the dynamic positioning system. The officer of the watch was ordered to manoeuvre the vessel outside of the 500m zone. The master then called the rig and the shore operator concerning the situation. During the master's call the master heard the rig call the vessel on VHF radio informing the vessel moving towards the rig. As manual control of the vessel was established using full engine power the vessel made contact with the rig again. The ship incurred minor damage.

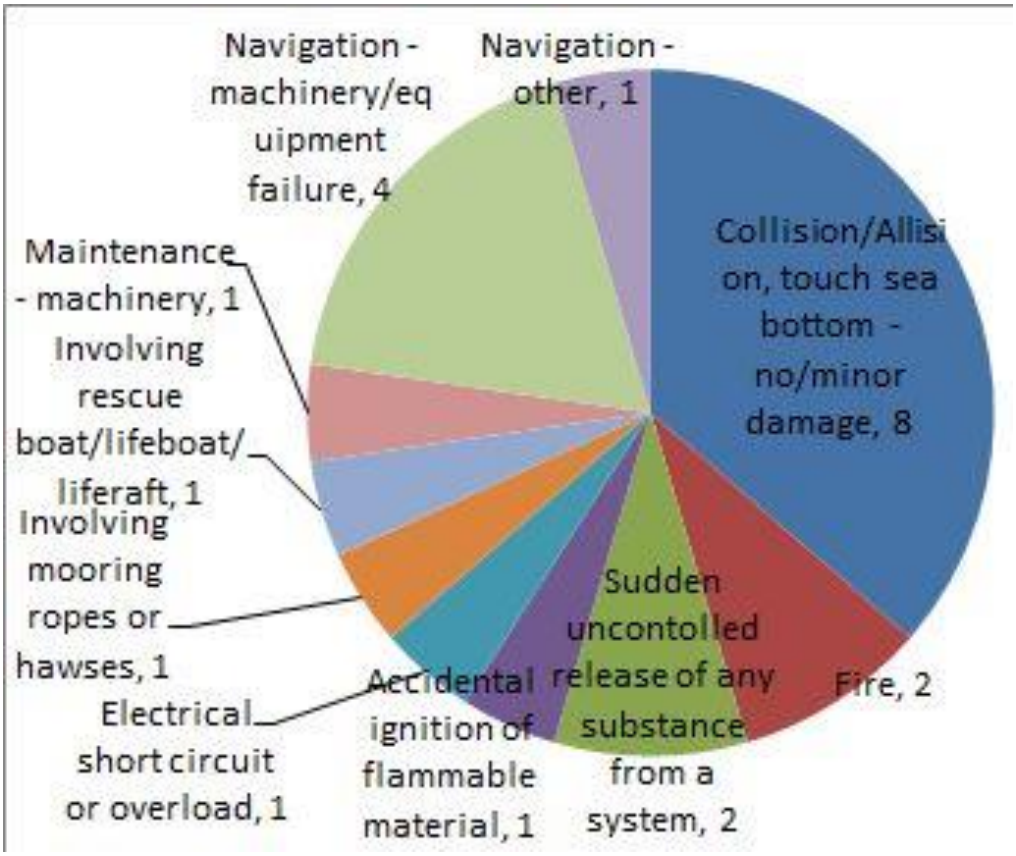
16 Gas carrier

The ship completed all required departure checks prior to departure. After the pilot/master information exchange was complete pilot the ship let go the lines and manoeuvred off the berth. As the ship was making way the main engine pitch went to zero causing the ship to turn to starboard and towards a river bank. Full astern engine, thrusters and let go anchor was ordered but the ship touched the soft mud river bank. After an initial inspection and sounding of the ship's tanks was completed indicating no damage the ship was manoeuvred to an anchorage to conduct further inspection.

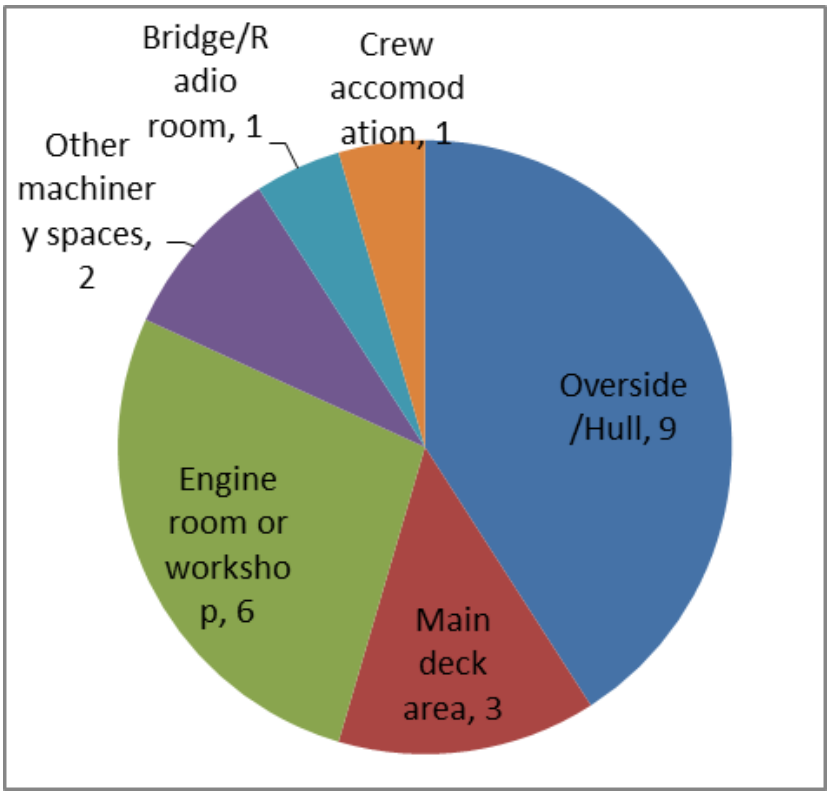
9.2 Incident Chart Representations



2015 Incident Activities



2015 Incident Types

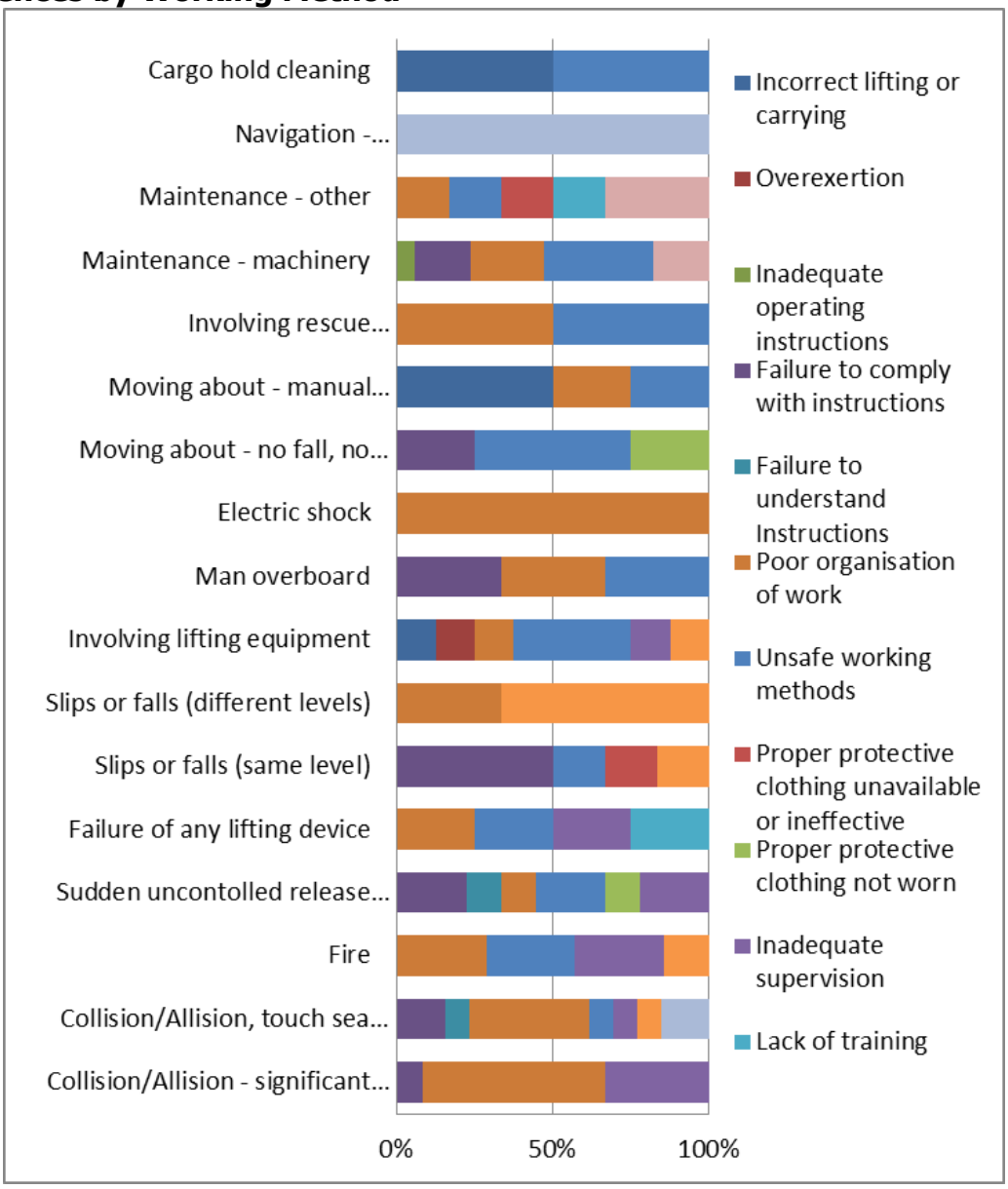


2015 Incident Places

Chapter 10 – Breakdown of Occurrences in 2015 by Cause

The following charts represent a breakdown of all the occurrences by cause divided into several categories represented on the ARF Form. Determination of the cause is following an investigation into the occurrence by ship's staff, company investigators or an external investigating body. **It is important to remember that an occurrence may be the result of several causes across different categories**.

10.1 Occurrences by Working Method



The chart above shows that the predominant working method cause has been attributed to "poor organisation of work" followed by "unsafe working methods", "failure to comply with instructions" "inadequate supervision" in that order. Seafarers should plan their work and safety precautions adequately and avoid taking shortcuts in order to get the job done more quickly. This highlights the importance of effective risk assessment. A seafarer should not feel they must put themselves in a dangerous situation to complete the job or to save a few minutes of time. Stop and re-evaluate!

"Poor organisation of work" stresses the need for effective planning and execution with good communication. Where "poor organisation of work" led to a collision or grounding this highlights the need for effective bridge team management.

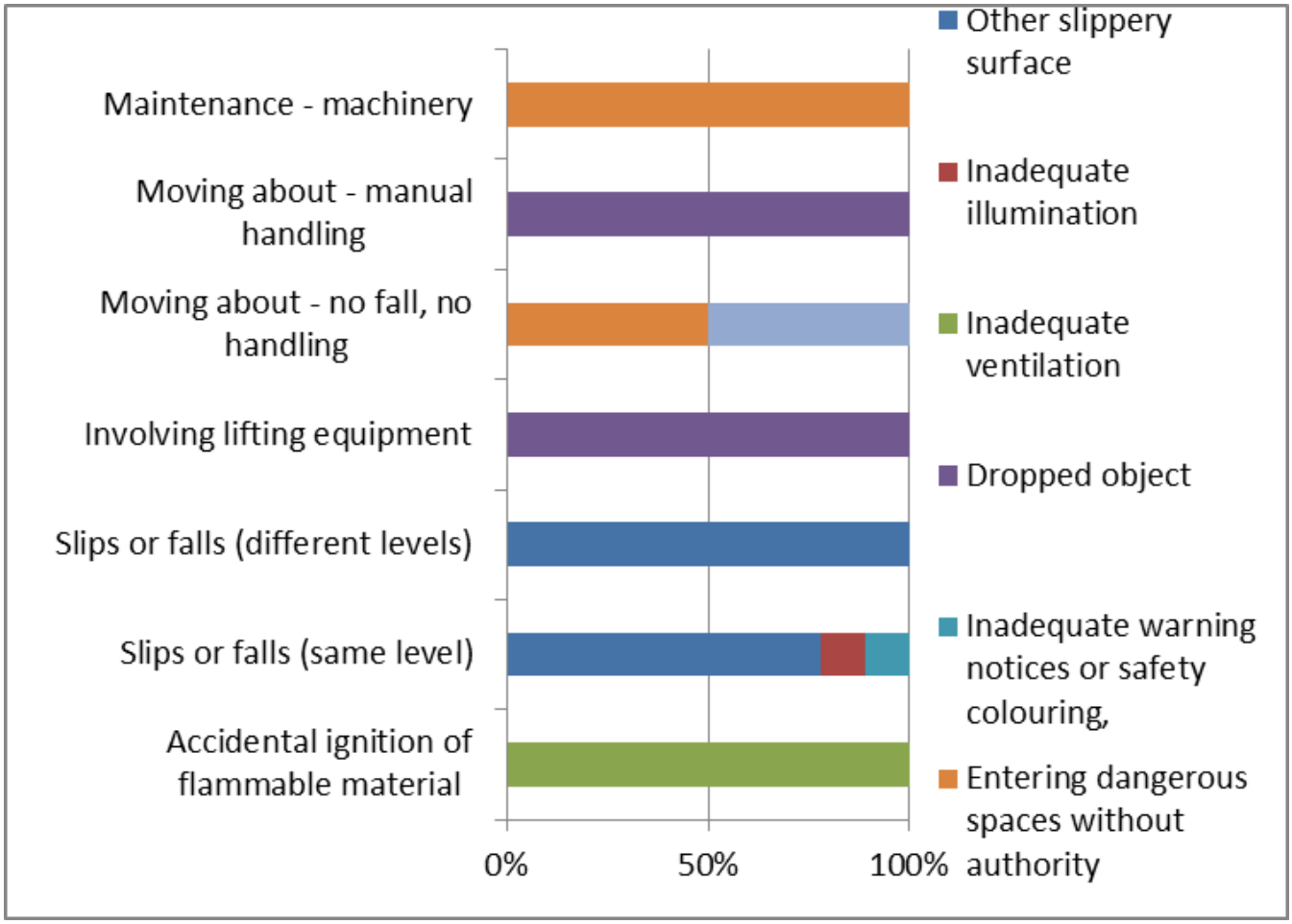
10.2 Occurrences by Ship Access

None reported in 2015.

All personnel boarding a vessel are required by the Regulations to use the means of access provided. The master is required to ensure that a safe means of access is provided to the vessel at all times and to ensure that it is maintained in a safe condition. Everyone intending to board or leave the vessel should be strongly encouraged by the ship's staff to use the safe means of access provided even if a shortcut appears to be an easier or shorter journey.

Crew members joining the vessel from a launch boat are strongly encouraged to wear appropriate lifejackets and only consider the transfer under suitable conditions taking into account the weather and vessel motion.

10.3 Occurrences by Movement About the Ship

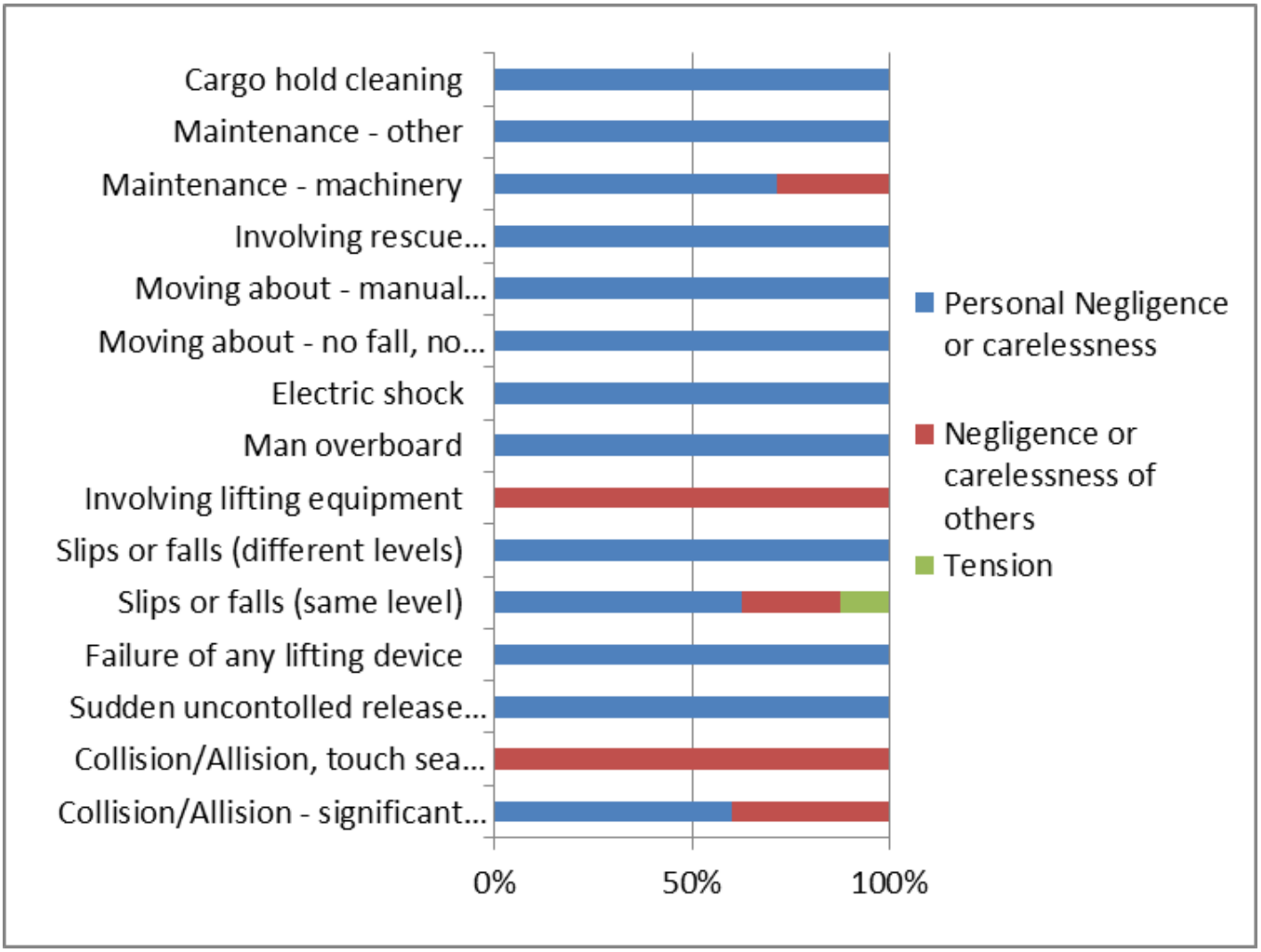


The chart above shows a variety of causes associated with moving about the vessel. Slips and falls on slippery surfaces was the predominant cause in 2015. Crew members should be aware of any associated risks of slipping when moving about the ship under various conditions.

Where appropriate masters should ensure that deck working areas have non-slip surfaces. This can be achieved by either clearing/cleaning the deck, placing non-slip mats or use of non-slip paint mixes.

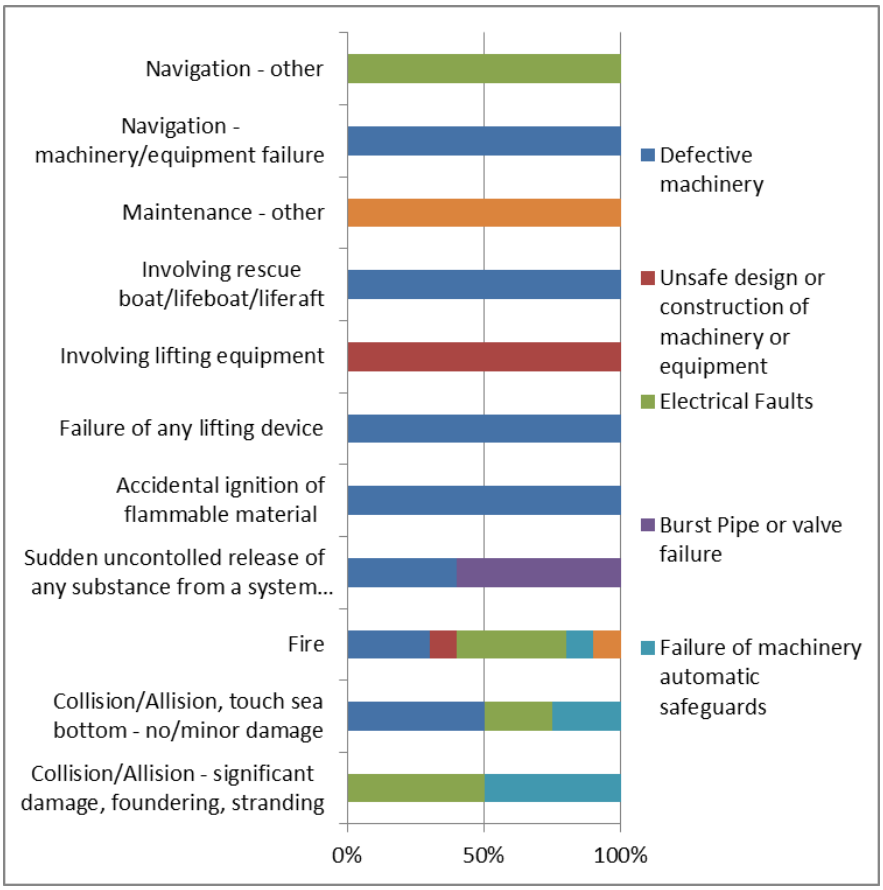
Injuries sustained through unprotected openings can be avoided by effective barriers, signs and communication.

10.4 Occurrences by Human Factor



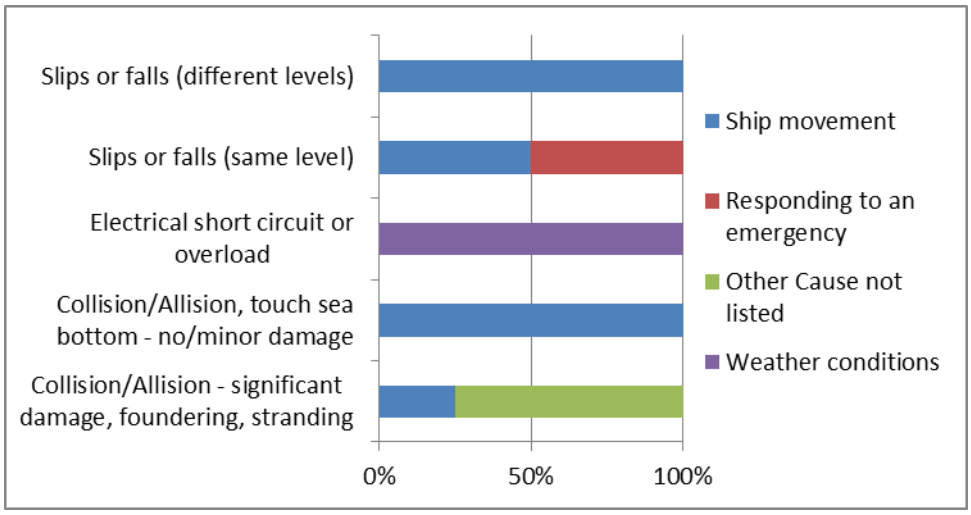
The chart above shows the predominant human factor cause has been attributed to "personal negligence or carelessness". By "human factor" we mean the act or omission of a person to do something that leads to the occurrence happening. This stresses the need for adequate knowledge and training associated with the particular work activity, for the crew member to be made aware of any associated risks and for crew members to pay attention to what they are doing.

10.5 Occurrences by Mechanical & Other Equipment



The chart above shows a variety of causes associated with mechanical and other equipment. "Defective machinery" and "electrical faults" was the predominant cause in 2015. Equipment failure stresses the need for effective inspection and maintenance to ensure they are in good condition and fit for purpose.

10.6 Occurrences by Other Miscellaneous Causes



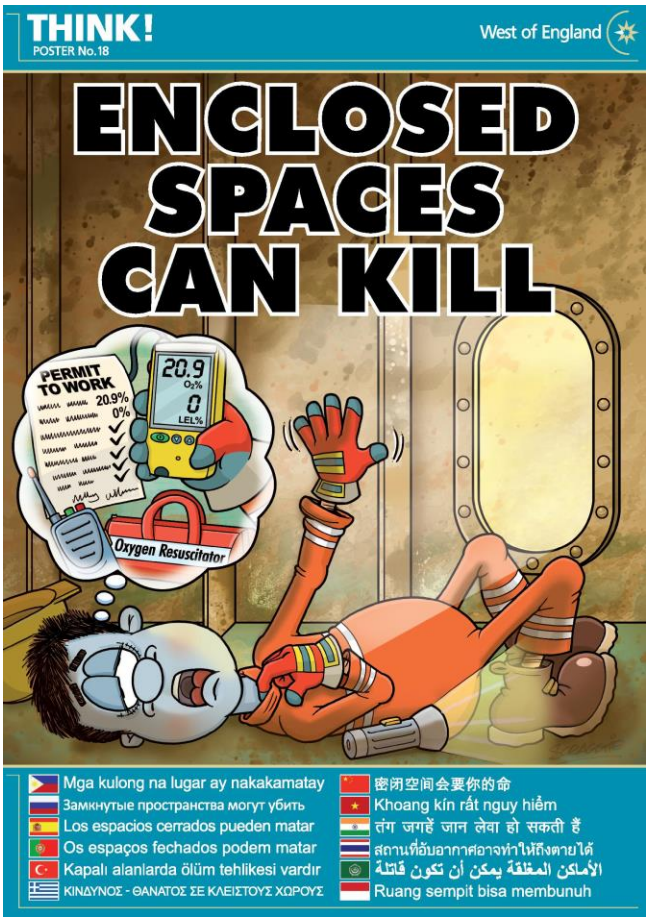
The chart above shows the predominant 'other miscellaneous cause' has been attributed to "ship movement". Crew members should take into consideration the movement of the vessel in the prevailing sea and tidal conditions when planning and carrying out work activities. If the movement of the vessel is too great the work activity should not be attempted or consideration should be given to manoeuvring the vessel to reduce the vessel's movement to an acceptable level.

Chapter 11 – Conclusion

Many of the ARFs received show that a large proportion of occurrences attributed to the human factor whereby personal negligence and carelessness remains prevalent and therefore highlights the importance of effective care and attention.

Chapter 4.1 shows the main occurrences in 2015 were cases involving fire (mainly electrical and incinerator fires), machinery maintenance causing personal injury and collisions and groundings (uncharted dangers, poor planning or lack of situational awareness). Occurrences involving slips and falls (same and different levels) feature heavily each year, again highlighting the importance of effective care and attention, particularly when the ship is rolling and pitching in a sea way.

2015 unfortunately saw yet more enclosed space deaths and a significant number of hand injuries. The Isle of Man Ship registry cannot over emphasise the importance of adequate identification of any space which may have a toxic or oxygen deficient atmosphere and adequate procedures for entering such spaces. Hand injuries resulted from a variety of causes but personal negligence and carelessness was the main cause of hand injuries. Companies are encouraged to remind seafarers of the various hazards when working on a ship through safety campaigns or similar.



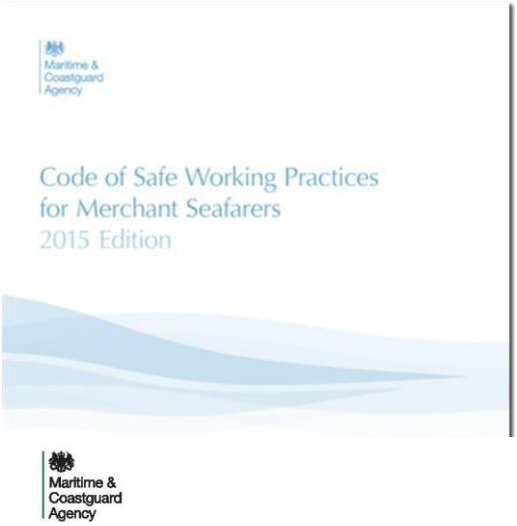
Source: http://www.westpandi.com

Source: http://www.safetyworld.com/

It is the responsibility of the master or skipper to ensure that all activities carried out on board are conducted safely, with an acceptable level of risk. Where vessels have technical managers ashore, then the technical managers should ensure that the master or skipper is given the necessary support and resources on board to determine the risk and to reduce the risk to an acceptable level.

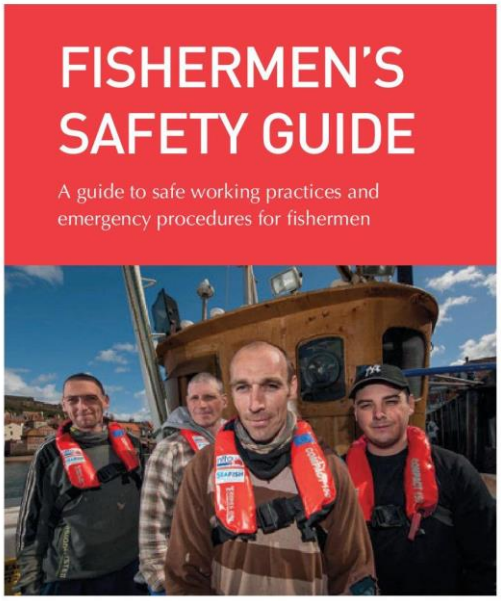
Seafarers should be aware of their own abilities and limitations and the limitations of the equipment they use. Seafarers should not attempt any work activity where they perceive the risks to be unacceptable. Should unacceptable risks present themselves, then the work should not commence until the risks are investigated and measures introduced to reduce the risks to an acceptable level. Risk assessments are designed to be used for this purpose. If the vessel has an appointed safety officer then he or she should be informed and the circumstances investigated. It is important to remember that if the risks cannot be reduced to an acceptable level then the work activity should not go ahead. Should this occur, then specialist advice should be sought.

Seafarers should not take any unnecessary risks with their safety in order to get the job done or take unsafe shortcuts in order to get the job done more quickly. Safety on board a vessel should be everyone's concern. Seafarers should be able to observe and monitor their own safety effectively and where possible the safety of those around them.



Where a vessel has established safety procedures, it is important that these are observed correctly. Appropriate personal protective equipment (PPE) should always be worn and used correctly. Any dedicated safety equipment should be regularly maintained and inspected before use.

The Code of Safe Working Practices for Merchant Seafarers and Fishermen's Safety Guide (right) are valuable references depending on the ship type for most work activities conducted on board and should be consulted frequently. Risk assessments, Permits to Work and plain old common sense are all important factors in reducing the level of risk posed by work activities.



If you are in any doubt about the safety concerned with a particular work activity, stop and re-evaluate.

Additional Information

- Manx Shipping Notice 003 – Accident Reporting
- Maritime Labour Notice 4.3E
- Code of Safe Working Practices for Merchant Seafarers and Fishermen's Safety Guide published by the UK Maritime and Coastguard Agency
- Master's / Yacht Master's Handbook (available free on the IOMSR website)
- Merchant Shipping (Accident Reporting and Investigation) Regulations 2001 SD815/01 (available free on the IOMSR website)
- Isle of Man Ship Registry website – www.iomshipregistry.com
- Contacting the Isle of Man Ship Registry – email marine.survey@gov.im

The Isle of Man Ship Registry welcomes any feedback concerning this report. If you have any comments or suggestions for future reports please contact the Isle of Man Ship Registry at the email address above.

The information in this report can be provided in large print or on audio tape, on request.