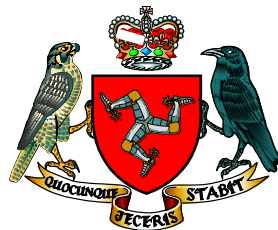




Annual Summary of Casualties, Accidents and Incidents on Isle of Man Registered Vessels

2025

**Isle of Man Government
Department for Enterprise**



**Isle of Man
Government**

Reiltys Ellan Vannin



Executive Summary

- There were 53 Incidents, 15 Accidents and 5 Casualty Reports in 2025
- The most common occurrences in 2025 were personal injury and machinery / equipment failures
- Mooring operations were the most common activity reported on the ARF forms
- There was 1 fatality, 10 serious injuries and 21 minor injuries reported in 2025
- Times of no activity and manoeuvring operations presented the most dangerous periods for seafarers
- The most common root cause were procedural and operational factors and human factors
- The most common causes identified for each causal factor were:
 - Workplace and Ergonomic Factors – Slippery, uneven floors and Awkward/Inaccessible equipment
 - Procedural & Operational Factors – Failure to comply with safe working practices
 - Management Systems Factors – Inadequate Processes and Inadequate supplies of spares or equipment
 - Machinery & Equipment Factors – Machinery/Equipment breakdown, Electrical installation failures/inadequacy
 - Human Factors – Poor judgement and decision making, Unsafe acts and negligence
 - External Factors – Navigational hazards and tides/currents

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Chapter 1 Introduction

The Isle of Man Ship Registry’s 2025 Casualty Summary report provides statistics and analyses the trends identified from the Accident Report Forms (ARF) submitted to the registry over the course of 2025. We hope providing this data will help to reduce similar accidents in the future. All identifying information has been removed to respect the confidentiality of our clients and seafarers.

This report does not include statistics relating to fatalities or injuries from natural causes or suicide unless they are directly related to an ‘occurrence’ on board.

An ‘occurrence’ is either a **casualty, accident** or an **incident** as defined in the Merchant Shipping Accident Reporting and Investigation Regulations ([SD815/01](#)), with casualty being the most severe type of occurrence. In some areas of this report, the classification ‘Fatality’ is used where a casualty occurrence has resulted in death. These occurrences are still casualties under SD815/01 but the distinction is made to highlight the severity of the occurrence.

In this report, a “**serious injury**” means an injury 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 the injury was suffered. A “**minor injury**” means any lesser injury that is not a serious injury.

It should be noted that the definition of ‘incident’ includes all occurrences that if not prevented would have endangered the safety of the ship, its’ occupants or the environment (near-misses). The IOMSR notes that the reporting of near-misses across the fleet varies by company and sector, this can create distortions within the reported data and make it appear as if particular sectors generally have a lower safety profile than others. The IOMSR generally considers that where this may appear to be the case in the following data that it is generally not due to an elevated risk present within that sector but rather created by effective reporting practices from that particular sector. Near-misses have value from a reporting perspective as lessons learned from them can still be used to prevent other more significant accidents, all operators are therefore reminded of the importance of implementing a ‘no-blame’ culture and reporting near-misses when they occur.

Companies are further reminded that [MSN 003](#) requires reporting of all Marine Incidents to IOMSR, which includes ‘high potential near misses’, where an event had significant potential to become a marine casualty or accident but did not. For example, swift intervention by the crew prevented a grounding or a tool dropped from a height avoided hitting a crew member by luck.

Chapter 2 Investigations

All reports received that are “Very Serious Marine Casualties” as defined by the IMO Casualty Investigation Code are investigated and have a report published.

For all other reports received, a decision is made by the Isle of Man Ship registry as to whether an investigation is required or not. Any reports published are available on the IOMSR website.

2.1 Investigations of incidents that took place by IOMSR in 2025

Type of Ship	Nature of Investigation
None	

2.2 VSMC Safety Investigations conducted by UK MAIB for IOM in 2025

Name of Ship	Type of Ship	Nature of Investigation
World Prize	Bulk Carrier	Man overboard

2.3 Reports Published by IOMSR in 2025

Ship Name	Type of Ship	Nature of Investigation
Berge Mawson	Bulk Carrier	Enclosed Space Entry Fatality
World Prize	Bulk Carrier	Man Overboard

2.4 Investigations on IOM Vessels by other investigation bodies in 2025

Type of Ship	Nature of Investigation	Investigation Authority
None		

Chapter 3 ARF Reports Received in 2025

3.1 Reports from Isle of Man Registered Ships

In 2025, the Isle of Man Ship Registry received 73 ARF reports from Manx ships, 1 report was received from a foreign flagged vessels in Manx waters over the period, this report relates to a passenger incident and not operational practices so has been disregarded from further analysis. The graph below shows the number of reported occurrences by vessel type in 2025.

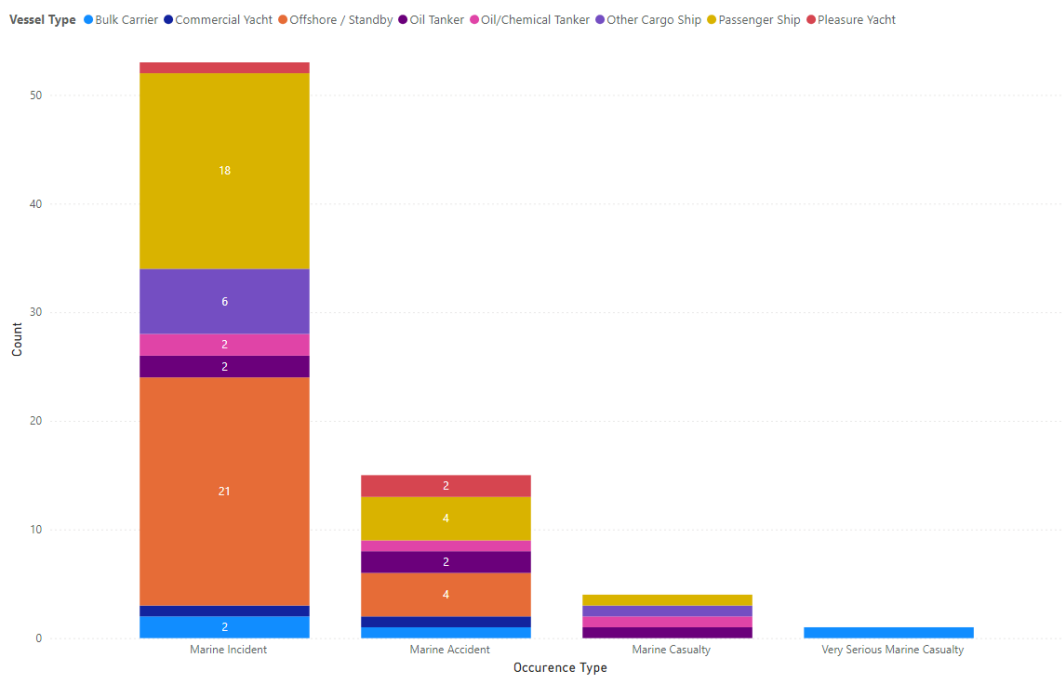


Figure 1 – ARF reports received in 2025 by vessel type

17 ARF reports were received relating to pollution and spills, 14 of these were related to minor leaks (<2ltr) of oil or other fluid to sea. These have been disregarded from further analysis to allow trends pertaining to safety to be highlighted without bias from these reports.

Chapter 4 Analysis of ARF Reports Received in 2025

The most common occurrences reported to the Isle of Man in 2025 were Personnel Injury, Machinery/Equipment Failure and Collision/contact (fig.2).

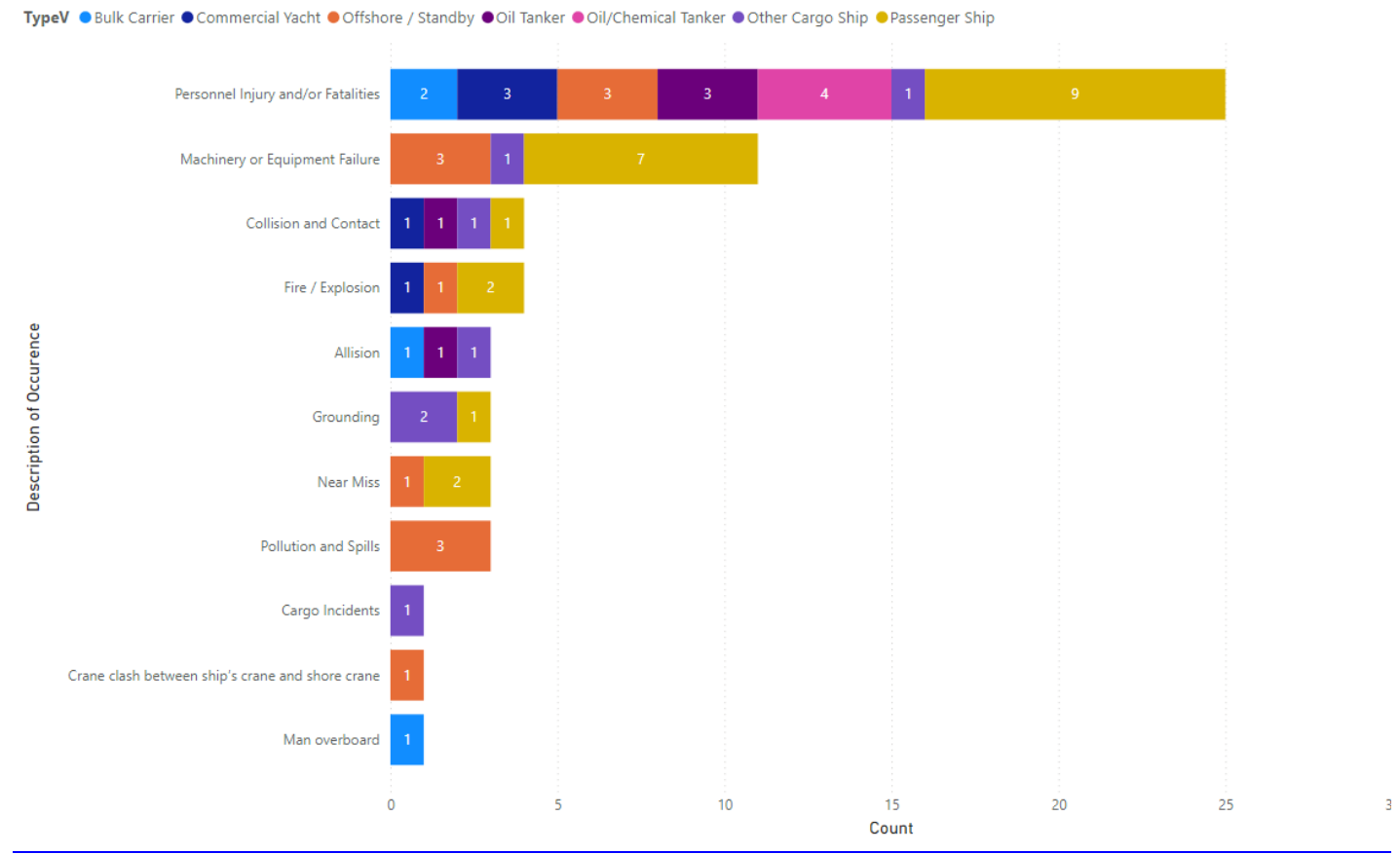


Figure 2 - ARF Occurrence by Ship Type

In 2025, the most frequently reported occurrence to the Ship Registry was personal injury. While the Ship Registry continues to emphasise the importance of undertaking comprehensive risk assessments and establishing clear plans of work before commencing any task, many of the injuries reported during the year appear to have resulted from momentary lapses in judgement, or a failure to follow standard procedures.

Shipowners are encouraged to ensure that all personnel receive appropriate guidance on fatigue, its potential effects on performance and decision-making, and the importance of remaining vigilant when moving around the vessel, including during periods when they are off duty. Senior officers and vessel managers should also take fatigue management into account when planning work schedules and consider postponing non-critical tasks where necessary to ensure that work is carried out by personnel who are adequately rested and alert.

The year also saw an increase in occurrences involving machinery and equipment failure. These incidents highlight the importance of effective planned maintenance systems, thorough inspections, and the prompt rectification of identified defects. Shipowners and operators are reminded to ensure that critical equipment is maintained in accordance with manufacturers' recommendations and statutory requirements, and that emerging issues are addressed before they develop into more significant failures that could affect the safety of the vessel or its crew.

Figure 3 below shows the ARF reports received in 2025 broken down by the activity being performed at the time of the accident:

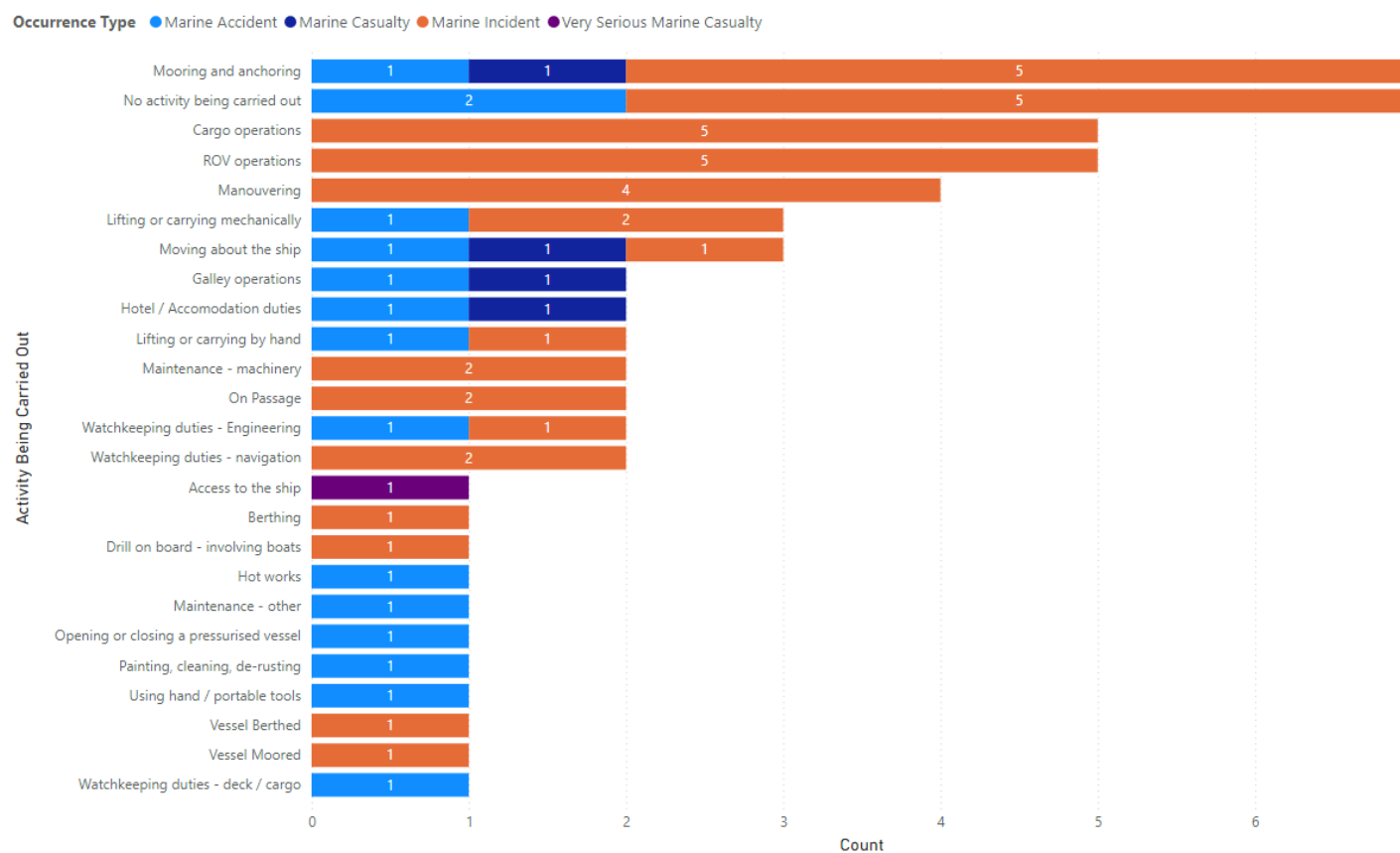


Figure 3 - ARF Reports by Activity Performed

Mooring and anchoring operations remained one of the most common activities being undertaken at the time of an incident. These operations present significant risks due to the substantial forces and stored energy involved in mooring lines and associated equipment. Operators should ensure that all mooring equipment is subject to regular inspection and maintenance to identify wear, damage, or deterioration. Reliance solely on manufacturers' recommended replacement intervals may not be sufficient, as the marine environment can accelerate degradation and adversely affect both the performance and service life of ropes and associated components. It is vital to ensure that all crew involved in mooring operations have been trained appropriately and are well aware of the risks involved in mooring operations, snap-back zones should be clearly marked by well maintained visuals and these areas should be covered as part of the pre-operation toolbox talk.

As in previous years, a notable number of occurrences took place when no work-related activity was being performed. Living and working at sea for extended periods can lead to complacency or lapses in concentration during routine movement around the vessel or while off duty. Although such activities may appear low risk, the shipboard environment presents hazards that are not typically encountered ashore. Seafarers should therefore remain vigilant at all times and be regularly reminded of the importance of maintaining situational awareness while on board

2025 also saw the tragic loss of a bosun overboard from the World Prize during incident involving setting up the pilot ladder. Investigations are ongoing however, initial facts appear to suggest that the Bosun lost their balance and fell overboard when trying to establish the height of the pilot ladder above the waterline by leaning over the ships side. Highlighting the need for correct adherence to procedures, thorough risk assessment and situational awareness at all times when on board.

Chapter 5 Reported Injuries and Fatalities

This section of the report analyses only the ARF reports received in 2025 that resulted in injury to a person. In 2025, there was a total of 1 fatality, 10 serious injuries and 21 minor injuries recorded.

5.1 Seafarer Injury Rate

The table below shows the approximate rate of injury and severity across the Isle of Man fleet extrapolated to the injury rate per 100,000 seafarers. This gives a standardised industry health performance and allows for comparison between other work sectors (i.e. construction).

Seafarers Injured	All Ships		MLC		Non-MLC	
	Number	Rate	Number	Rate	Number	Rate
Fatalities	1	10	1	14	0	0
Serious injuries	10	101	7	98	3	110
Minor injuries	21	212	12	167	9	329

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**” means any seafarer to which the Maritime Labour Convention 2006 applies.
3. “**Non-MLC**” generally means passengers, industrial personnel, visitors or crewmembers employed on a non-MLC ship or shoreside personnel such as stevedores.
4. See introduction for definition of “Serious Injuries” and “Minor Injuries”.

5.2 Number of Injuries and Fatalities Reported

The tables below show a breakdown of injury by rank on board.

MLC Seafarer Injuries

Capacity	Fatality	Minor Injury	Serious Injury	Total
Able Seaman (AB)		2		2
Bosun	1			1
Chief Officer (C/O)		1		1
Cook		1		1
Deck rating (capacity not specified)			1	1

Deckhand			1	1
Engine Fitter			1	1
Fitter			1	1
Officer (capacity not specified)			1	1
Ordinary Seaman (O/S)		1		1
Passenger Services Assistant (PSA)		2		2
Rating (capacity not specified)		3	2	5
Second Officer (2/O)		1		1
Steward		1		1
Total	1	12	7	20

Non-MLC Seafarer Injuries

Injured Party	Minor Injury	Serious Injury	Total
Cadet	1		1
Other / project personnel (capacity not specified)		1	1
Passenger	8	1	9
Rigger		1	1

In 2025 Ratings were the most likely rank to obtain an injury during the course of their working duties. It should be noted that several ARF reports were unclear in noting the rank of the seafarer involved in an incident. Operators are reminded of the importance of recording all information that may be relevant in a marine accident, including the rank of any personnel involved.

5.3 Injury by Activity

Figure 4 shows the injury severity by the activity being performed.

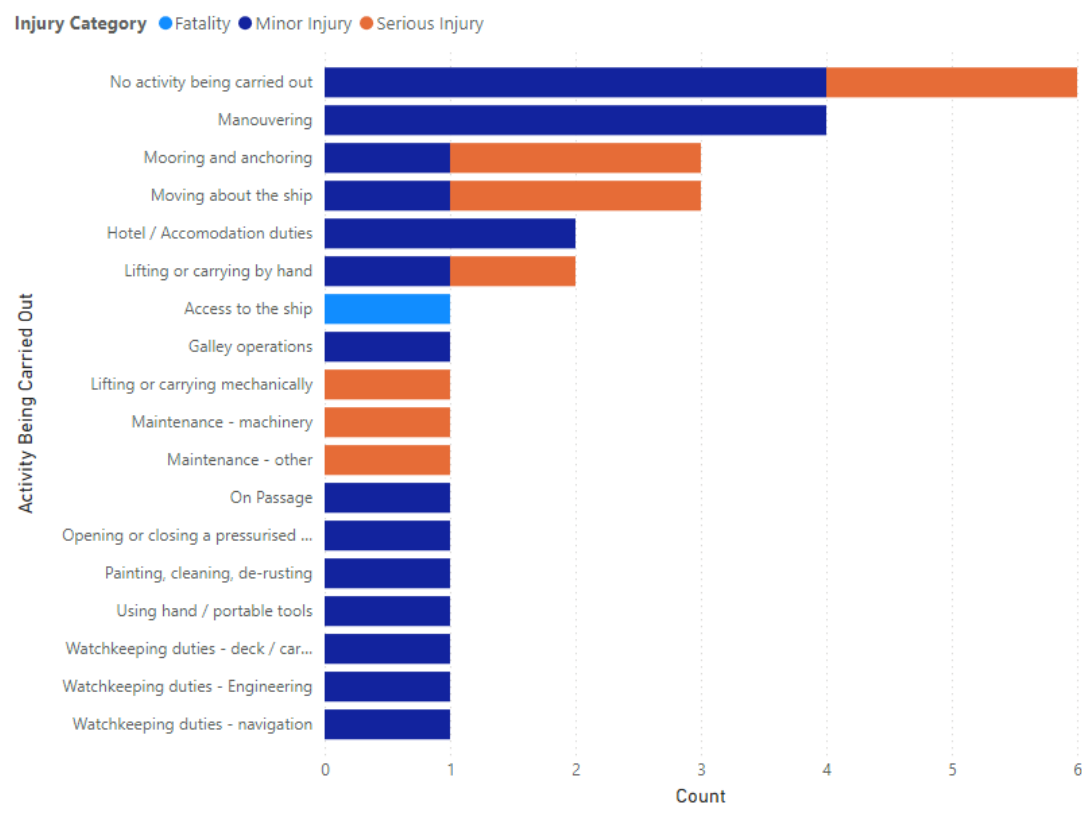


Figure 4 - Injury Severity by Activity

In 2025, most injuries occurred when no activity was being carried out, followed by incidents occurring during manoeuvring operations. Incidents occurring outside of work-related activities highlight the risks associated with living and moving about a vessel for extended periods. Fatigue, complacency, and lapses in concentration can all contribute to accidents. Seafarers should be encouraged to maintain situational awareness at all times, both on and off duty, and operators should ensure that vessel housekeeping standards are maintained to minimise trip, slip, and fall hazards.

Manoeuvring operations present elevated risks due to the dynamic nature of vessel movements, changing environmental conditions, and the need for effective coordination between bridge and deck personnel. Thorough planning, clear communication, and adherence to established procedures are essential in reducing the likelihood of accidents during such operations.

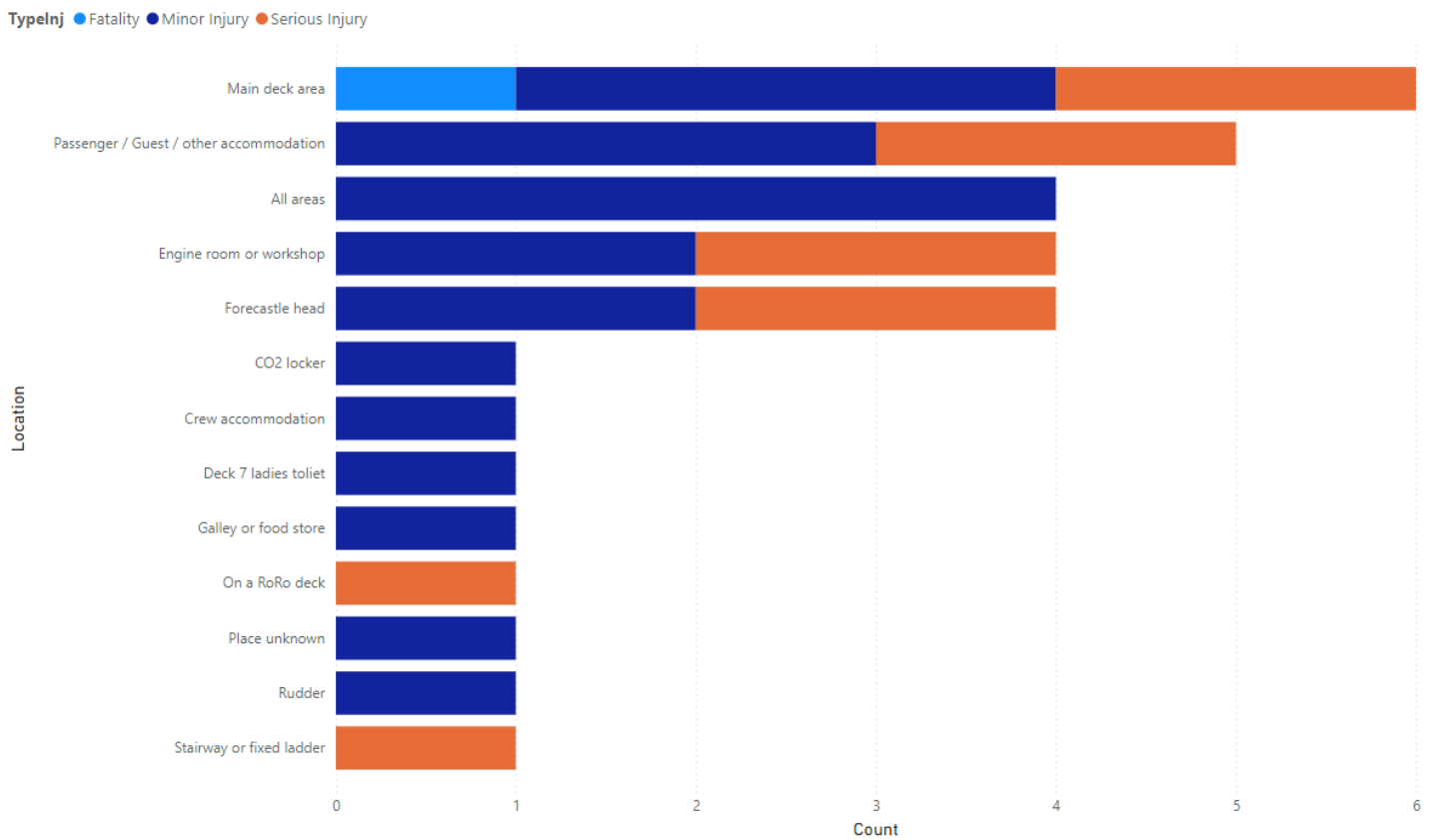


Figure 5 – Injury severity by Location

Deck areas carried the greatest risk of injury. The exposed and operational nature of deck spaces means that seafarers are routinely required to work in close proximity to moving equipment, lifting operations, mooring arrangements, and changing environmental conditions. Wet surfaces, vessel motion, and adverse weather can further increase the likelihood of slips, trips and other accidents. Operators should ensure that deck areas are maintained in a safe condition, hazards are identified and addressed promptly, and that personnel remain alert to the risks associated with working on deck. Regular training, effective supervision, and adherence to safe working practices are key to reducing injuries in high-risk areas.

Chapter 6 Breakdown of Occurrences in 2025 by Root Cause

The following charts represent a breakdown of all the occurrences by the root cause. Determination of the various causes follows an investigation into the occurrence by the ship's staff, company investigators or an external investigating body.

It should be noted that this data is weighted by the number of Root Causes reported to the Ship Registry in association with a particular occurrence, any individual occurrence may be the result of several Root Causes across different categories.

Figure 6 below shows occurrences split by the Root Cause categories.

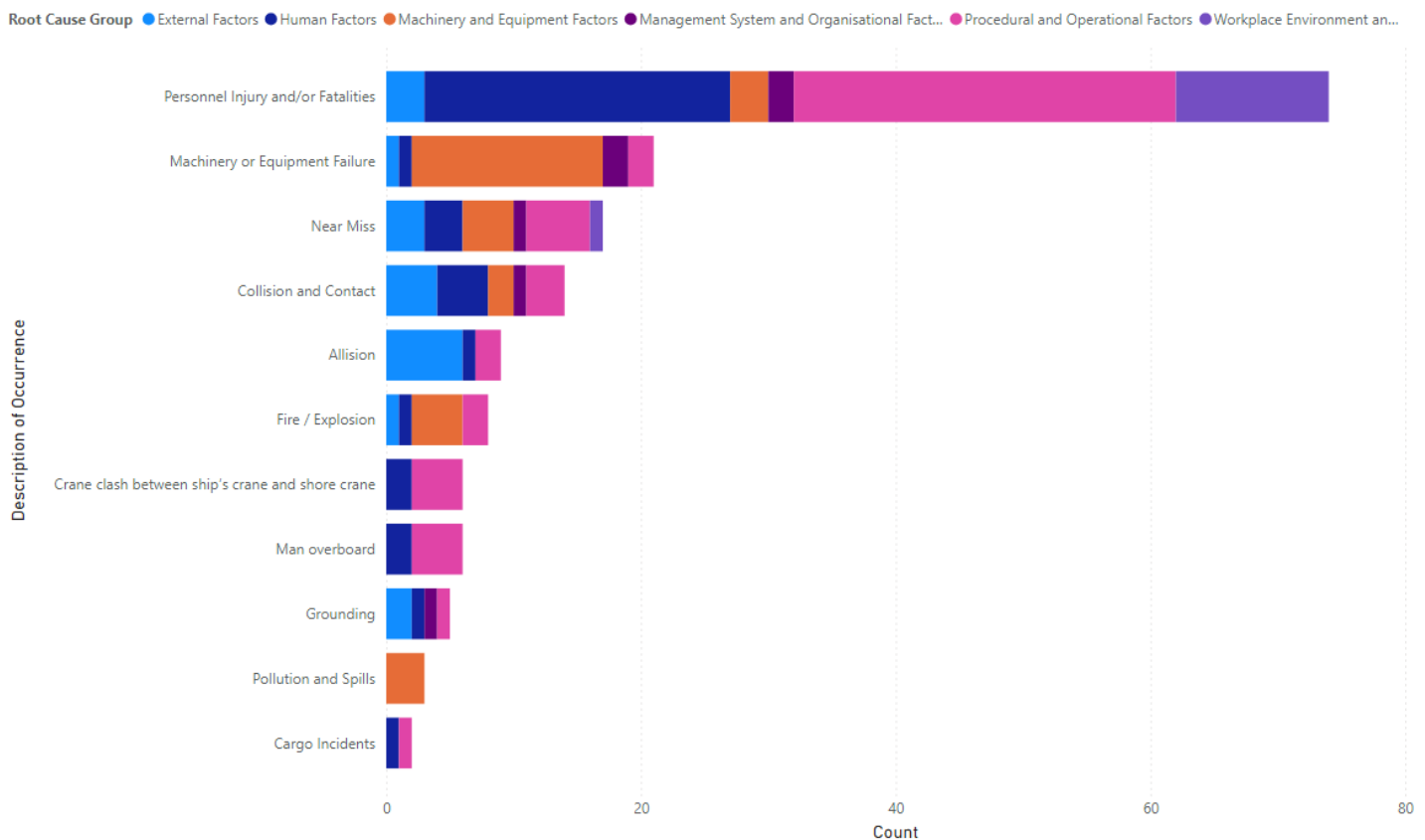


Figure 6 - Occurrence by Root Cause Group

The most common Root Cause Categories were Procedural and Operational Factors followed by Human Factors.

6.1 Occurrences by Workplace Environment & Ergonomic Factors

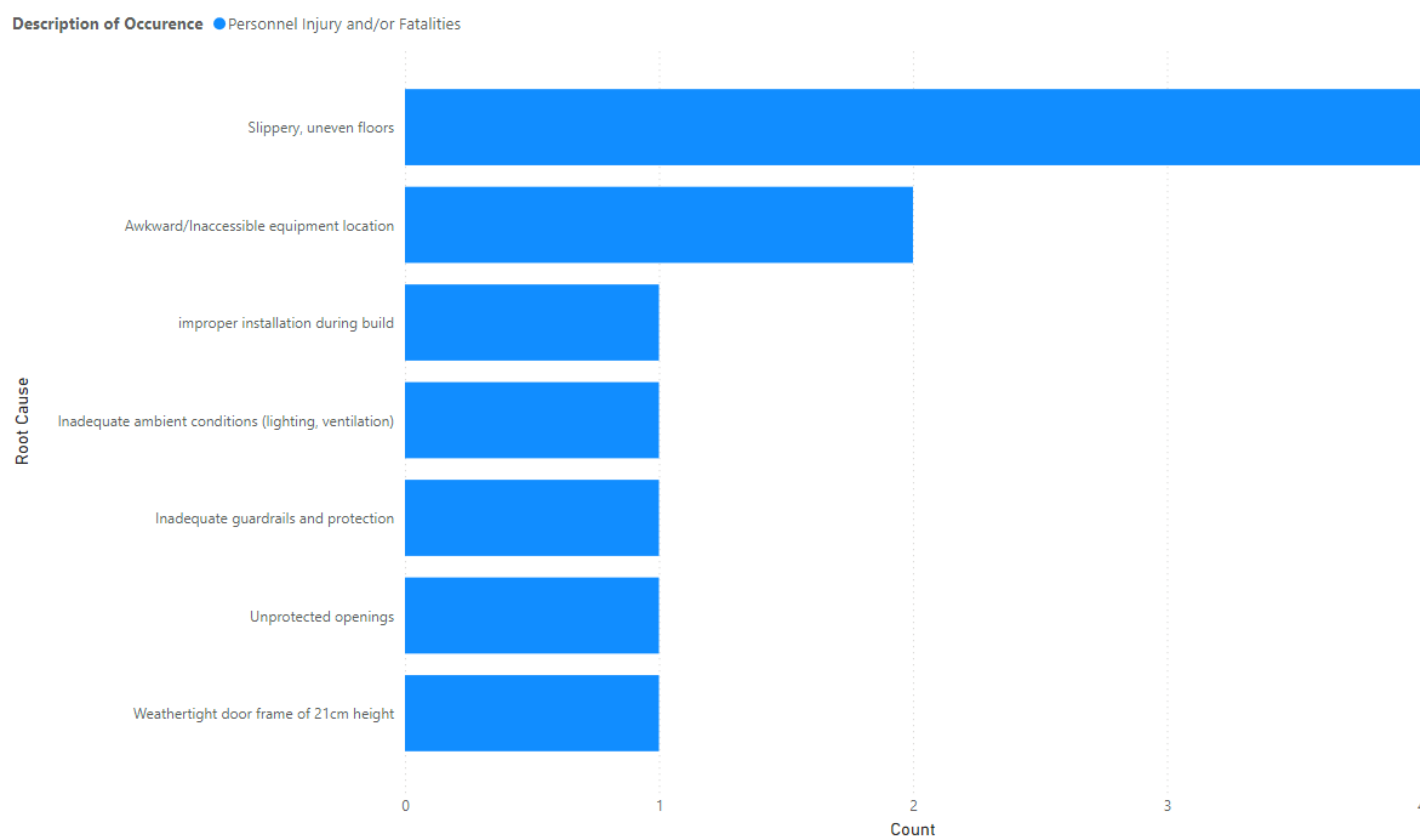


Figure 7 - Occurrences by Workplace Environment & Ergonomic Factors

Several occurrences resulted from Workplace Environment & Ergonomic Factors, such incidents often arise from conditions such as poor housekeeping, inadequate workspace design, restricted access, and environmental hazards such as uneven surfaces or poor lighting. Whilst addressing such factors is generally routine, they can significantly increase the likelihood of injury when not adequately managed.

Operators should ensure that working environments are regularly assessed to identify and mitigate ergonomic and environmental risks. Maintaining clear walkways, providing appropriate equipment, promoting good housekeeping practices, and considering ergonomic principles when designing work processes can help reduce the potential for injuries. Encouraging personnel to report hazards and near misses remains an important element of preventing accidents and fostering a positive safety culture on board.

6.2 Occurrences by Procedural & Operational Factors

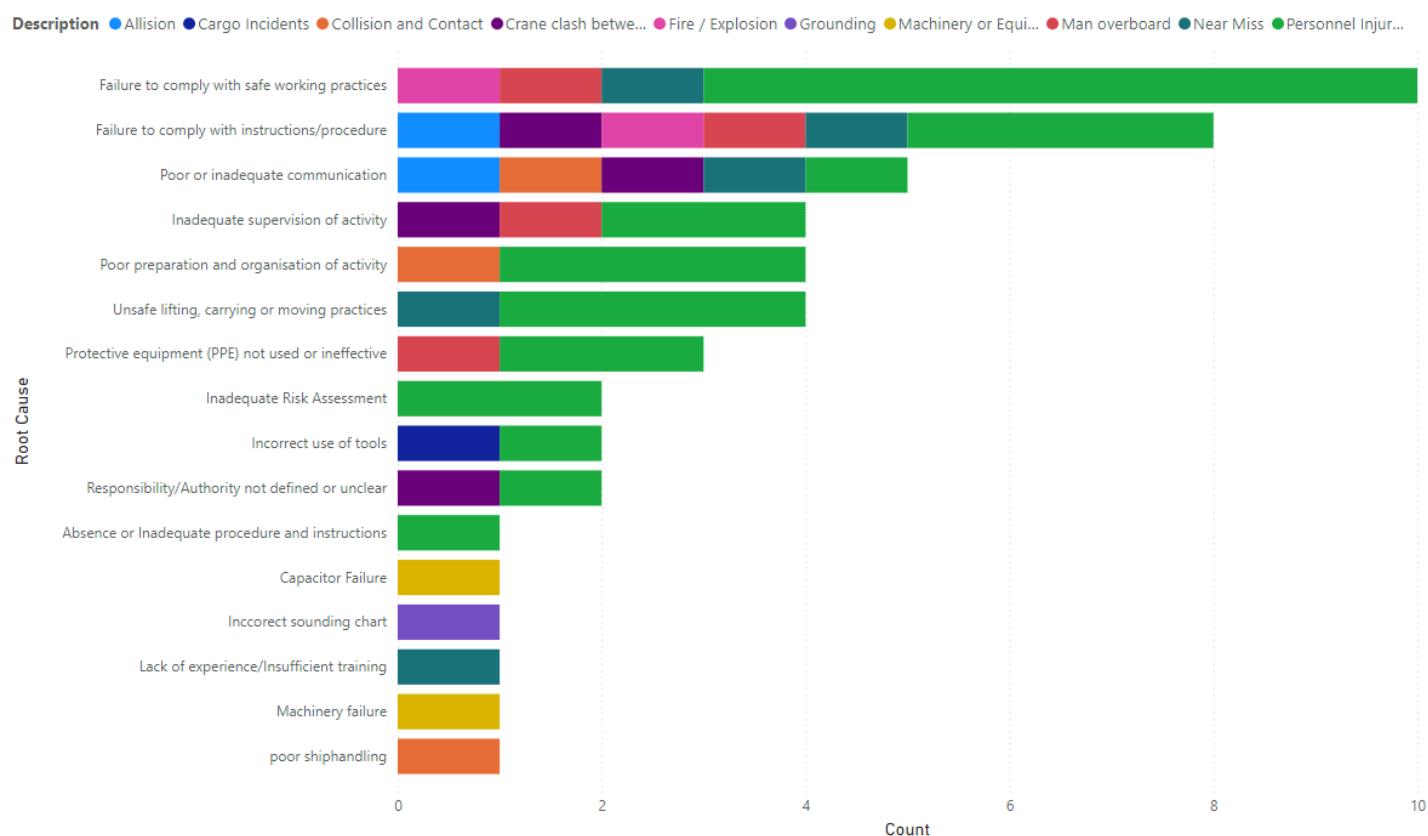


Figure 8 - Occurrences from Procedural and Operational Factors

The most common root cause identified in 2025 were operational and procedural factors. These incidents highlight the importance of effective planning, clear procedures, and adherence to established safe working practices. In many cases, accidents can be prevented through robust risk assessments, effective supervision, and ensuring that personnel are adequately trained and familiar with the tasks being undertaken.

Operators should regularly review operational procedures to ensure they remain relevant and effective, particularly where lessons can be learned from previous incidents and near misses. Encouraging a strong safety culture, where personnel feel empowered to challenge unsafe practices and report concerns, remains essential in reducing the likelihood of accidents arising from operational and procedural shortcomings.

6.3 Occurrences by Management Systems Factor

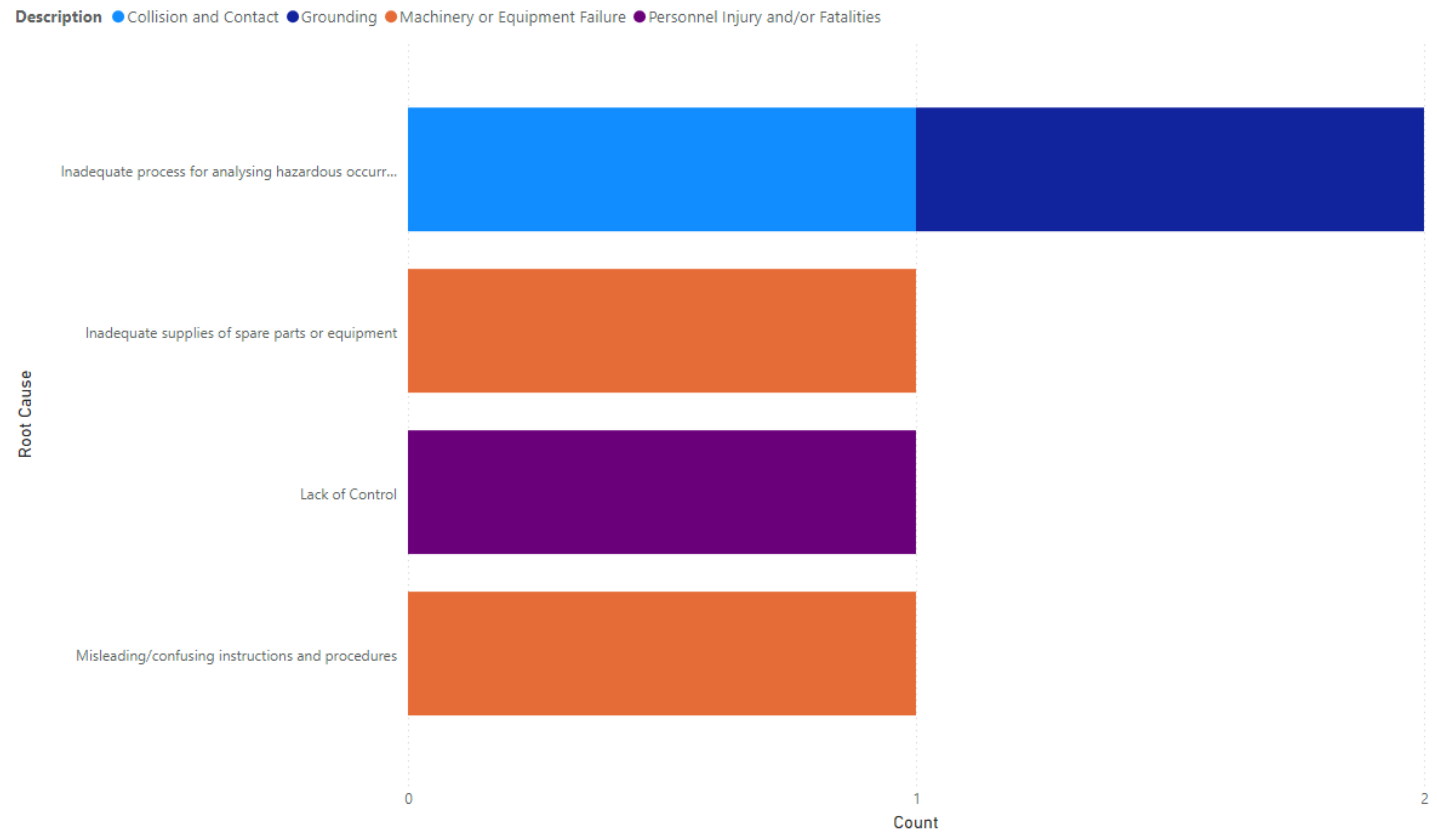


Figure 9 - Occurrences by Management Systems Factor

Occurrences arising from deficiencies in management systems were relatively few in 2025, however, their significance should not be understated. Unlike other incidents which may be influenced or mitigated by the actions of those directly involved, management system failures frequently originate from organisational decisions, processes, or controls that are outside the immediate influence of the crew on board.

Effective safety management systems play a critical role in identifying hazards, managing risks, and providing personnel with the procedures, resources, and support necessary to operate safely. Where deficiencies in management systems are identified, companies should take prompt corrective action and review whether broader systemic improvements are required. Learning from incidents and near misses, together with regular audits and management reviews, are essential to ensuring that safety management systems function as intended and support the prevention of future occurrences.

6.4 Occurrences by Machinery & Equipment Factor,

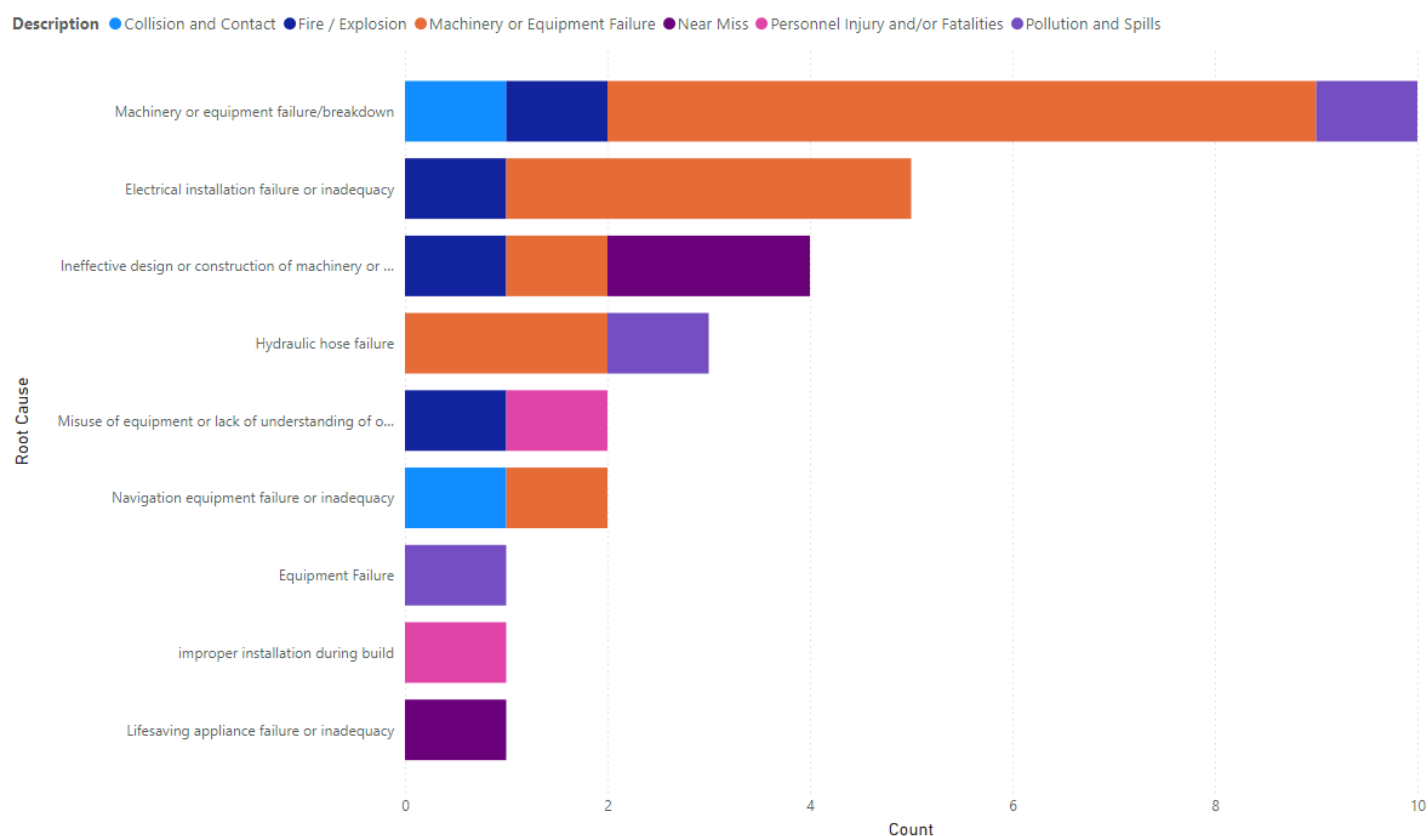


Figure 10 - Occurrences by Machinery & Equipment Factors

In 2025, breakdowns and equipment failures were the most commonly identified machinery and equipment factors contributing to reported occurrences. The reliability of onboard machinery is heavily dependent upon effective inspection, maintenance, and timely replacement of worn or defective components. Planned maintenance should be carried out in accordance with manufacturers' recommendations and supplemented by regular condition monitoring where appropriate.

Where there is any doubt regarding the suitability or integrity of equipment, components should be repaired or replaced before operations commence. Delaying corrective action can significantly increase the likelihood of equipment failure and may expose personnel to unnecessary risks. Companies should foster a safety culture in which seafarers feel empowered to stop work when defects are identified, without concern for operational delays or commercial pressures. Prioritising safety over expediency remains essential in preventing machinery-related incidents and ensuring the continued safe operation of vessels.

6.5 Occurrences by Human Factors

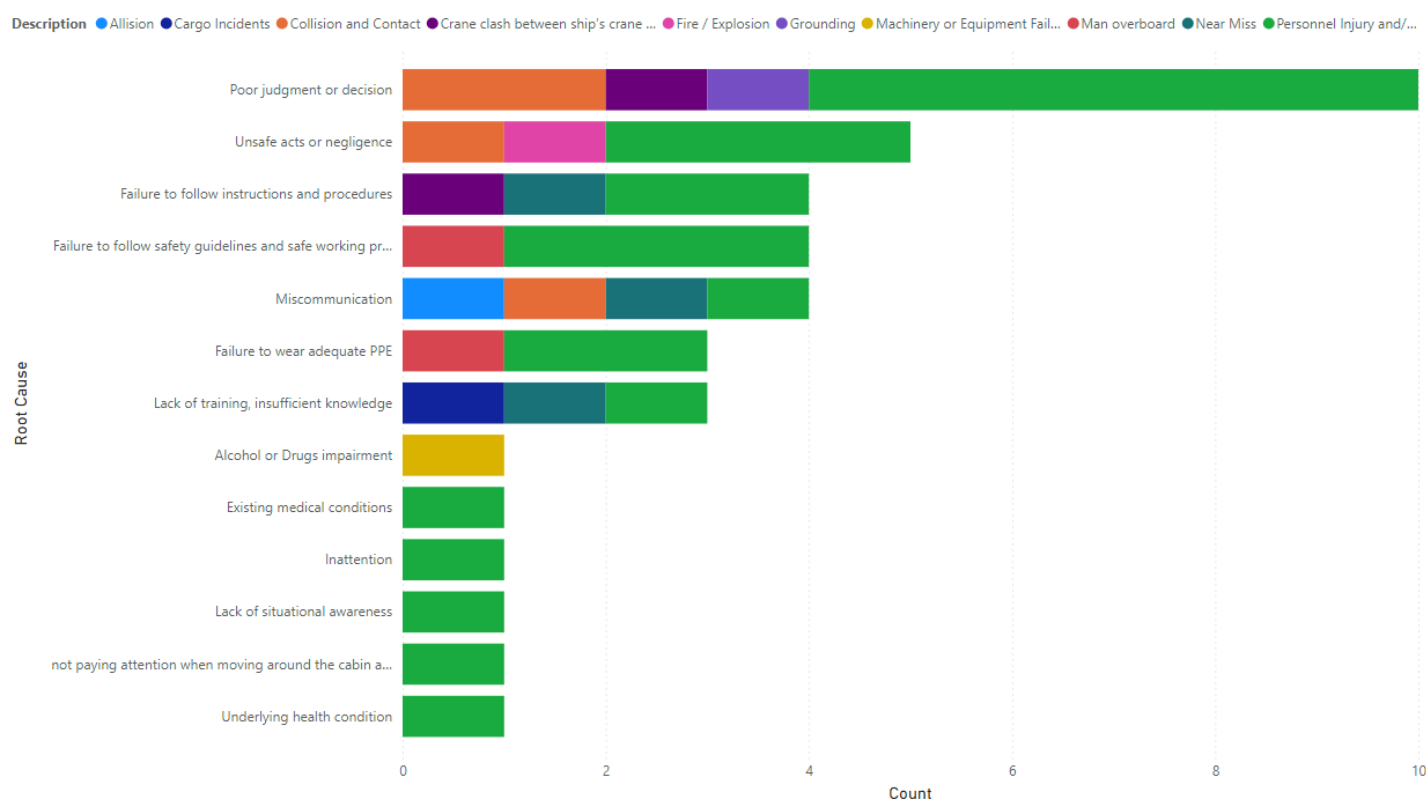
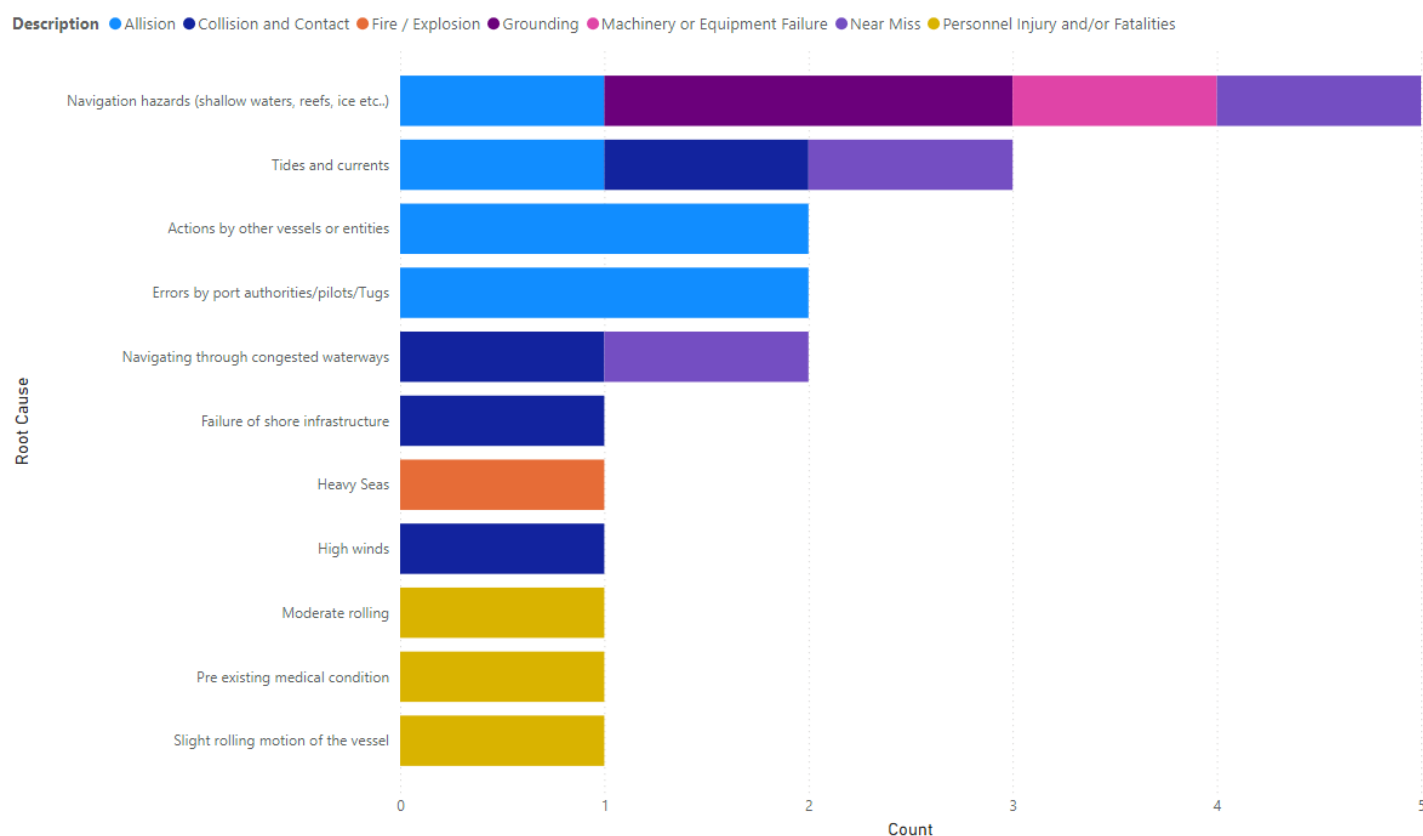


Figure 11 - Occurrences by Human Factors

In 2025, the predominant human factors identified were poor judgement or decision-making and unsafe acts or negligence. Whilst these factors may suggest individual failings, such actions are seldom intentional. In many cases, they arise from underlying factors such as inadequate training, insufficient experience, ineffective supervision, fatigue, time pressures, poor communication, or a lack of understanding of the risks involved.

The findings highlight the importance of ensuring that seafarers are provided with appropriate training, familiarisation, and support to make informed decisions and perform tasks safely. Companies should also seek to identify and address the organisational and environmental factors that can influence human performance. A positive safety culture, where personnel are encouraged to report concerns, seek clarification, and learn from mistakes without fear of blame, remains essential in reducing the likelihood of incidents arising from human factors.

6.1 Occurrences by External Factors



There were several occurrences attributed to external factors, such as navigational hazards, adverse weather conditions, and the actions of other vessels. While such factors may be outside the direct control of a vessel's crew, their impact can often be mitigated through effective voyage planning, situational awareness, and adherence to established navigational and operational procedures.

Seafarers should remain vigilant to changing environmental and traffic conditions and make full use of all available information, including weather forecasts, navigational warnings, and vessel traffic services where appropriate. Maintaining a proactive approach to risk assessment and decision-making remains essential in reducing the likelihood of occurrences arising from external influences. Although these hazards cannot always be eliminated, effective preparation and prudent seamanship can significantly lessen their consequences.

Chapter 7 Conclusions

The most prevalent occurrences reported in 2025 were personal injuries and machinery/equipment failure.

There was 1 fatality, 7 serious injuries and 12 minor injuries to MLC seafarers reported in 2025 along with 3 serious injuries and 9 minor injuries to non-MLC seafarers.

Moving about the ship and mooring operations resulted in the most severe injuries in 2025.

The ARFs received highlight the causes identified when occurrences happened. The most common causes identified for each ARF theme in 2025 were:

- Workplace and Ergonomic Factors – Slippery, uneven floors and Awkward/Inaccessible equipment
- Procedural & Operational Factors – Failure to comply with safe working practices
- Management Systems Factors – Inadequate Processes and Inadequate supplies of spares or equipment
- Machinery & Equipment Factors – Machinery/Equipment breakdown, Electrical installation failures/inadequacy
- Human Factors – Poor judgement and decision making, Unsafe acts and negligence
- External Factors – Navigational hazards and tides/currents

The findings of the 2025 casualty data continue to demonstrate that many occurrences arise not from a single cause, but from a combination of human, operational, technical, environmental, and organisational factors. While the specific circumstances of each incident vary, common themes remain evident, including the importance of effective planning, robust maintenance regimes, clear procedures, good communication, and ongoing training.

A strong safety culture remains one of the most effective safeguards against accidents. Companies should ensure that personnel are provided with the tools, resources, and support necessary to work safely, while seafarers should be encouraged to take an active role in identifying hazards, reporting concerns, and learning from incidents and near misses. Adherence to safe working practices, established procedures, and industry best practice is fundamental to preventing harm and maintaining safe vessel operations.

Ultimately, the lessons identified from the occurrences reported in 2025 reinforce the need for continuous vigilance both on and off duty. By promoting a proactive approach to risk management and fostering an environment where safety takes precedence over operational or commercial pressures, the maritime industry can continue to reduce the likelihood of future casualties and improve outcomes for all those working at sea

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](#)
- Contacting the Isle of Man Ship Registry – email marine.survey@gov.im

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