



**SMAIC**  
STATE MARINE ACCIDENT  
INVESTIGATION COMMISSION

# ANNUAL ANALYSIS

## **2019**

### **MARINE CASUALTIES AND INCIDENTS**



## ANNUAL ANALYSIS 2019



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STATE MARINE ACCIDENT  
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## 1. INTRODUCTION

State Marine Accident Investigation Commission (SMAIC) established by the Act of 31 August 2012 on State Marine Accident Investigation Commission<sup>1</sup> hereinafter referred to as the act, commenced operations in May 2013 upon the appointment by the Minister of Transport, Construction and Maritime Economy of a third one of the statutory five members of the Commission.

The investigation of marine casualties and incidents has been conducted by the Commission under the act and the Code of International Standards and Recommended Practices for the Investigation of Marine Casualties and Incidents (Casualty Investigation Code) adopted by the Maritime Safety Committee (MSC) of the International Maritime Organisation (IMO).<sup>2</sup>

The purpose of the investigation of a marine casualty or incident is to determine its causes and circumstances in the prevention of marine casualties and incidents in the future and to improve State of the safety at sea.

In the course of investigation the Commission does not determine liability nor apportion blame to persons involved in the marine casualty or incident and the investigation reports shall be inadmissible in any judicial or other proceedings whose purpose is to attribute blame or liability for the casualty referred to in the report. It means that none of the organs adjudicating in such proceedings can refer to the information included in the report of the Commission.

The Commission is required by law to investigate each very serious and serious casualty.

A *very serious marine casualty* is an accident that resulted in total loss of a vessel, a human death or a severe damage to the environment. A *serious marine casualty* is an accident that results, among others, in the damage to the propulsion of a vessel, extensive damage to the superstructure, changes in the vessel's stability, a damage to the underwater part of the hull causing the vessel to pose a threat to the safety of persons or the environment, making it unsuitable for continuing the journey. A serious casualty is also the one that causes damage to the environment, including pollution or a failure resulting in the need to tow the vessel or to apply help from the land.

In the event of a serious marine casualty, the Commission may discontinue the investigation after a preliminary assessment of the reasons for its occurrence. In the event of a *less serious marine casualty* or *marine incident*, the Commission decides to undertake the investigation or

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<sup>1</sup> Act of 31 August 2012 on the State Marine Accidents Investigation Commission (Journal of Laws: Dz.U.2019.1374 i.e. of 24.07.2019)

<sup>2</sup> Resolution MSC.255(84) – Adoption of the Code of the International Standards and Recommended Practices For a Safety Investigation into A Marine Casualty or Marine Incident (Casualty Investigation Code).



to desist from it. When making the decision the Commission shall take into account the gravity of the occurrence, the type of a vessel or cargo, and whether the results of the investigation shall contribute to the prevention of marine casualties and incidents in the future.

The Commission investigates marine casualties and incidents involving vessels of Polish affiliation, and vessels of foreign affiliation - if the casualty has occurred on Polish internal waters or territorial sea. The Commission is obliged to undertake the investigation in relation to which Poland is a substantially interested state, i.e. in a case in which Polish sailors died in the casualty.

It should be emphasized that after the SMAIC has received a notification about the casualty involving vessels in any way, a WIM Card is made (marine casualty/incident information card) with serial number containing basic data about the event.

In each case, the Commission undertakes actions necessary to make a preliminary assessment of the causes of the casualty, and based on the collected materials, under the above mentioned legal acts, takes the decision not to investigate, to withdraw from the investigation or to continue it.

The actions of the Commission conform to the regulations of the act and the rules of the SMAIC Statute.

## **2. INFORMATION ABOUT THE COMMISSION**

SMAIC has been working since 01.01.2019 in the following composition:



Master Mariner Tadeusz Wojtasik – Chairman of the Commission



Master Mariner Marek Szymankiewicz – Secretary of the Commission



Chief officer Monika Hapanionek – Member of the Commission



Chief engineer Zbigniew Łosiewicz –Member of the Commission

The following personal changes took place in 2019:

- on 22.02.2019 former Vice-Chairman of the SMAIC, Master Mariner Tadeusz Wojtasik was appointed Chairman of the Commission,
- on 05. 06. 2019 the position of a Vice-Chairman of the SMAIC was taken by Master Mariner Grzegorz Suszczewicz and that composition was in power until the end of 2019.



Master Mariner Grzegorz Suszczewicz – Vice-Chairman of the Commission

State Marine Accident Investigation Commission is an independent body. It acts at the Minister competent for the maritime economy. It is not an organization unit subordinate or supervised by the Minister of the Maritime Economy and Inland Navigation.<sup>3</sup>

Since 01.06.2017 Szczecin has been the seat of the Commission (Order No 12 of the Minister of Maritime Economy and Inland Navigation of 15 March 2017).

The mailing address and contact data of the Commission are the following:

Pl. Stefana Batorego 4, 70-207 Szczecin, Poland

tel. 91 44 03 290,

e-mail: [pkbwm@mgm.gov.pl](mailto:pkbwm@mgm.gov.pl)

[www.pkbwm.gov.pl](http://www.pkbwm.gov.pl)

tel. alarmowy: 664 987 987 (24 h)

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<sup>3</sup> Notice of the Minister of the Maritime Economy and Inland Navigation of 7 February 2020 published in the “*Monitor Polski*” of 25 February 2020, item 208 on the list of organizational unit subordinate or supervised by the Minister the Maritime Economy and Inland Navigation.



### 3. ANALYSIS OF MARINE CASUALTIES AND INCIDENTS SUBMITTED IN 2019

#### 3.1. Notifications of the casualties and incidents in 2019

In 2019, the Commission was notified of **144** marine casualties and incidents.

Following the initial analysis of the notifications, the Commission considered that:

- in **23** cases the events had not met the criteria of a marine casualty contained in its definition included in art. 2.1.1 of the SMAIC Act.<sup>4</sup>

- in **48** cases the casualties were not investigated due to the provisions of art. 15.2 of the SMAIC Act.<sup>5</sup>

- in **73** cases the Commission initiated further investigation.

#### 3.2. Specification of marine casualties and incidents according to their type

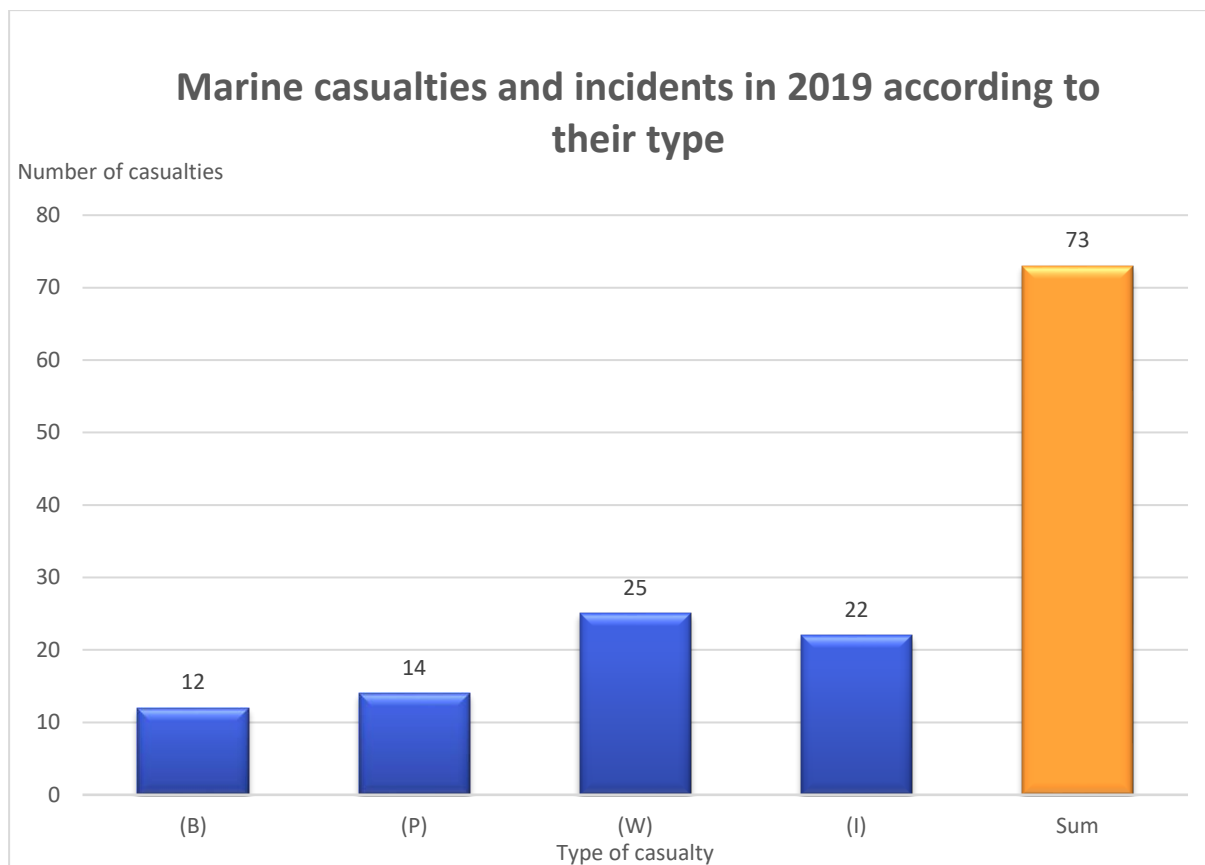
These remaining **73** cases under investigation consisted in:

- **12** very serious casualties (**B**),
- **14** serious casualties (**P**),
- **25** casualties (**W**),
- **22** incidents (**I**).

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<sup>4</sup> The content of the footnote can be found in the Excerpts from the Regulations.

<sup>5</sup> The content of the footnote can be found in the Excerpts from the Regulations



*Figure 1: Specification of a number of marine casualties and incidents with regard to their type in 2019*

### 3.3. Specification of marine casualties and incidents according to ship type and flag

In **12** very serious marine casualties there participated totally **12** vessels **2** of which sank (fishing boat, commercial yacht) and **1** was damaged.

In the marine casualties and incidents under investigation there were involved totally **88** vessels composed of the following:

Merchant vessels:

- **9** general cargo vessels,
- **4** bulk carriers,
- **4** container ships,
- **1** Ro-Ro vessels,
- **1** Ro-Pax vessels,
- **3** chemical carriers,
- **3** tankers
- **13** passenger vessels,

Fishing boats:



- **13** cutters,
- **2** fishing boats,

Yachts:

- **2** commercial sailing yachts,
- **5** recreational sailing yachts,
- **2** commercial motor yachts,
- **2** recreational motor yachts,

Service vessels:

- **8** tugboats or towing units,
- **1** floating crane
- **2** dredgers,
- **10** other service vessels,

Inland vessels:

- **3** inland passengers ships.

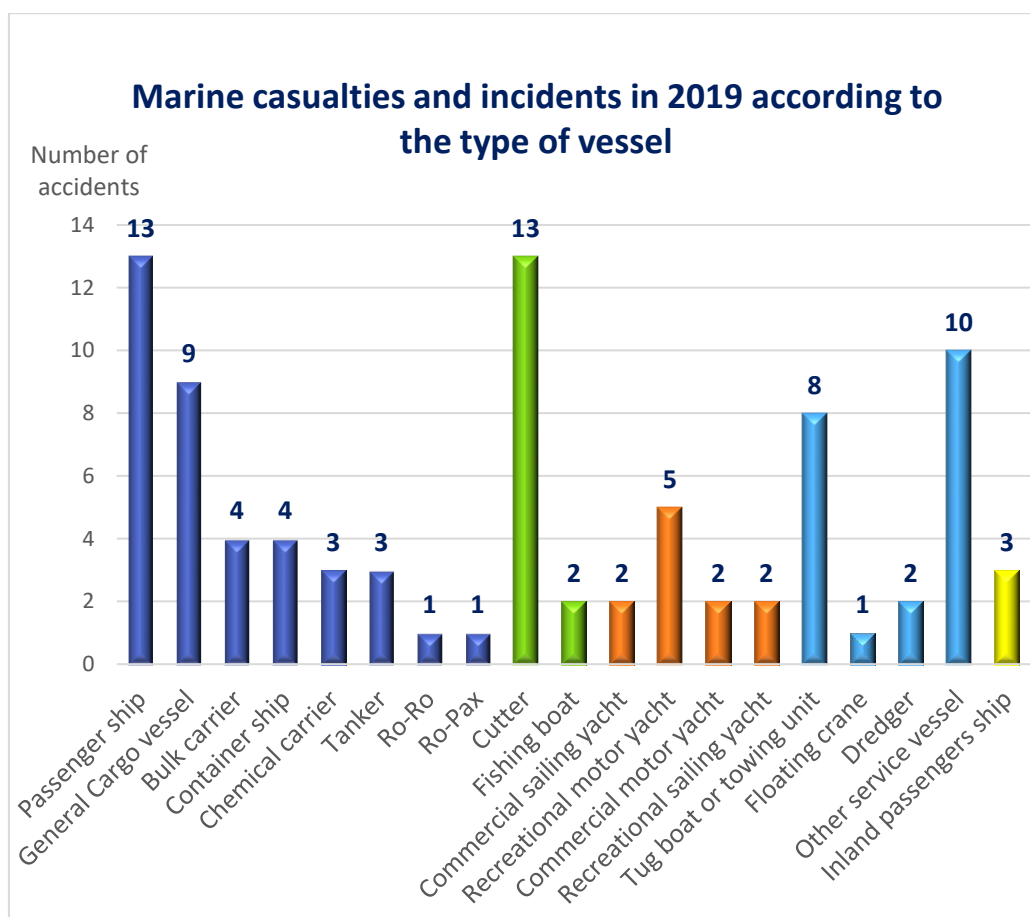
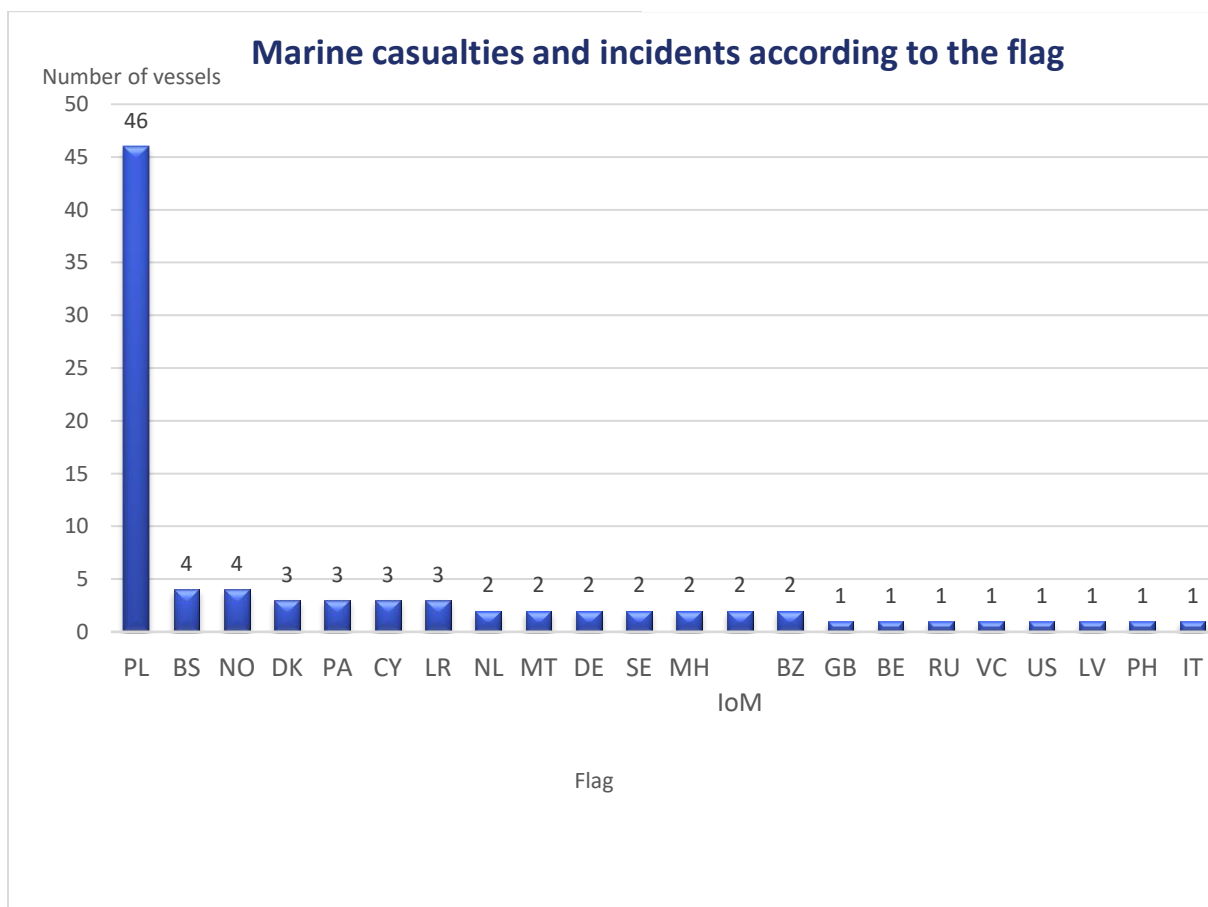


Figure 2: Specification of marine casualties and incidents in 2019 according to the type of vessel

**Specification of 88 vessels according to the flag:**

- **46** vessels under the flag of Poland (PL),
- **4** vessels under the flag of the Commonwealth of the Bahamas (BS),
- **4** vessels under the flag of Norway (NO),
- **3** vessels under the flag of Denmark (DK),
- **3** vessels under the flag of Panama (PA),
- **3** vessels under the flag of Cyprus (CY),
- **3** vessels under the flag of Liberia (LR),
- **2** vessels under the flag of the Netherlands (NL),
- **2** vessels under the flag of Malta (MT),
- **2** vessels under the flag of Germany (DE),
- **2** vessels under the flag of Sweden (SE),
- **2** vessels under the flag of the Marshall Islands (MH),
- **2** vessels under the flag of the Isle of Man (IoM),
- **2** vessels under the flag of Belize (BZ),
- **1** vessel under the flag of Great Britain (GB),
- **1** vessel under the flag of Belgium (BE),
- **1** vessel under the flag of Russia (RU),
- **1** vessel under the flag of St. Vincent (VC),
- **1** vessel under the flag of the SA (US),
- **1** vessel under the flag of Latvia (LV),
- **1** vessel under the flag of the Philippines (PH),
- **1** vessel under the flag of Italy (IT),

*Figure 3: Specification of 88 vessels according to the flag*

### 3.4. Specification of marine casualties and incidents according to human involvement (occupational accidents)

In result of **12** very serious marine casualties **15** people died. All victims were crew members of the vessels.

Generally, in all **73** investigated cases, **31** crew members had accidents.

The extent of the loss of health was different and so:

- **15** persons died,
- **7** persons had serious accidents requiring treatment of more than 3 days (72 hours),
- **9** persons were injured,

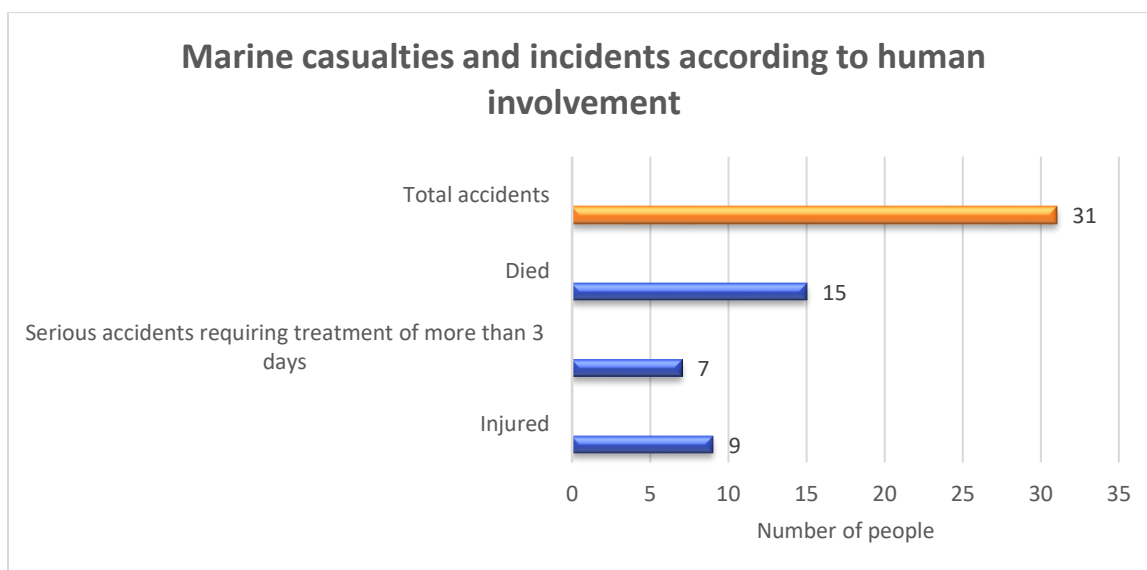


Figure 4: Specification of marine casualties and incidents according to human involvement

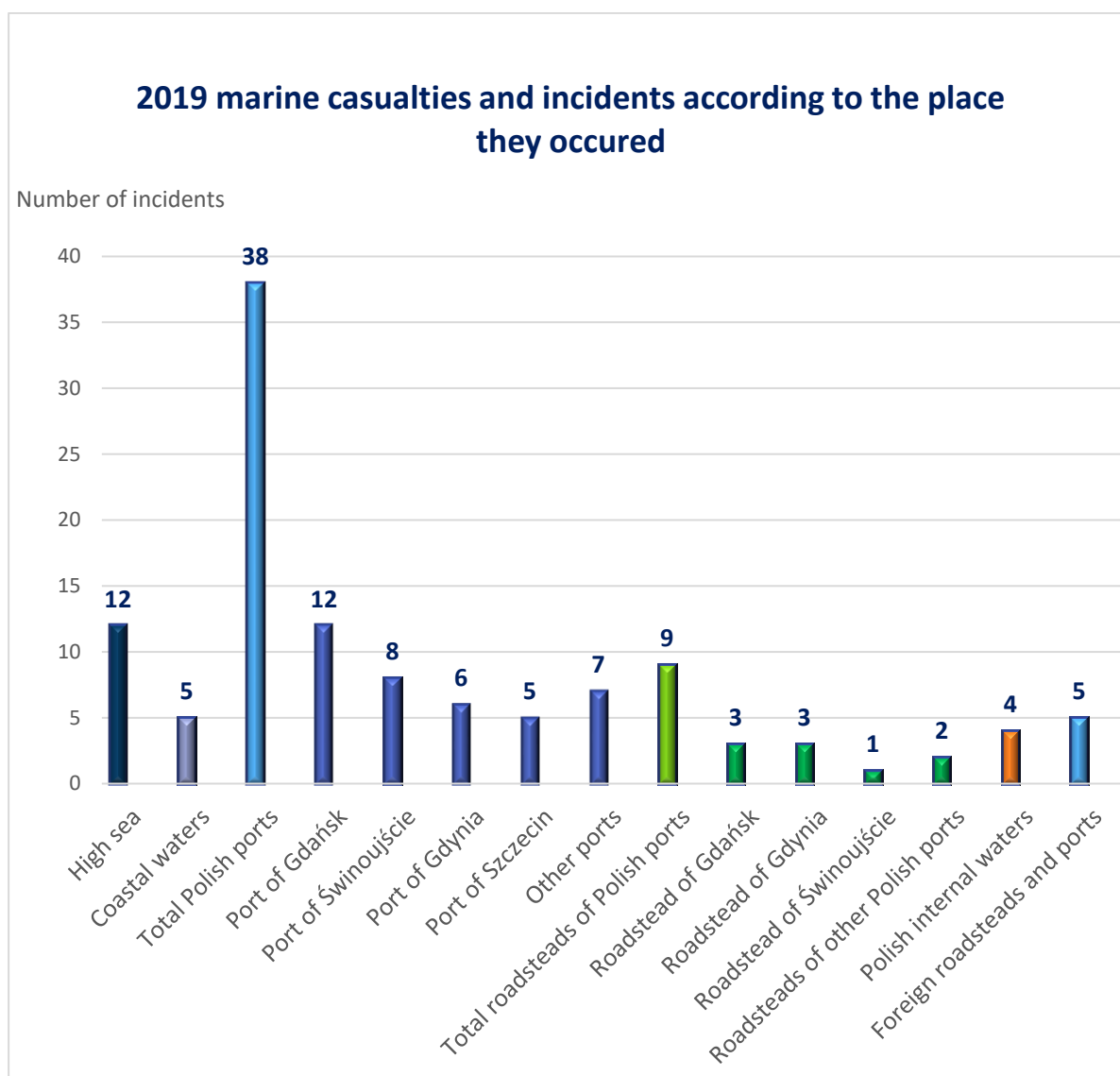
### 3.5. Specification of marine casualties and incidents according to the place they occurred

**73** marine casualties and incidents occurred in the following places::

- **12** at high sea (over 12 Nm from shore)
- **5** at coastal waters,
- **38** in Polish ports:
  - **12** in Gdańsk,
  - **8** in Świnoujście,
  - **6** in Gdynia,
  - **5** in Szczecin,
  - **7** in other ports,



- **9** at roadsteads of Polish ports:
  - **3** at the roadstead of Gdańsk,
  - **3** at the roadstead of Gdynia,
  - **1** at the roadstead of Świnoujście,
  - **2** at the roadstead of other Polish ports,
- **4** at Polish internal waters,
- **5** at foreign roadsteads and ports.



*Figure 5: Specification of marine casualties and incidents according to the place they occurred*



### 3.6. Specification of marine casualties and incidents according to the cause

Of the **73** cases examined, the causes of marine casualties and incidents were the following:

- technical reasons (**20**):
  - **9** engine or ME control failures (main propulsion engine),
  - **3** failures of the steering gear,
  - **1** break of the jack ladder,
  - **1** break of the towline,
  - **1** break of the mooring line,
  - **1** case of protruding screw fixing the fender to the berth,
  - **1** stop of the screw during contact with a floating tire,
  - **1** damaged lighting lamp,
  - **1** leaky valve,
  - **1** technical problem when setting sail
- hydro-meteorological reasons (**2**):
  - **1** case due to hydro-meteorological conditions,
  - **1** wave produced by a vessel passing by too fast.
- human errors (**29**):
  - **17** cases of a lack of caution during maneuvers,
  - **3** lack of attention,
  - **2** cases of navigation errors,
  - **2** unreliable observation from the navigation bridge,
  - **1** bad radar observation,
  - **1** failure to observe safety rules at work
  - **1** pilot's interference in the control,
  - **1** case of falling at the bridge and knocking against an object
  - **1** careless behavior of a bystander,
- **6** cases in which the cause could not be determined,
- **16** cases are undergoing investigation.

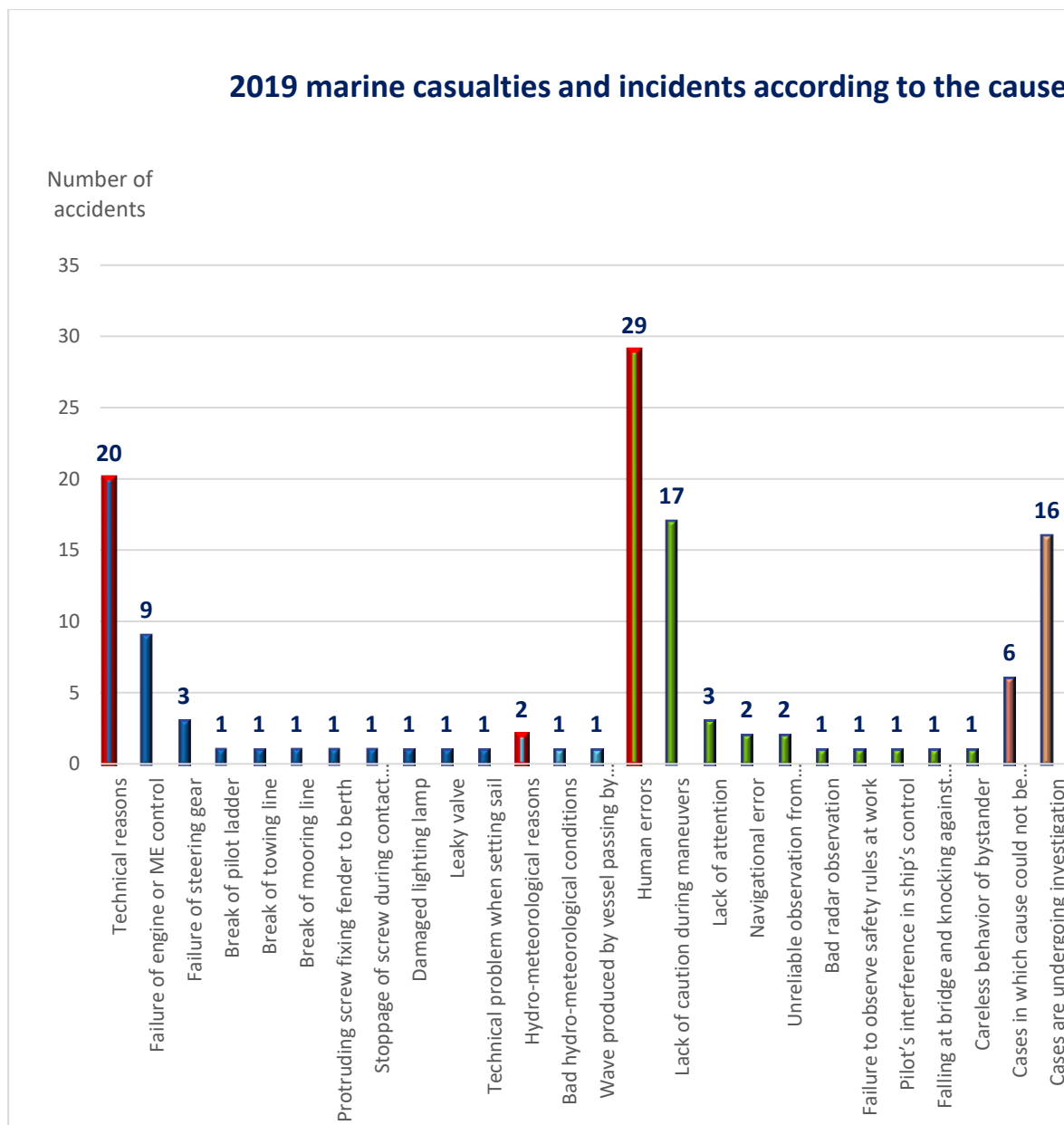


Figure 6: Specification of marine casualties and incidents according to the cause

### 3.7. Assessment of the justification for continuation of investigations

Of the **73** reported in 2019 and initially investigated marine casualties and incidents, after collecting the necessary information and evidence, the Commission adopted resolutions - taking into account the severity of the occurrence, the type of ship or cargo, and the belief that the results of the investigation would not contribute to the prevention of marine casualties and incidents in the future - that:



- in **6** cases, it withdraws from the investigation under way pursuant to Article 20.2<sup>6</sup> of the act on SMAIC,

- in **43** cases, it withdraws from the investigation pursuant to Article 20.3<sup>7</sup> of the act on SMAIC.

The Commission decided that in **24** reported cases an investigation would be conducted.

In consultation with other states substantially interested in the investigation of some of the above-mentioned accidents, the Commission on the basis of art. 21 of the act on SMAIC, has decided that:

- **18** cases of investigation are being conducted independently:

- WIM 3 *Bielik IV*
- WIM 4 *Situla*
- WIM 7 *San Diego*
- WIM 24 *UST-31*
- WIM 28 *PM-WEJ-1891-A*
- WIM 35 *ŚWI-82*
- WIM 39 *KUŻ-102*
- WIM 41 *JAS-57 Magdalena (1)*
- WIM 49 *SXX 6777*
- WIM 54 *Xela*
- WIM 65 *WŁA-184 Helot*
- WIM 72 *JAS-57 Magdalena (2)*
- WIM 89 *Atlant 1 & Barka*
- WIM 123 *KOŁ-212*
- WIM 137 *Sonia*
- WIM 139 *Hunter & Amelia Max*

- **1** case of investigation is being conducted with the participation of a substantially interested state:

- WIM 112 *Lilla W* (Lithuania)

- is joining **5** cases of investigation conducted by other states:

- WIM 8 *EF AWA* (Portugal)
- WIM 32 *MF Gryf* (Commonwealth of the Bahamas)
- WIM 34 *Express 1 & Baltic Condor* (Denmark)
- WIM 40 *Seatruck Progress* (Great Britain)

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<sup>6</sup> The content of the footnote can be found in the Excerpts from the Regulations.

<sup>7</sup> The content of the footnote can be found in the Excerpts from the Regulations.



- WIM 144 *FAST JEF* (Belgium)

#### 4. INVESTIGATION OF ACCIDENTS IN 2019

##### 4.1. Publication of accident investigation reports

The year 2019 was started by the Commission with **14** ongoing investigations of the accidents that had taken place in 2018.

It is necessary to add **24** marine casualties, which occurred in the period of 01.01.2019 - 31.12.2019.

During 2019, the Commission completed investigations of **18** marine casualties and published final reports, including **4** investigations conducted by other states. In the event of a very serious marine casualty of the *KOL-73* fishing boat in the Baltic Sea in August 2018, the Commission published an interim report in August 2019, and then, in November 2019 - the final report.

*Table 1: Publication of reports in 2019*

No	WIM	Vessel	Date	Publishing date	
				Interim report	Final report
Independent investigations					
1.	06/18	m/v City of Rome	29.01.2018	-	January 2019
2.	07/18	Tugboat, Euros	06.02.2018		February 2019
3.	24/17	Tugboat, Ikar & river passenger and car ferry, Siebengebirge	30.04.2017	-	February 2019
4.	96/17	Sailing yacht, Prodigy 2	13.10.2017	-	March 2019
5.	22/18	Fishing boat, HEL-103	14.04.2018	-	April 2019
6.	32/18	m/v Translontano & motor yacht, Hunter	05.03.2018	-	May 2019
7.	45/18	Tugboat, Zeus & pontoon T-6	12.07.2018	-	June 2019
8.	51/18	Sailing yacht, Karukera & motor yacht, Flipper	30.07.2018	-	July 2019
9.	54/18	m/v Skagerak	07.08.2018	-	August 2019
10.	72/18	Fishing boat, KOL-73	26.08.2018	August 2019	November 2019
11.	77/18	m/v Peak Bergen	20.09.2018	-	August 2019
12.	92/18	m/y Miętus & m/v Begonia	04.11.2018	-	November 2019
13.	04/19	m/v Situla	10.01.2019	-	November 2019
14.	07/19	m/v San Diego	19.01.2019	-	December 2019
Investigation conducted by other states					
15.	78/18	m/v Stena Spirit	20.09.2018	-	March 2019
16.	109/18	m/v Seatruck Pace	17.12.2018	-	July 2019
17.	08/19	m/v EF Ava	28.01.2019	-	July 2019



18.	34/19	Catamaran HSC <b>Express 1</b> & m/y <b>Baltic Condor</b>	10.05.2019	-	September 2019
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The Commission has not completed the investigation of **20** accidents that occurred in 2019, of which 17 cases of investigation have been conducted independently, including **1** independent investigation in cooperation with a significantly interested state (Lithuania) and joins the investigation of 3 casualties conducted by other countries (the Commonwealth of the Bahamas, the United Kingdom, Belgium).

#### 4.2. Safety recommendations based on accident investigations completed in 2019

In order to emphasize the educational mission of the SMAIC, the Commission considered that the annual analysis should recall the most serious marine casualties investigated in 2019. The excerpts from the reports including the recommendations aimed at increasing safety of navigation are presented below. For each case in question, a WIM number is provided to facilitate the search of the report on the SMAIC website ([www.pkbwm.gov.pl](http://www.pkbwm.gov.pl)).

##### 4.2.1. WIM 06/18 - m/v *City of Rome*

As a result of the investigation, the Commission has recognized that the main factor that caused the accident was an early release of the tugboat. When making a plan of exit manoeuvres the master with the pilot did not analyse the weather forecast accurately, and the data had been read only from the vessel's gauges at the time when it had berthed at the wharf partially covered by port structures. Failure to take account of the prevailing weather conditions affected planned manoeuvres and the way they were effected.

##### Recommendations resulting from the final report WIM 06/18 – m/v *City of Rome*.

The State Marine Accident Investigation Commission has found it justified to refer safety recommendations, which were proposals for actions that may contribute to the prevention of similar accidents in the future, to the following entities.

##### 1. Pilot Station in Gdańsk

The Commission has recommended that all pilots should recall the contents of the final report of *Horizon Aphrodite* and become acquainted with the final report of the *City of Rome*. At the same time, the Commission reiterated the recommendation contained in the *Horizon Aphrodite* final report – “*The Commission has recommended that pilots should use tugboats and advise the captains to use their assistance until the vessel is pulled away to the roadstead – behind the head of the eastern breakwater to the water region with safe depths (for a given*



*draught of a vessel), taking into account weather conditions during the pilotage and manoeuvrability of a vessel.*“ In addition, the Commission drew attention to the avoidance of unnecessary haste during manoeuvres and negative routine behaviour which causes that not all factors affecting safety of manoeuvres are taken into consideration.

## 2. Maritime Administration

The Commission recommended the director of the Maritime Office in Gdynia to include in the current order of the Maritime Office in Gdynia - Port Regulations, a rule regulating the release of tugboats during unberthing of vessels with a large windage area from the port channel only after the vessel has been moved to the roadstead depending on the existing weather conditions.

### 4.2.2. WIM 07/18 – tugboat, *Euros*

Serious injury of 3 fingers of the right hand of an AB while attempting to secure one of the towing ropes with a canvas protective cuff on the *Euros* tugboat while participating in the towage of *Multibrava* barge. As a result of the investigation, the Commission found that the main reason that caused the accident was the position of the AB's hand on a mooring line that was being eased off.

#### Recommendations resulting from the final report WIM 07/18 - *Euros* tugboat

The State Commission on the Investigation of Maritime Accidents has found it justified to address safety recommendations constituting a proposal of actions that may contribute to preventing a similar accident in the future to the following entities:

#### 1. Owner of the *Euros* tugboat.

Special attention should be paid to communication between crew members working on board tugs, especially the older type ones due to a difficult or impossible observation of crew members working on board by the captain and the engineer operating the elevator. With modern technical capabilities, voice communication devices - which enable fast communication, do not require eye contact, have greater possibilities to convey precise information than gestures - can be (and must be) used. The handset guarantees good communication with the colleagues and partial isolation from external interference. Because the *Euros* tugboat is a small vessel, the use of a wireless voice communication system is not a problem.<sup>8</sup> It is also recommended that the captains of vessels be reminded that seafarers starting work after a break on shore should be

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<sup>8</sup> For example a system of communication between the crew members at work on vessels servicing the drilling rigs.

reminded of health and safety rules, especially when handling mooring lines while the vessel is moving.

#### **4.2.3. WIM 24/17 - tugboat, *Ikar* and car and passenger ferry, *Siebengebirge***

Sinking of a ferry under tow at the North Sea. The *Siebengebirge* ferry was designed and built for navigation on closed waters and internal waters. There were noticeable spots of rust on that 46-year-old vessel. A part of the hull plating was made of 5 mm thick steel, which was adequate to operate the vessel on internal waters. It was not adapted to go out in the high sea. The protection of external openings could only make them splash-proof but it did not prevent water from entering the internal spaces of the ferry through leaks. The reason for capsizing and sinking of the ferry was flooding the watertight compartments at the bow and water coming to the deck in the forebody.

#### Recommendations resulting from the final report WIM 24/17 – *Ikar* tugboat and *Siebengebirge* ferry

The State Marine Accident Investigation Commission has found it justified to refer safety recommendations, which are proposals for actions that may contribute to the prevention of similar accidents in the future, to:

##### **1. The Operator of *Ikar* tugboat**

It is the responsibility of the tugboat operator to prepare instructions for the tugboat master that contain requirements for having the necessary documents before towing. The ship's agent appointed by the operator should have been required to present the regulations binding in the port of Rotterdam related to obtaining permission to start towing. The knowledge of the role of individual entities involved in the process of preparing a towing unit to start the voyage would let them avoid treating the document issued by the subcontractor of the insurance company as a document authorizing the commencement of towage.

#### **4.2.4. WIM 96/17 – sailing yacht, *Prodigy 2***

Sinking of a yacht as a result of breaking the ballast fin in the North Sea. The reason for the sinking of the "Prodigy 2" yacht was the loss of the keel by the yacht.

As a result of the investigation, it was not possible to clearly determine the factors that had a decisive impact on the breaking of the keel during navigation. Based on the received test reports and its own expert opinions, the Commission assumed that a low quality of the laminate

in the production of the keel of the monolithic plating of the hull in the area where the ballast fin is attached, significantly contributed to the detachment of the ballast fin.

Recommendations resulting from the final report WIM 96/17 - sailing yacht, *Prodigy 2*

The State Maritime Accident Investigation Commission has found it reasonable to address safety recommendations, which are proposals for actions that may contribute to preventing similar accidents in the future, to the following entities:

1. Polski Rejestr Statków S.A. (Polish Register of Shipping)

The Commission recommended conducting product certification for compliance with the provisions of the Directive 2013/53/EU based on the essential requirements set out in Annex 1 to that Directive or on the basis of its own classification and construction rules for sea yachts, ensuring that they contain at least the same level of requirements and are periodically verified. In addition, it indicates the need to clearly specify the moment of construction of a vessel from which it is not possible to start PRS supervision to obtain the \* mark in the class symbol.<sup>9</sup>

2. Kalif Yacht Kamila Błazucka

The Commission recommended a detailed analysis of the remarks indicated in this report, especially with regard to applicable regulations to ensure the construction of further yachts in compliance with the requirements.

**4.2.5. WIM 22/18 – fishing boat, *HEL-103***

Sinking of a fishing boat in the fishery in the Bay of Gdańsk while boarding the net with the fish. According to the testimonies of the crew members, the cutter could have a slight tilt, which began to increase rapidly when lifting the last packet of fish. This led to overturning of the vessel, keel up. In order to determine the cause and state of loading of fish causing the cutter to capsize, a stability analysis of the casualty was carried out. The direct reason for capsizing and sinking of the *HEL-103* fishing boat was taking too much fish on the stern deck and maintaining a large trim on the stern.

Recommendations resulting from the final report WIM 22/18 - fishing boat, *HEL-103*

Sinking of a vessel caused by loss of stability is very dynamic and the crews have little time to collect individual life-saving equipment and to prepare rescue equipment such as boats and rafts to launch on water. The way they are attached on the deck and their size should be adapted to the ship's structure and size of the crew so that these activities can be carried out without

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<sup>9</sup> Clause 3.2.1 11. Regulations for Classification and Construction of Sea-going Yachts, Part I Principles of Classification (2012 as amended No 1/2013) issued by PRS Gdańsk.



undue delay and effort of the crew abandoning the vessel. The fishing boat, *Hel-103* was equipped with a 12-person life raft, which was heavy and which the crew (2 people) pushed into the water with great effort. The crew who was on the raft (3 people) was unable to make about 20 m in a heavy raft to reach the crew members staying in water and holding on to the lifebuoy. For the fishing boat's crew of 6 man, the size of the raft could have been decisive for survival in water in other weather conditions and circumstances.

#### 1. Minister competent for maritime economy

In most cases, the insufficient level of general education of the crews of fishing boats makes it difficult for them to fully and correctly read and understand the records contained in the stability information on ships. This makes it impossible to read the calculations correctly and understand the dangers arising from incorrect loading of fish. The situation is similar in other countries where fishing boats are exploited. Based on the Strategic Plan (of cooperation of the Baltic States) for the Baltic Sea Region approved in 2009 by the European Union, the Maritime Administration of Denmark and Finland, using funds allocated for this purpose, commissioned a guidebook on stability issues for small fishing vessels. The assumption in creating<sup>10</sup> the guide was to present issues related to stability in a simple and understandable way for the crews of small fishing vessels. Stability Guide for smaller vessels - Danish Fishermen's Occupational Health Service.

The guide has also been translated into English and has been made available on the Internet.<sup>11</sup> The Commission recommends considering the preparation of provisions to use the abovementioned guide during trainings for the crews of the fishing vessels, as well as compulsory literature on each fishing boat.

#### 2. Inspection units

The Commission recommends that inspection units - PRS and maritime offices - as part of the inspections, carried out the following controls:

##### 2.1. Polish Register of Shipping

The Commission recommends that the inspectors check the correct marking of life-saving equipment on board vessels. At the same time, the Commission recommends that wooden fish boxes on board be dimensioned accurately and their size limit the possibility of transporting too much fish on deck. Information about the dimensions of the box should be included at the

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<sup>10</sup> Stability Guide for smaller vessels –Danish Fishermen's Occupational Health Service.

<sup>11</sup> Translation into Polish language requires former consent of the Danish Fishermen's Occupational Health Service.



beginning of the vessel's stability documentation, so that its size can be easily verified during the inspection.

## 2.2. Maritime Office

The Commission recommends that during the inspections the correct marking of life-saving equipment is checked, and that tests are carried out on the possibility of using the raft, especially in conditions of possible heeling and trimming of a vessel, and whether crew drills are carried out in this respect.

### 4.2.6. WIM 32/18 - m/v *Translontano* and motor yacht, *Hunter*

The collision on the 43rd km of the Szczecin-Świnoujście fairway. It should be assumed that poor organization of the work of the navigation bridge crew on *Translontano* was the main cause of the collision. The watch crew composed of three men on the bridge of *Translontano* was navigating the middle of the fairway, despite the obligation contained in port regulations to navigate on the right side of the fairway.<sup>12</sup> In addition, despite the three-man watch and technical means at their disposal, they not carry on the observation required by regulation 5 of the provisions of the COLREG Convention<sup>72</sup>.

#### Recommendations resulting from the final report WIM 32/18 - m/v *Translontano* and the motor yacht, *Hunter*

The State Maritime Accident Investigation Commission, having become acquainted with the actions taken by the director of the Maritime Office in Szczecin, refrained from making recommendations to him and at the same time found it justified to direct safety recommendations, which are proposals for actions that may contribute to preventing similar accidents in the future, to:

#### 1. The Minister competent for maritime economy

It is recommended that amendments be made to the act of 18 August 2011 on the Safety at Sea<sup>13</sup> or the act of 21 March 1991 on Maritime Areas of the Republic of Poland and Maritime Administration<sup>14</sup> by introducing permission for the harbour master to detain a vessel at port or on at the roadstead in the event of suspected participation in a marine casualty for a period not exceeding 24 hours.

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<sup>12</sup> § 32 of the Port Regulations.

<sup>13</sup> Uniform text in the Journal of Laws: Dz.U.2018 poz.181.

<sup>14</sup> Uniform text in the Journal of Laws: Dz.U.2018 poz.2214.



#### 4.2.7. WIM 45/18 – tugboat, *Zeus* and pontoon, *T-6*

The capsizing of the T-6 pontoon and the loss of excavators transported on its deck in the South Baltic Sea. The casualty could have been caused by the owner of the tug boat, *Zeus* who did not show adequate support for the tugboat master, who due to the lack of clear instructions, exposed to the pressure of a local agent, decided to go to sea with a loaded pontoon that did not meet the requirements of safe towing.

##### Recommendations resulting from the final report WIM 45/18 – tugboat, *Zeus* and pontoon, *T-6*

###### 1. Zakład Usług Żeglugowych Sp. z o.o. & Co. Sp. K

The State Marine Accident Investigation Commission recommended that there be created procedures describing the principles of cooperation and information exchange between the ship owner (especially the Operations Department) and vessels (tugboats) performing services for the ship owner's clients.

These procedures should include a catalogue of activities for which the ship owner is responsible due to the implementation of contracts serviced by designated tugboats. This applies, among others, to extracts from the terms of contracts signed by the ship owner with a chosen client, instructions for masters for a given voyage, the absolute obligation to help masters awaiting additional information and instructions, providing them with adequate communication facilities on the operated vessels enabling constant contact with the ship owner's office, control of the performance of duties imposed on the masters of vessels, organization of towage, taking into account the recommendations contained in the IMO MSC/Circ.884 Circular. As part of the recommended procedures, each time an instruction should be prepared for the master of the vessel, containing, among other things, an extract from the signed contract and the resulting responsibilities for the master. It should be required to create a voyage plan which is mistaken for a towing plan, as well as a cargo restraint plan<sup>15</sup> on the vessel under tow. Each time the master must be notified of the documents he should possess to start the towage, regardless of his autonomous decision about going out to sea with an object under tow. A copy of the IMO MSC/Circ.884 Circular should be sent to the vessels in service and masters should be obliged to become acquainted with it. Tugboats should be equipped with appropriate photographic equipment that allows taking photographs, even in difficult weather conditions to secure photographic documentation of the objects under tow.

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<sup>15</sup> IMO MSC. 884 Resolution, Chapter 13.



## 2. UAB Topada – the Owner of the T-6 pontoon

The State Marine Accident Investigation Commission recommended that the provisions of signed contracts be implemented correctly and reliably, especially when they concern maritime safety. Misleading the parties to the contract that could result in a risk to the safety of shipping should not take place when executing a commercial contract.

### 4.2.8. WIM 51/18 – sailing yacht, *Karukera* and motor yacht, *Flipper*

The collision of yachts in the Adriatic Sea.

Recommendations resulting from the final report WIM 51/18 - *Karukera* sailing yacht and *Flipper* motor yacht

The State Marine Accident Investigation Commission, following the investigation of the collision of *Karukera* and *Flipper* yachts, recognized that the cause of the casualty was mainly the lack of continuous visual observation on both vessels. Especially on *Flipper* sailing at a high speed, nearly 7 times faster than *Karukera*, visual observation should be carried out continuously and with special attention. A few years ago, one of the experienced inspectors of the MAIB (British Marine Accident Investigation Branch) stated that over the period of ten years when collisions of vessels had been investigated, in 43% of cases the navigating bridge crew had not seen the vessels opposite, or had noticed them too late.<sup>16</sup> Similarly, the lack of observation led to a collision of vessels in two cases investigated by SMAIC in 2018 (*Translontano & Hunter* as well as *Begonia S & Miętus II*). The State Marine Accident Investigation Commission directs the content of the prepared report to a wider sailing environment, so that it becomes an incentive for discussion and introduction of such a watch organization that would ensure careful observation around the yacht by a designated crew member.

### 4.2.9. WIM 54/18 - m/v *Skagerak*

Bumping of the vessel's bow against the Odstawcze wharf at the B-1 slipway during mooring manoeuvres in Gdańsk at the "Nauta" Repair Shipyard. The casualty could have been caused by a lack of sufficient experience in operating specific steering and propulsion systems which are installed on the B871 vessel and a lack of practiced procedures for the use of

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<sup>16</sup> Source: David Patraiko FNI, All available means -The Navigator, Issue no. 19, (October 2018) The Nautical Institute.



spare/alternative systems of control of the helm and main propulsion. This applies to both the master of the vessel and the assisting ship's crew and the shipbuilding crew.

Recommendations resulting from the final report WIM 54/18 - m/v *Skagerak*

1. Stocznia Remontowa „Nauta” S.A. (“Nauta” Repair Shipyard)

The shipyard is an employer of crews mustered on ships for the period of shipbuilding trials and manoeuvres until the vessel is transferred to the buyer. The Commission recommended, as part of the corrective actions resulting from the implemented ISO 9001:2015 quality management system, to review the training of the marine staff and rules for familiarizing shipyard crews with the service, including emergency skills on vessels being repaired or under construction. In addition, the Commission recommended to comply applicable shipping safety regulations, with particular regard to port regulations.

2. Pilot station in Gdańsk

The Harbor Master of Gdańsk at the request of Stocznia Remontowa Nauta S.A. presented the conditions that must be met for *Skagerak* to enter the port of Gdańsk. Pilot Station in Gdańsk received a copy of the letter sent to Stocznia Remontowa Nauta S.A. One of the conditions was that the port should be entered during the daytime. The State Marine Accident Investigation Commission recommended Pilot Station in Gdańsk to take into account the conditions presented by the Harbour Master and to notify the master of a vessel requesting the pilot service of the need to obtain the Harbour Master's consent for a deviation from the provided conditions of the ship's entry into the port.

**4.2.10. WIM 77/18 - m/v *Peak Bergen***

The vessel run aground at the port of Świnoujście. The Commission considered that improper accomplishment of the voyage plan had had a decisive impact on *Peak Bergen* stranding. Both the master of the vessel and the officers had not carried out a detailed analysis of threats and navigational hazards on the route.

Recommendations resulting from the final report WIM 77/18 - m/v *Peak Bergen*

The State Marine Accident Investigation Commission found it reasonable to address safety recommendations, which are proposals for actions that may contribute to preventing similar accidents in the future, to the following entities:

1. The operator

The Commission recommended the operator of *Peak Bergen* to send the report to the vessels of its fleet as an example of non-compliance with the guidelines of the SOLAS Convention and



IMO Resolution A.893(21), which relate to proper planning of the voyage. The presented report may be one of the topics to be discussed at the safety meeting.

## 2. Maritime Office in Szczecin

The Commission proposed to analyze the changes made to the port regulations regarding the length of vessels exempted from the pilotage. The task of the analysis would be to assess the risk of berthing and unberthing of a vessel, taking into account the maneuverability of vessels and the nature of the water region. Along the Świna River there are many port basins where manoeuvring requires practical experience and knowledge of local conditions. Changing nature of the current related to weather conditions causes significant difficulties for vessels maneuvering in the port. The Atlantic Basin in the port of Świnoujście is one of the most difficult water regions requiring experience in performing manoeuvres.

### 4.2.11. IM 92/18 - m / y *Miętus* and m / v *Begonia S*

Collision of ships on the Baltic Sea. By analyzing the collected information, the Commission was not able to assess why the yacht's echo had not been detected on the radar screen despite the fact that both radars were technically able to do so. The reason could be wrong settings of radar operating parameters removing weaker echoes, conducting occasional radar observation or assuming that all units have AIS installed. When conducting other accident investigations, the Commission noted that since the AIS equipment had been installed on vessels, the quality of radar observations carried out by watch officers had decreased.

#### Recommendations resulting from the final report WIM 92/18 - m/y *Miętus* and m/v *Begonia S*

The State Marine Accident Investigation Commission found it reasonable to address safety recommendations, which are proposals for actions that may contribute to preventing similar accidents in the future, to the operators of both vessels:

#### 1. The operator of *Begonia S*

- it is recommended that this report be forwarded to the crews of other vessels of the operator to get familiarized and discuss them at crew safety meetings; - it is recommended that the operator ensure proper watch keeping and observation on their vessels, especially at night, - it is recommended that the operator ensure that the watchkeepers' instructions are properly followed by watch keeping officers during watch keeping, - the operator is recommended to provide regular drills and training for the crew related to the emergency situations.

#### 2. The operator of the yacht, *Miętus II*

- it is recommended to forward this report to the crew of the other vessel of the operator to draw attention to the importance of taking appropriate security measures with respect to groups



of anglers on board, in port and at sea, - it is recommended that the operator review the watch keeping procedures to ensure that the watchman substituting the master has appropriate competence and certificate to comply with provisions on the prevention of collisions at sea.

### 3. The Minister competent for maritime economy

To improve the detectability of fishing boats and commercial yachts at night (the collision of the commercial yacht *Miętus II* with *Begonia S*) or during low visibility (the collision of the Polish yacht, *Baltic Condor* with Danish vessel, *HSC Express 1*), enabling SAR services to detect a vessel and provide quick assistance (sinking of *ŚWI 82*), as well as establishing the actual route of a vessel for the purpose of investigations carried out by appropriate organs, the Commission recommended to make the automatic identification system (AIS) mandatory on board these vessels.

### 4. President of the Office of Electronic Communications

In order to ensure that SRC certificate holders acquire necessary skills to call for assistance effectively using any electronic equipment available on board, the Commission recommended to analyze training programs and scope of the examination to obtain the SRC certificate and take appropriate actions.

#### **4.2.12. WIM 72/18 – fishing boat, *KOL-73***

Loss of stability and sinking when fishing in the Baltic Sea. Based on the analysis of stability states, the Commission was unable to clearly determine the cause of the loss of stability and sinking of the *KOL-73* fishing boat, while the loss of significant weight in the underwater part or the lack of ballast as a reason for loss of stability and sinking is reflected in the stability calculations.

#### Recommendations resulting from the final report WIM 72/18 - fishing boat, *KOL-73*

The State Marine Accident Investigation Commission found it reasonable to address safety recommendations, which are proposals for actions that may contribute to preventing similar accidents in the future, to the following entities:

#### 1. The Minister competent for maritime economy

Recognizing that monitoring the drift of a sinking vessel and issuing appropriate warnings is necessary to ensure navigation safety, location of the wreck of the vessel is necessary to ensure navigation safety, protect the fishing gear from damage and counteract the effects of marine pollution during the release of pollutants from the wreck, the Commission recommended to develop, together with the Minister of National Defense and the Minister responsible for internal affairs, the procedures for subordinate bodies or services regarding

monitoring, warning of drifting objects and determining the location of sinking vessels and parameters for safe navigation in this area.<sup>17</sup>

#### **4.2.13. WIM 04/19 - m/v *Situla***

Disappearance of a crew member in the Baltic Sea. In the conducted investigation the Commission found no grounds for the recognition of that event as a consequence of human error or omission. Based on the crew's testimonies, it can be presumed that the missing person could have fallen into depression due to length of the voyage and family problems. No evidence was found that would indicate suicidal death, while no third parties were identified that could have caused the disappearance of the able seaman.

##### Recommendations resulting from the final report WIM 04/19 - m/v *Situla*

Analyzing the material collected in the course of investigation, there were found no information unequivocally indicating the reason for the disappearance of the AB on the *Situla* vessel. However, the State Marine Accident Investigation Commission found it reasonable to address safety recommendations, which were proposals for actions that may contribute to preventing similar accidents in the future, to the following entities:

##### **1. The Minister competent for maritime economy**

The Commission proposed to consider introducing changes to the training framework for providing medical care to patients. The changes would consist in extending the training program with additional topics related to mental illness of seafarers. The knowledge acquired during such training would be useful for diagnosing depressive conditions and, consequently, for providing immediate help to the patient.

##### **2. The operator**

The Commission proposes that the operator considers equipping crew members working on board with Personal Locator Beacons (PLB). The use of this type of equipment will shorten the search and rescue action due to the exact location of a missing person, which will result in a greater likelihood of finding that person.

#### **4.2.14. WIM 07/19 - m/v *San Diego***

Falling of a seafarer on deck of the pusher, *Nosorożec* as a result of breaking of the pilot ladder fastened to the vessel, m/v *San Diego* in the Bay of Gdańsk. Considering the way and conditions in which most pilot ladders are used on vessels, the Commission believes that the

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<sup>17</sup> Appropriate actions in this respect are described in the report of the Commission:  
<http://pkbwm.gov.pl/images/Raporty/Raport-Kocowy-Prodigy-2-WIM-96-17.pdf>



lack of testing of their strength in accordance with ISO 799:2014 standard after 30 months in operation causes excessive risk for pilots providing pilot services.

Recommendations resulting from the final report WIM 07/19 - m/v *San Diego*

Despite the provisions contained in the SOLAS Convention, the ISO 799:2004 standard specifying the conditions to be met by pilot ladders and the manner of their use, accidents involving pilots during pilot service, constitute a significant position in the marine casualties statistics. They are very dangerous for the lives of pilots, because they often end in severe injuries, as well as death. Therefore, the State Marine Accident Investigation Commission made recommendations to:

1. Żegluga Gdańska Sp. z o. o.

The Commission recommended to check the state of wear and tear of all pilot ladders used on vessels of the Żegluga Gdańska Sp. z o. o. and the way they are attached to appropriate places on board of their vessels. Such inspections should be carried out periodically with a frequency specified by the Żegluga Gdańska Sp. z o. o. The Commission has recommended to carry out on board of Żegluga Gdańska Sp. z o. o. vessels, safety meetings for familiarization with this report and the requirements contained in the Regulation V/23 of the SOLAS Convention and related IMO resolutions.

2. Pilot Station in Gdańsk

A pilot boarding a vessel, especially from a vessel other than a pilot boat, should pay special attention to the possibilities of safe boarding, including the correct setting of the height of the prepared pilot ladder. Any rush in assessing the safe positioning of the pilot ladder poses a threat to the pilot entering that ladder. The Commission has recommended that the content of the prepared report be made available to pilots performing pilot services at the Pilot Station in Gdańsk in order to indicate the risk that may result from improper installation of the pilot ladder.

3. The Minister competent for maritime economy

the State Marine Accident Investigation Commission has proposed to apply to the Polish Committee for Standardization<sup>18</sup> for recognition by Poland of the ISO 799-1:2019 standard.<sup>19</sup>

Its recognition will harmonize the requirements that must be met by producers of pilot ladders during their production, classification societies and maritime administration when inspecting vessels, shipowners and crews during operation and maintenance of pilot ladders.

4. Director of the Maritime Office in Gdynia

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<sup>18</sup> Chairman of the Technical Committee No 18.

<sup>19</sup> The standard ISO 799-1:2019: Ships and marine technology -Pilot ladders -Part 1: Design and specification was published in February 2019 replacing the withdrawn ISO 799:2004 standard.



The State Marine Accident Investigation Commission has noted the lack of identification of the entity responsible for ensuring safe transport of pilots during the provision of pilot services. Port regulations<sup>20</sup> in chapter III specify the requirements for safe transport of pilots (§39) but they do not indicate the entity responsible for this transport. It is presumed that this obligation is imposed on pilot stations but it does not result from the regulations of the pilot station operation<sup>21</sup> or the provisions of the Act of 18 September 2001 – the Maritime Code. The Commission has recommended that the question of determining the entity responsible for the safe transport of pilots should be regulated by proposing appropriate additions to the regulations of pilot stations.

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<sup>20</sup> Order No 9 of the Director of the Maritime Office in Gdynia of 16 July 2018.

<sup>21</sup> Annex No 1 to the order No 12 of the Director of the Maritime Office in Gdynia of 20 August 2015.



**4.3 Specification of recommendations of the Commission sent to appropriate entities in the period of 01.07. 2018 to 30.06.2019 and their responses** *Table 2.*

No	WIM No	Vessel's name	Report publication date	Addressee of the recommendations	Report dispatch date	Deadline for the response	Response reception date	Fulfillment of recommendations
1	84/17	Kamelia	August 2018	Ship's Operator	10.09.2018	10.04.2019	28.06.2019	Yes
2	108/17	Vagant	November 2018	SAR	11.12.2018	11.06.2019	03.06.2019	In progress
				Minister competent for maritime economy	11.12.2018	11.06.2019	05.06.2019	Yes
				Office of Electronic Communications (UKE)	11.12.2018	11.06.2019	06.06.2019	Yes
				Minister of Sport and Tourism	11.12.2018	11.06.2019	5.03.2019	Yes
3	63/17	Selfoss	December 2018	Minister competent for maritime economy	18.12.2018	18.06.2019	28.06.2019	Yes
				OT Port Świnoujście	18.12.2018	18.06.2019	28.03.2019	Yes
				Selfoss Operator	15.02.2019	15.08.2019	No response despite reminders	No
4	06/18	City of Rome	January 2019	Pilot Station in Gdańsk	07.01.2019	07.07.2019	15.02.2019	Yes



				Maritime administration – Gdynia local authority	07.01.2019	07.07.2019	2019.07.15	No
5	7/18	Holownik Euros	February 2019	Fairplay Towage	12.02.2019	12.08.2019	08.07.2019	No
6	24/17	Holownik Ikar i prom Siebengebirge	February 2019	Operator of the tugboat, Ikar	27.02.2019	27.08.2019	04.10.2019	No
7	96/17	Prodigy 2	March 2019	Polish Register of Shipping	20.03.2019	20.09.2019	26.09.2019	No
				Klif Yacht Kamila Błazucka	20.03.2019	20.09.2019	02.10.2019	Yes
8	22/18	Hel - 103	April 2019	Minister competent for maritime economy	01.04.2019	01.10.2019	18.10.2019	Yes
				Polish Register of Shipping	08.04.2019	08.10.2019	27.11.2019	Yes
				Maritime Office in Gdynia	08.04.2019	08.10.2019	29.11.2019	Yes
9	32/18	Translontano & Hunter	May 2019	Minister competent for maritime economy	30.05.2019	30.11.2019	19.11.2019	Yes
10	45/18	Zeus & Ponton T-6	June 2019	Zakład Usług Żeglugowych Sp. z o.o. & Co. Sp. k	21.06.2019	21.12.2019	07.02.2020	Yes
				UAB Topada - Lithuania	21.08.2019	21.12.2019	The company closed down	No



## 5. EARLY ALERT

In 2019 the Commission did not publish any early alerts.

## 6. COOPERATION WITH OTHER ENTITIES

It should be noted that in 2019 the Commission was working intensively with casualty investigation organizations in other countries.

It concerned the exchange of experience during international meetings:

MAIIF - 13-19.10.2019 (Naples, Italy) - Chairman and Secretary,

EMAIF - 13-14.05.2019. (Ljubljana, Slovenia) - Chairman and Secretary,

EMSA (PCF) - 12-13.06.2019 (Lisbon, Portugal) – Chairman and Secretary,

IMO (III Subcommittee) - 1-5.07.2019 (London, UK) – Chairman.

When investigating **1** accident in 2019 The Commission established cooperation with the administration of Lithuania in whose waters there occurred the accident (WIM 112/19) of the commercial sailing yacht **LILLA W** under the Polish flag. The yacht turned over at the entrance to the port of Klaipeda, in very bad weather and high tide, and ran aground, turned overboard. Lithuanian services saved 5 people, one person died, one person was found missing. The crew of the yacht was of Polish nationality.

When investigating **5** accidents in 2019 by other countries, the Commission joined the investigations as a substantially interested state (SIS):

**WIM 08/19** a container ship **EF AVA** under the flag of the Marshall Islands, death of the master, a Polish citizen, during watch keeping on the bridge in bad weather. The investigation was conducted by the Portuguese Marine Accident Investigation Commission.

**WIM 32/19 GRYF** ferry under the flag of the Commonwealth of The Bahamas, fatal accident involving a crew member, a Polish citizen during the ferry stop at the marina in Świnoujście. The investigation conducted by the Department of Marine Accident Investigation of the Commonwealth of The Bahamas.

**WIM 34/19** collision of the **HSC Express 1** catamaran under the Danish flag with the **Baltic Condor** motor yacht under the Polish flag. The investigation conducted by the Danish Marine Accident Investigation Commission (DMAIB).

**WIM 40/19** Ro-Ro vessel **Seatruck Progress** under the flag of the Isle of Man. Death of the master on board, Polish citizen. The investigation conducted by the British Marine Accident Investigation Board (MAIB).



**WIM 144/19** the **FAST JEF** vessel under the Belgian flag. The vessel ran aground when leaving the port of Ueckermuende, Germany. The investigation conducted by Belgian Marine Accident Investigation Commission (FeBIMA)

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## 9. EXCERPTS FROM REGULATIONS

**The act of 31 August 2012 on State Marine Accident Investigation Commission (Journal of Laws: Dz. U. of 2019 item 1374)**

Footnote [5]

Art. 2

1. Whenever the act mentions:

- 1) a marine casualty – it should be understood as an event, or a sequence of events directly related to the operation of the vessel, in which the following occurred:
  - a) death or serious injury to human health, or
  - b) loss of a man stationed on a vessel, or
  - c) sinking, loss of, or loss of the vessel in a different way, or
  - d) damage to the vessel, affecting to a large extent its design, maneuverability, or operational ability, requiring major repairs, or



- e) vessel's grounding, contact with the bottom, hitting an underwater obstacle, the immobilization of the vessel or the collision of vessels, fire, explosion, impact on the structure, device or installation, shifting of cargo, damage caused as a result of unfavourable weather conditions, damage by ice, cracking the hull or suspected damage to the hull, or
- f) significant damage caused by the vessel to the port infrastructure, infrastructure providing access to ports or harbours, installations or structures on the sea, causing a serious threat to the safety of the vessel, other vessels or persons, or
- g) harm to the environment or danger of causing such harm by the vessel
  - however, a marine casualty shall not be considered a conscious act or omission taken with the intent to breach the security of the vessel, causing personal injury or damage to the environment;

Footnote [6]

### **Art. 15**

2. The Commission shall not investigate marine casualties and incidents:

1) involving exclusively:

- a) vessels of the Navy, Coastguard or Police,
- b) vessels without mechanical propeller or wooden vessels of simple construction;

2) involving exclusively:

- a) other vessels than those referred to in point 1 letter a, vessels performing only a special state duty or operated by the State for non-commercial purposes,
- b) fishing vessels of an overall length of 15 m,
- c) recreational yachts - with the exception of very serious casualties;
- d) vessels and floating objects forming a towing unit other than the vessel having in tow
  - except for very serious marine casualty;

3) on fixed offshore platforms, in which the sea-going vessels have not participated.

Footnote [7]

### **Art. 20**

2. Following initial assessment of the causes of a serious marine casualty the Commission may decide to renounce the investigation.



Footnote [8]

**Art. 20.**

3. In the event of an accident other than a casualty, referred to in paragraph 1, or a marine incident, the Commission shall decide either to undertake the investigation or to withdraw from it.

Footnote [9]

**Art. 21**

1. The Commission shall carry out the investigation of a marine casualty or incident individually.

2. The Commission may:

- 1) transfer the management of the investigation of a marine casualty or incident to a state other than the Republic of Poland which is substantially interested in a marine casualty or incident;
- 2) allow to participate in the investigation of a marine casualty or incident another state than the Republic of Poland significantly interested in a marine casualty or incident;
- 3) join in the investigation of a marine casualty or incident conducted by another state than the Republic of Poland substantially interested in a marine casualty or incident.

3. A state substantially interested in a marine casualty or incident, hereinafter referred to as a “substantially interested state” shall be deemed a state:

- 1) of the flag of a vessel involved in a marine casualty or incident, or
- 2) a coast, in whose internal waters or territorial sea a marine casualty or incident has occurred, or
- 3) whose natural environment, including water and territory, under the jurisdiction of that state, suffered a major damage as a result of a marine casualty, or
- 4) which in regard to artificial islands, installations and structures under the jurisdiction of that state, has suffered damage as a result of a marine casualty or incident, or injury, or prospective injury, or
- 5) whose citizens suffered death or a serious injury as a result of a marine casualty, or
- 6) possessing relevant information, which the Commission considered useful in the investigation of the causes of a marine casualty or incident, or
- 7) which is otherwise interested in the investigation of a marine casualty or incident and considered essential by the Commission.