Isle of Man Ship Registry

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

2024

Isle of Man Government
Department for Enterprise

Isle of Man Government
Reiltys Ellan Vannin

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Executive Summary

- There were 53 Accidents, 34 Incidents and 7 Casualty Reports in 2024
- The most common occurrences in 2024 were personal injury and involving mooring ropes or hawses
- Lifting or carrying by hand and mooring operations were the most common activity reported on the ARF forms
- There was 1 fatality, 8 serious injuries and 22 minor injuries reported in 2024
- Lifting or carrying by hand and moving about the ship were the most dangerous activities for seafarers
- The most common causal factors were the working method used and mechanical factors
- The most common causes identified for each causal factor were:
    - Working method – Failure to comply with instructions and poor design or layout
    - Mechanical and other equipment – Defective Machinery
    - Human factor – Negligence or carelessness of others
    - Other miscellaneous causes – Ship movement
    - Movement about the ship – Unprotected openings and slippery surfaces

Isle of Man Ship Registry, Department for Enterprise, St George's Court,
Upper Church Street, Douglas, Isle of Man IM1 1EX, British Isles
www.iomshipregistry.com

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Chapter 1 Introduction

The Isle of Man Ship Registry's 2024 Casualty Summary report provides statistics and analyses the trends identified from the Accident Report Forms (ARF) submitted to the registry over the course of 2024. 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 2024

Type of Ship	Nature of Investigation
Fishing Vessel	Grounding
Fishing Vessel	Sinking
Passenger Ship	Serious Injury During Mooring Operations

2.2 VSMC Safety Investigations conducted by UK MAIB for IOM in 2024

Name of Ship	Type of Ship	Nature of Investigation
Baton Rouge	Yacht	Fatality – Electrical Work

2.3 Reports Published by IOMSR in 2024

Ship Name	Type of Ship	Nature of Investigation
Mona Manx	Bulk Carrier	Fatality – Mooring Operations
Silver Viking	Fishing Vessel	Lifting Equipment Failure Resulting in Serious Injury

2.4 Investigations on IOM Vessels by other investigation bodies in 2024

Type of Ship	Nature of Investigation	Investigation Authority
None		

Chapter 3 ARF Reports Received in 2024

3.1 Reports from Isle of Man Registered Ships

In 2024, the Isle of Man Ship Registry received 94 ARF reports from Manx ships, no reports were received from foreign flagged vessels in Manx waters over the period. The graph below shows the number of reported occurrences in 2024.

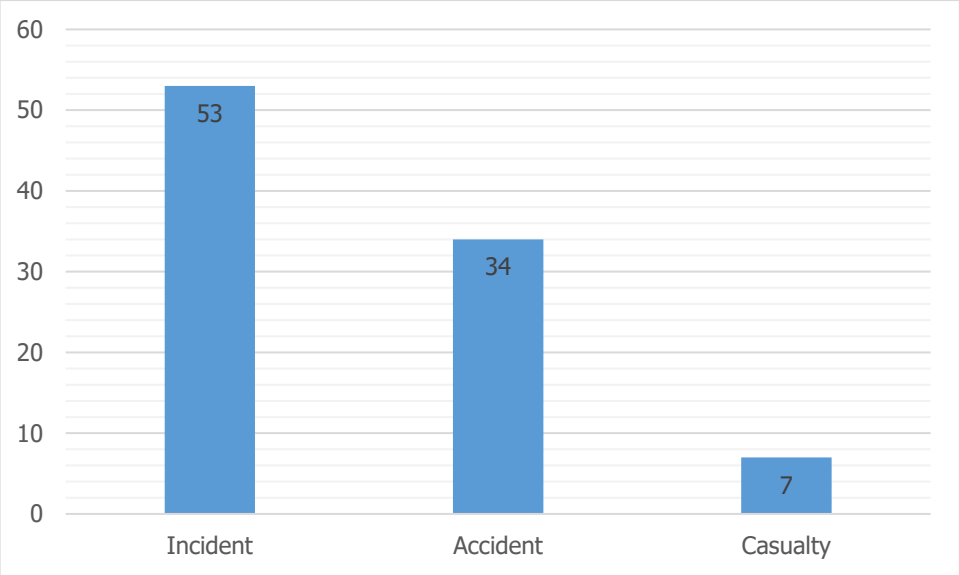

Figure 1 – ARF reports received in 2024

The table below gives a breakdown of cases reported per ship type in 2024.

	Bulk Carrier	Oil/Chem Tanker	Gas Carrier	Offshore / Standby	Other Cargo Ship	Passenger Ship	Commercial Yacht	Pleasure Yacht
Casualty	1	0	0	2	1	2	1	0
Accident	2	5	0	7	6	13	1	0
Incident	1	2	1	14	5	27	2	1

Of the 25 accident ARF reports relating to a sudden release of any substance, 18 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 2024

The most common occurrences reported to the Isle of Man in 2024 were collisions, sudden uncontrolled release of substances from a system and seafarer injuries (fig.2).

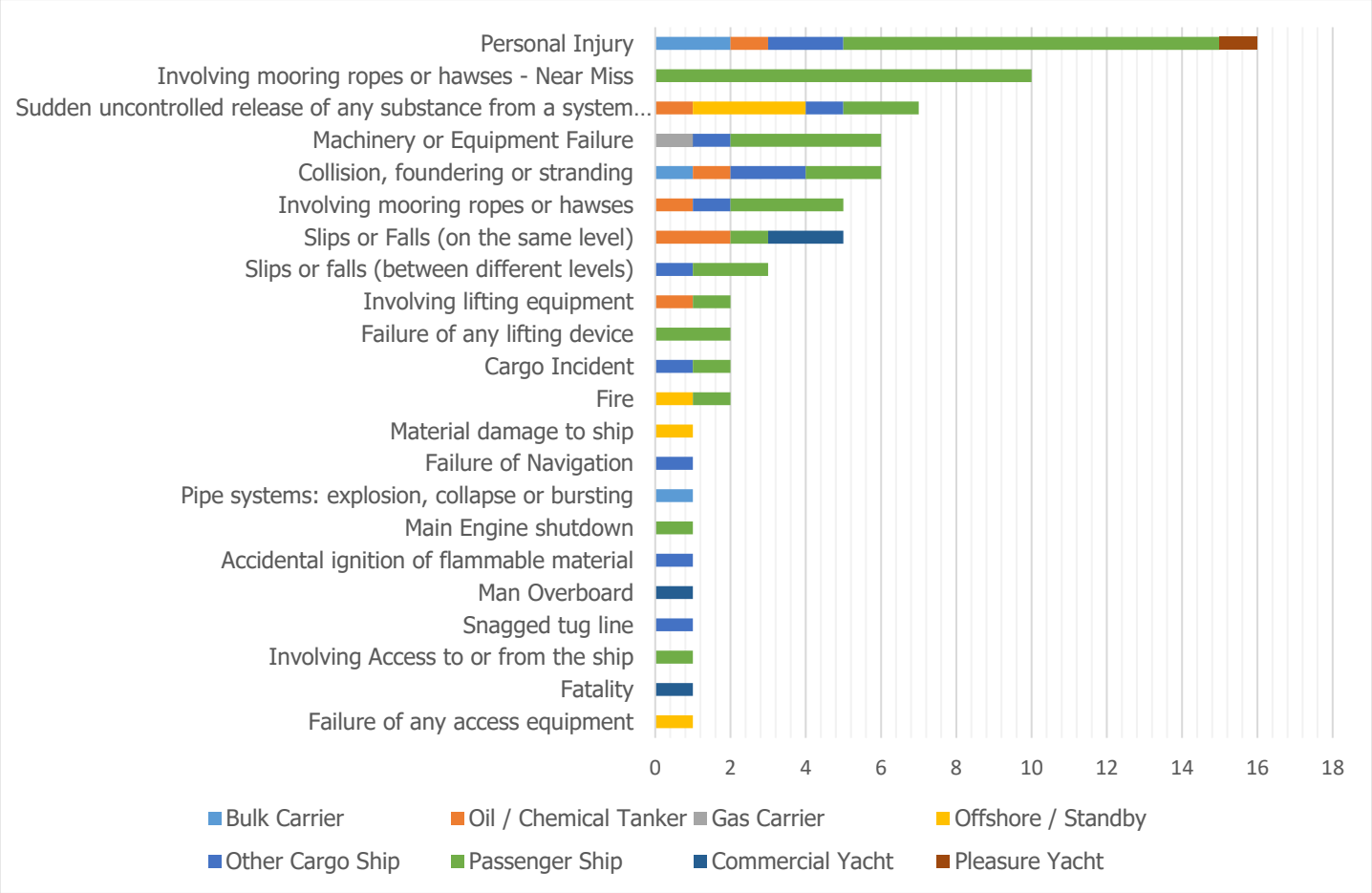

Figure 2 - ARF Occurrence by Ship Type

In 2024, the predominate occurrence reported to the Ship Registry was Personal Injury. Whilst the Ship Registry emphasises the importance of thorough risk assessments and detailed plans of work before starting any job, a significant number of the injuries reported to the Ship Registry appear to have been caused by momentary lapses in judgement or concentration.

Shipowners are advised to ensure all personnel are briefed on fatigue and managing its impact on board and of remaining vigilant when moving about the ship even when off-duty. Senior management on board are advised to take fatigue planning into account when arranging work rotas and consider delay of non-critical jobs to ensure they are performed by well rested and alert crew.

This year also saw a rise in the number of occurrences involving sudden release of a substance from a system. When transferring a substance from one system to another, thorough inspection of all hoses, couplings and other associated components of the sealing arrangement is strongly recommended. Particularly if equipment not belonging to the vessel is involved i.e. bunkering from shore to vessel. All crew involved in a transfer should be competent and trained for use upon the equipment they are responsible for.

Figure 3 below shows the ARF reports received in 2024 broken down by the activity being performed at the time of the accident:

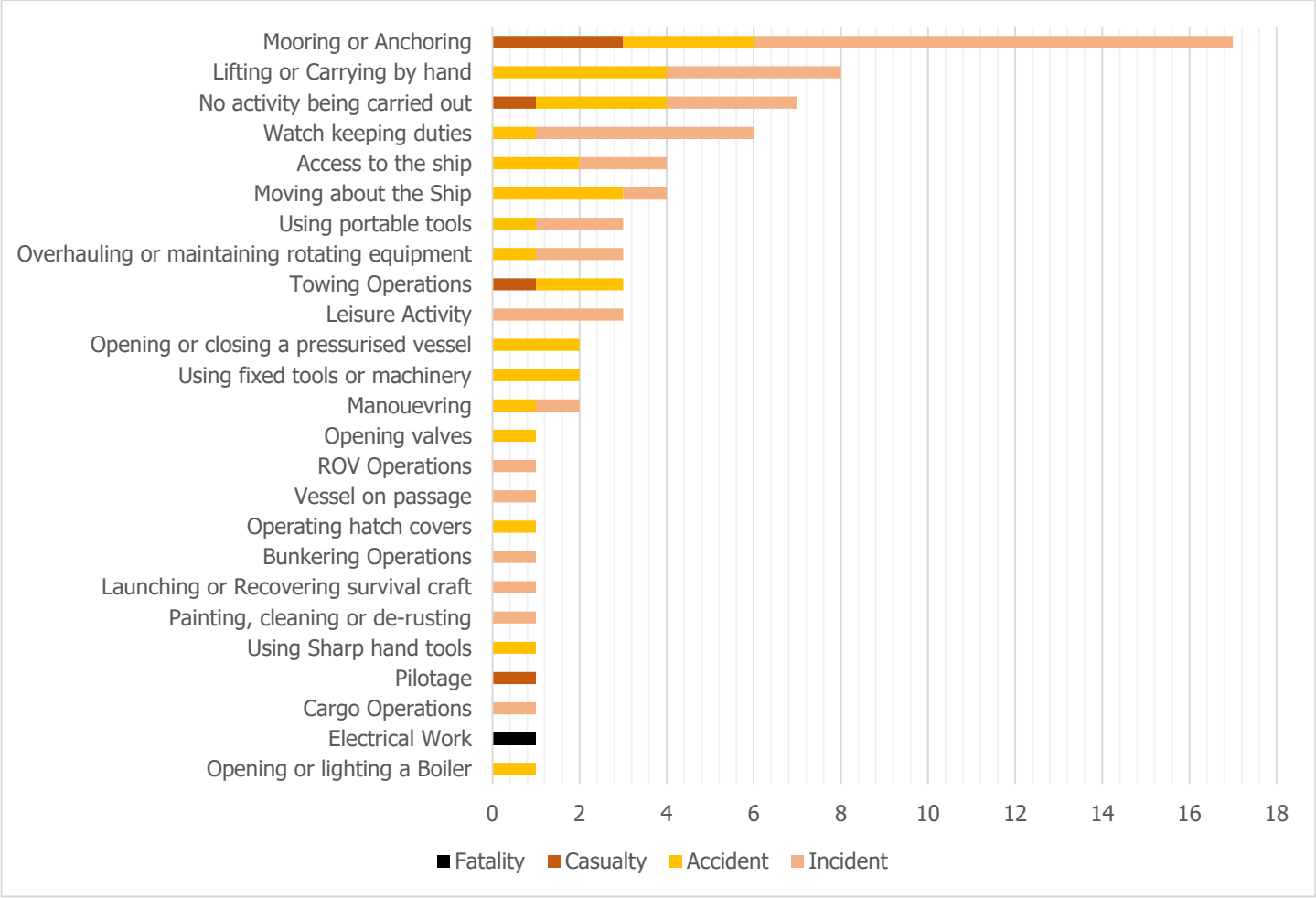

Figure 3 - ARF Reports by Activity Performed

Mooring/Anchoring and lifting or carrying by hand were the most prevalent activities being performed at time of incident. Mooring is one of the most dangerous activities on board when a marine accident occurs due to the significant potential energy bound within the tension of the ropes. All mooring ropes and other associated equipment should be regularly checked for wear and defects, it is not sufficient to rely solely upon the manufacturer's guidance for replacement or repair work. The sea is a dynamic environment which may lead to unexpected deterioration in performance of a rope or its' longevity.

This year saw a rise in the number of occurrences where no activity was taking place at the time. Spending significant periods of time on board can cause seafarers to lose focus when moving about the ship or relaxing after work. There is an ever-present risk on board compared to shore however and seafarers should be regularly reminded of the need for vigilance when living on board a vessel.

2024 also saw the tragic loss of an officer on board the Baton Rouge due to an incident that occurred during electrical maintenance work. This was the only such occurrence relating to electrical work reported to the Registry during this period highlighting the significant risk associated with such work. Operators are reminded of the importance of effective job planning and ensuring all isolations are in place and coordinated between relevant parties prior to commencement of any high-risk work.

Chapter 5 Reported Injuries and Fatalities

This section of the report analyses only the ARF reports received in 2024 that resulted in injury to a person. In 2024, there was a total of 1 fatality, 8 serious injuries and 22 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).

	All Ships		MLC		Non-MLC	
Seafarers Injured	**Number**	**Rate**	**Number**	**Rate**	**Number**	**Rate**
Fatalities	1	10	1	14	0	0
Serious injuries	8	82	8	114	0	0
Minor injuries	22	225	20	284	2	73

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

MLC Seafarer Injuries by Rank	Minor	Serious	Fatality	Total
Master	1	0	0	**1**
Chief Officer	0	1	0	**1**
OOW Nav.	1	1	0	**2**
Chief Engineer	1	0	1	**2**
2nd Engineer	2	0	0	**2**
OOW Engineer	1	0	0	**1**
ETO	0	0	0	**0**
Deck Rating	6	3	0	**9**
Engine Rating	1	1	0	**2**
Deck/Eng. Cadet	0	0	0	**0**
Cook/Steward	2	1	0	**3**
Others/Unspecified	5	1	0	**6**
Total	**20**	**8**	**1**	**29**

Non-MLC Seafarer Injuries

Non-MLC Seafarers	Minor	Serious	Fatality	Total
Passenger / Yacht Guest	1	0	0	1
Visitor/Contractor/Stevedore	1	0	0	1
Fishing Vessel Crew	0	0	0	0
Total	**2**	**0**	**0**	**2**

In 2024 Deck Ratings were the most likely rank to obtain an injury during the course of their working duties. It should be noted however that this year saw a rise in the number of ARF reports that 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.

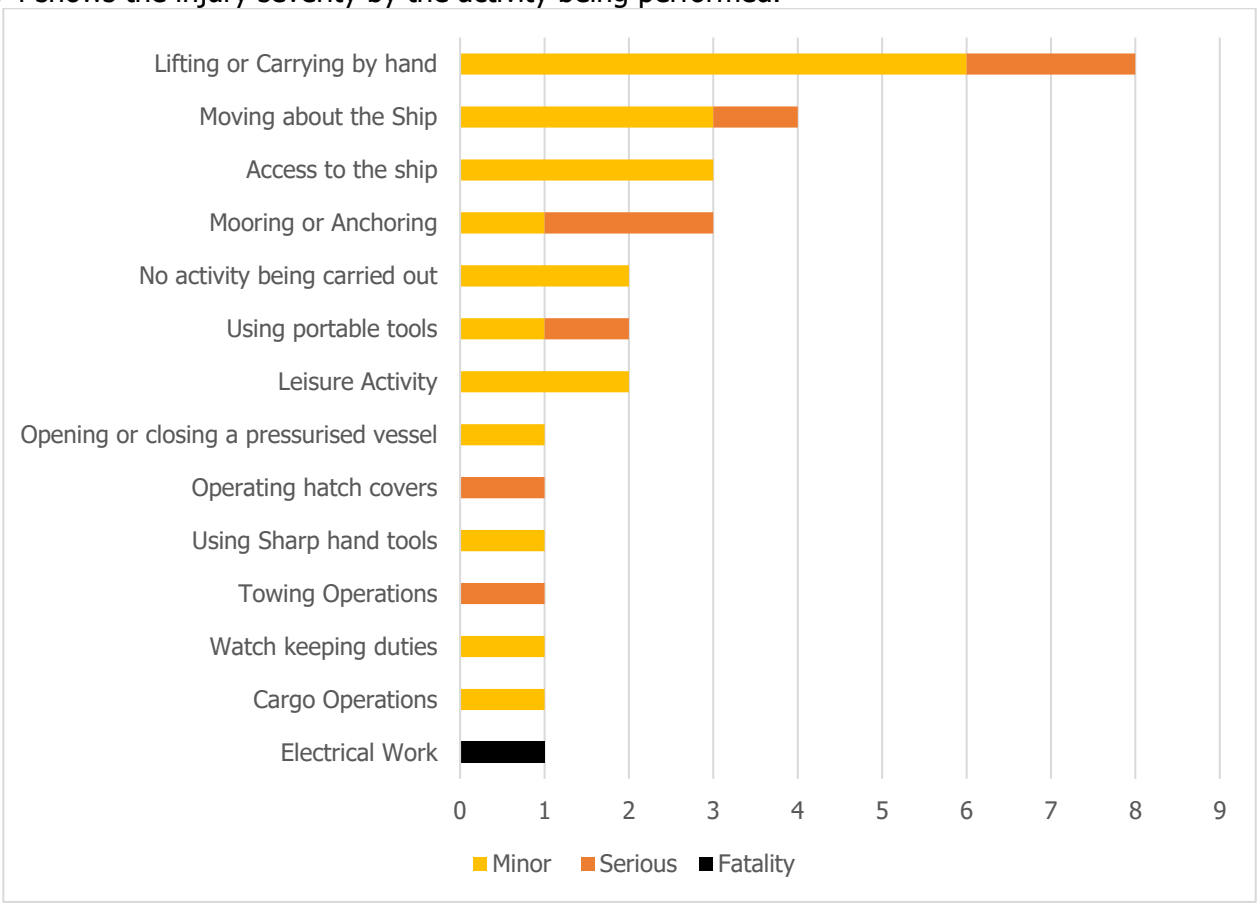

Figure 4 - Injury Severity by Activity

Lifting or carrying by hand, moving about the ship and access to the ship all carried the greatest risk of injury to a seafarer. In line with the data relating to personal injuries above, the importance of emphasizing proper technique and maintaining focus when carrying out routine tasks is key to minimising the risk of injury.

Mooring activities, whilst having a lower risk of injury, carried the greatest risk of serious injury when an accident did occur. Correct risk assessment, training, PPE and clear marking of snapback zones are all crucial to reducing the risk of serious injury when a mooring accident does occur.

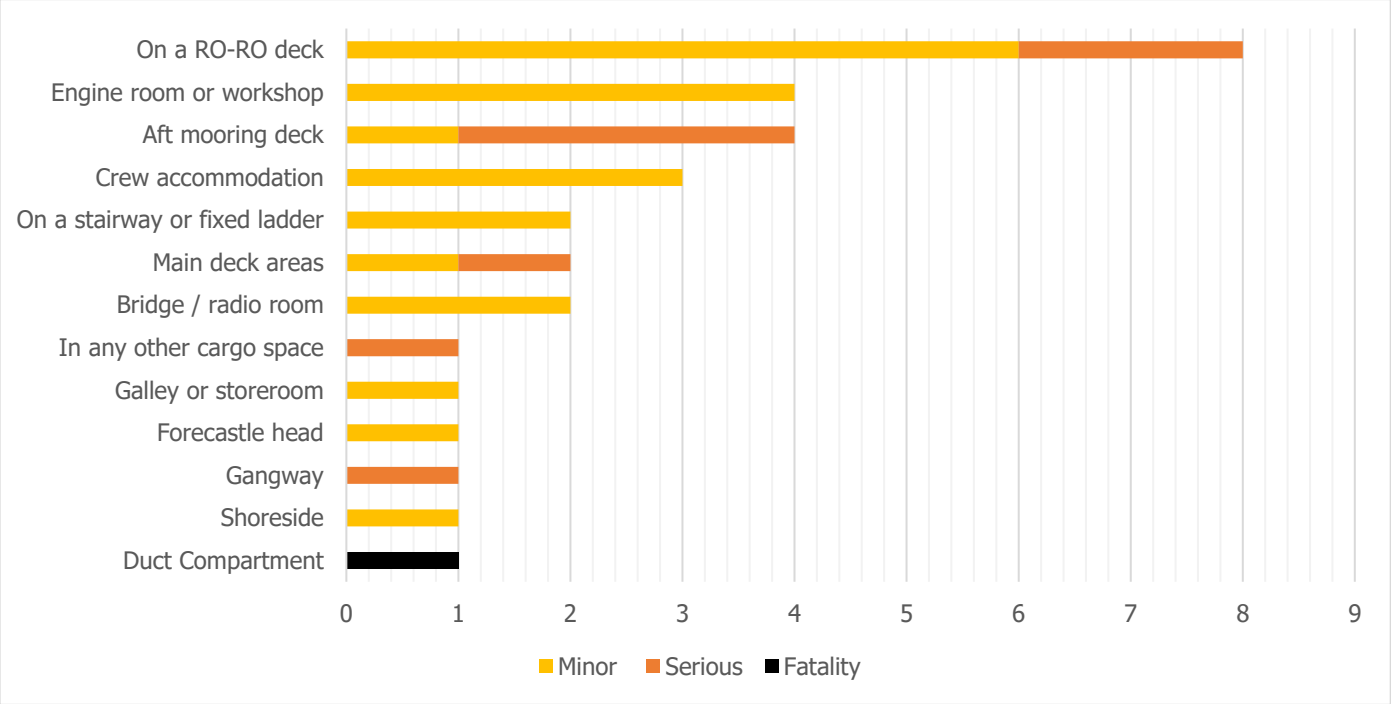

Figure 5 – Injury severity by Location

Deck areas and the engine room carried the greatest risk of injury. Stairways/ladders also reported a higher number of incidents in 2024, care should be taken when moving between different levels of the ship, particularly in times of inclement weather.

Chapter 6 Breakdown of Occurrences in 2024 by Cause

The following charts represent a breakdown of all the occurrences by the causal factor. 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 causal factors reported to the Ship Registry in association with a particular occurrence, any individual occurrence may be the result of several factors across different categories.

Figure 6 below shows occurrence split by the causal factor categories.

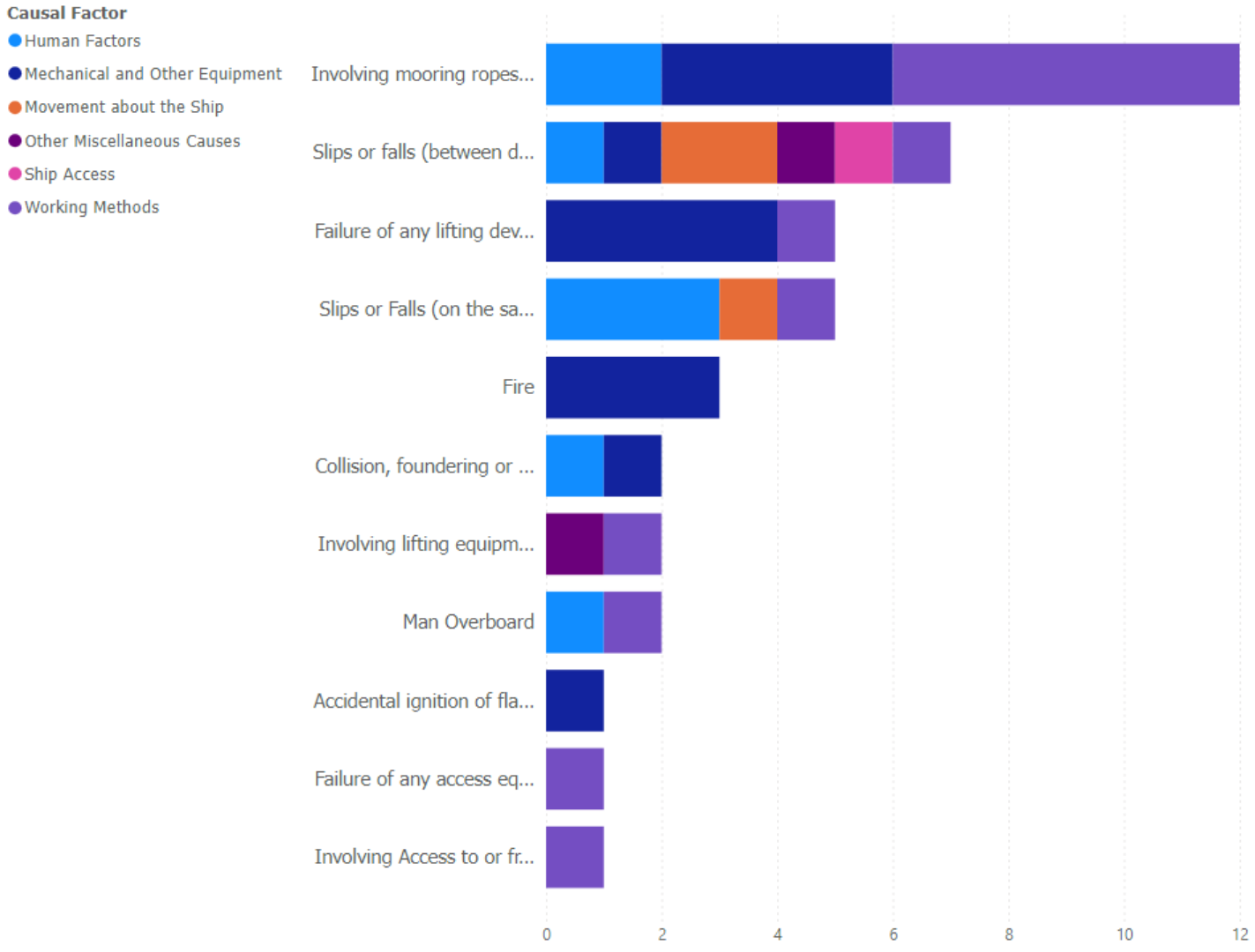

Figure 6 - Occurrence by Causal Factor

The most common causal factors were the working method used and mechanical related factors.

6.1 Occurrences by Working Method

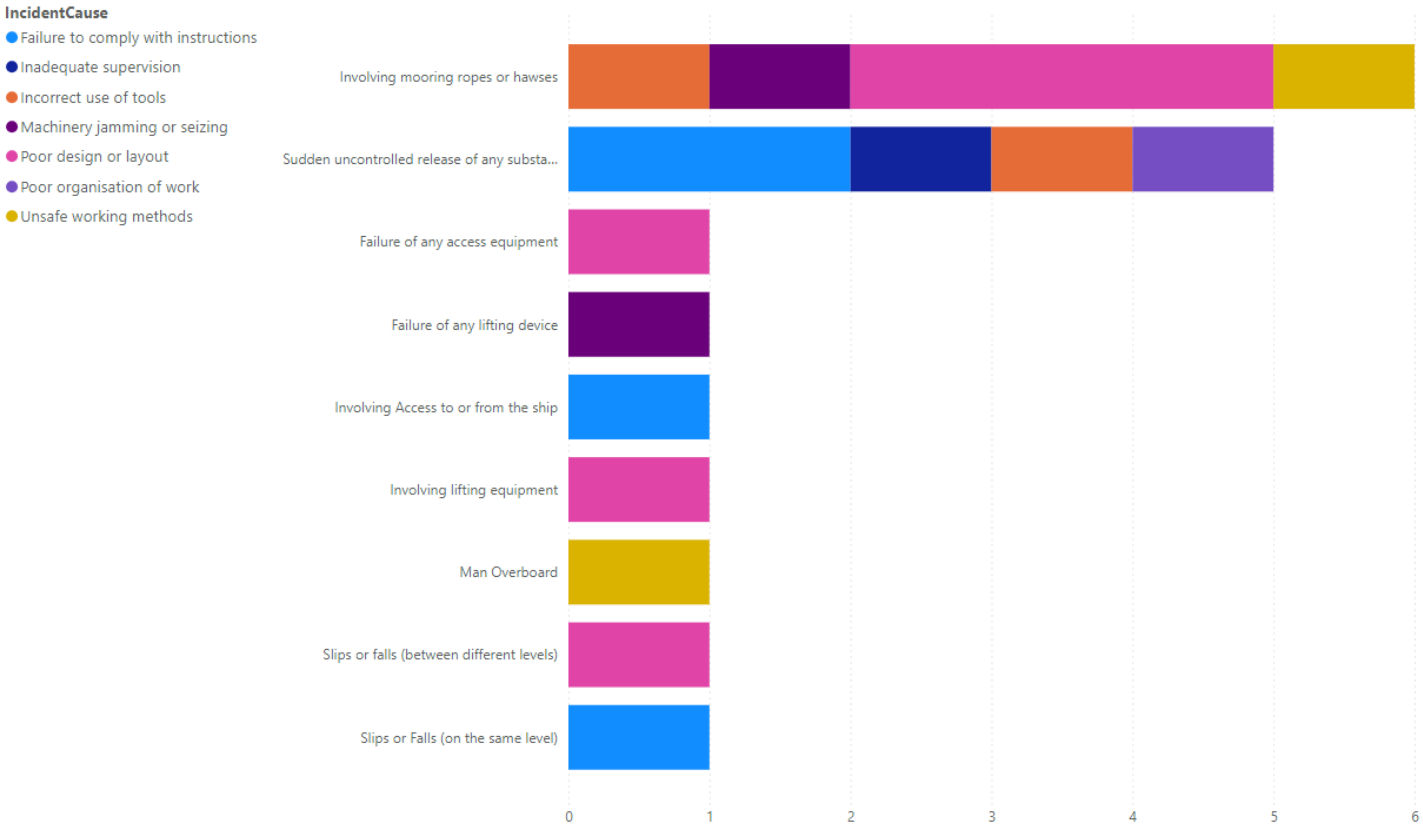

Figure 7 - Occurrences by Working Method

In 2024, the predominant working method causes were reported to be failure to comply with instructions and poor design or layout.

It is rare that the Ship Registry receives an occurrence that can be attributed to an intentional failure to comply with instructions, rather, most occurrences in this area generally relate to a breakdown in communication or a misunderstanding by a party involved in a particular task. Thorough toolbox talks should be held before every job to ensure each seafarer is fully briefed and understands the instructions associated with a job. Regular training on all vessel equipment should be provided to not only ensure that crew are fully competent in its use but also to ensure they feel confident in stepping in where they see a colleague about to misuse any particular piece of equipment.

Poor design and layout can be mitigated when it cannot be fully resolved by use of through risk assessment to identify any potential danger zones and clear marking of such areas on deck. Crew should be regularly trained and advised upon the location of any ship specific markings and the condition of any markings should be maintained to ensure they remain visible and legible.

6.2 Occurrences by Movement about the Ship

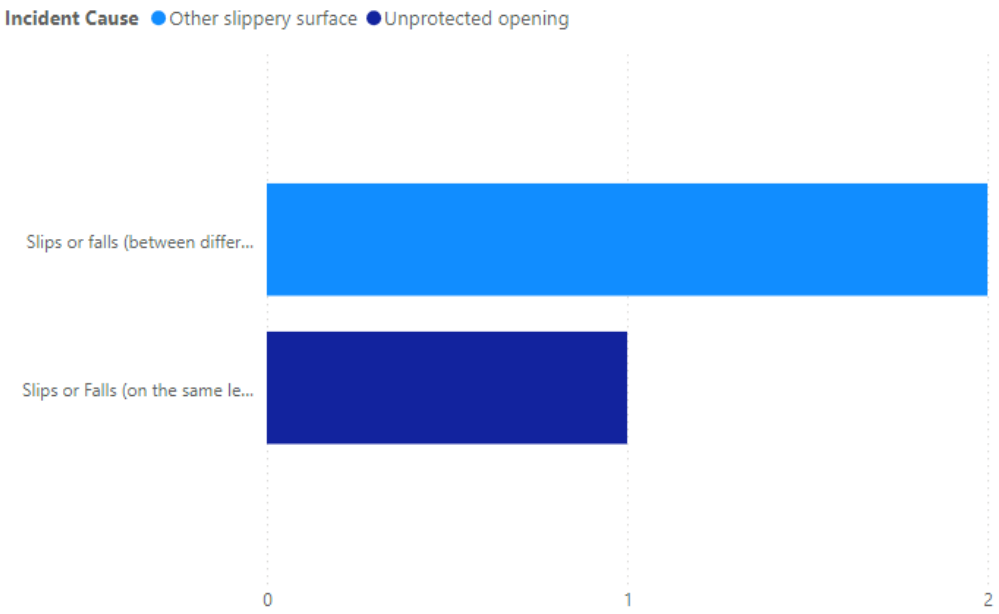

Figure 8 - Occurrences from Moving about the Ship

Seafarers should always remain aware of other jobs occurring in their vicinity when performing a task onboard, tools should be safely stowed when not in use, particularly when working at height.

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. Where cleaning or similar work is being performed, all products should be thoroughly washed off and signage or other means deployed to raise awareness to others of the risk until the area is completely dry.

6.3 Occurrences by Human Factor

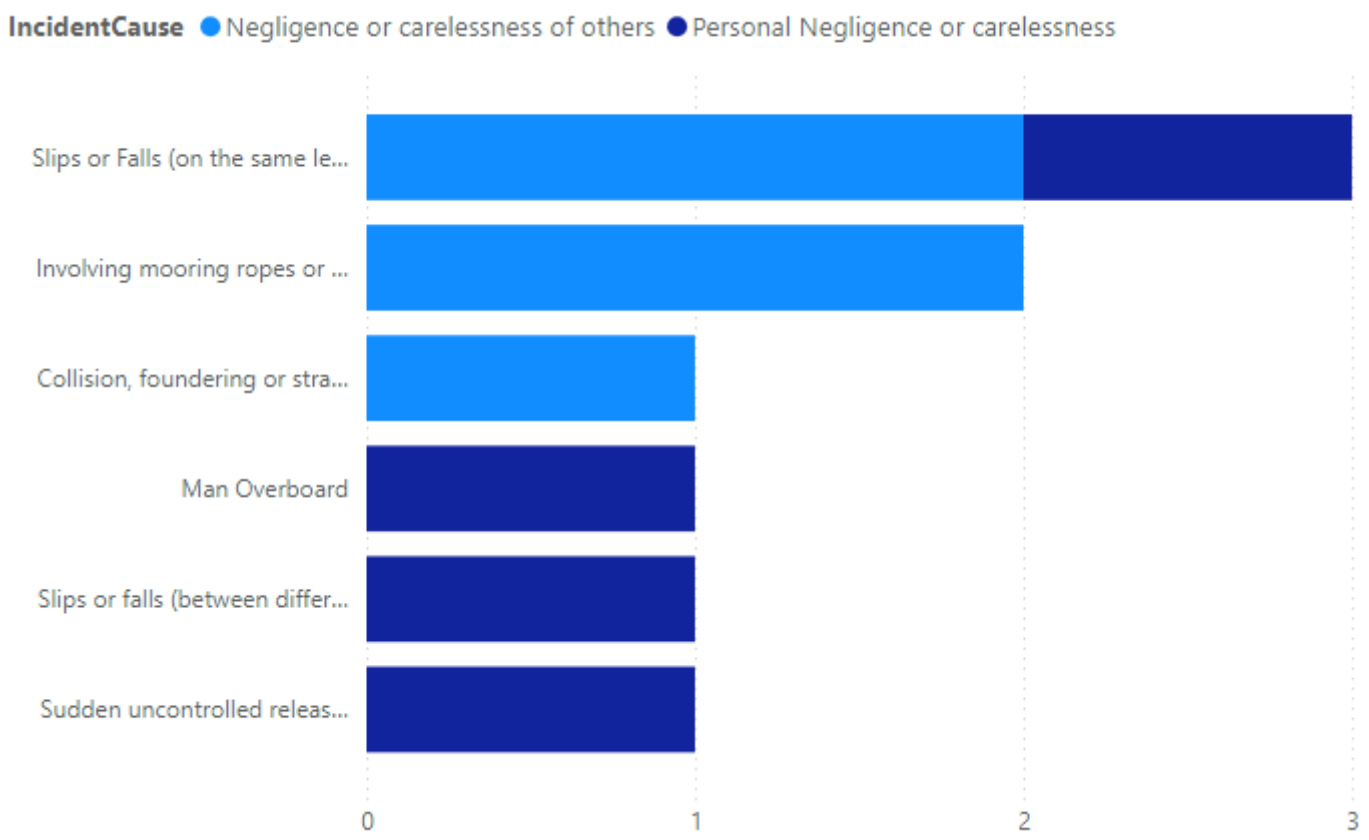

Figure 9 - Occurrences by Human Factor

By "human factor" we mean the act or omission of a person to do something that leads to the occurrence happening. It is rare that a particular occurrence can be attributed to direct malicious action by a crew member, rather, inadequate training, the temptation to cut corners on a job to try and save time and fatigue are far more prevalent reasons that the human element may factor into the reason for an occurrence happening. It is important that all crewmembers feel confident in completing the tasks assigned to them and under no time-pressure to cut corners and complete the job. Rest periods should be adequately managed onboard to ensure that seafarers do not accumulate fatigue and begin to suffer during performance of their tasks.

6.4 Occurrences by Mechanical & Other Equipment

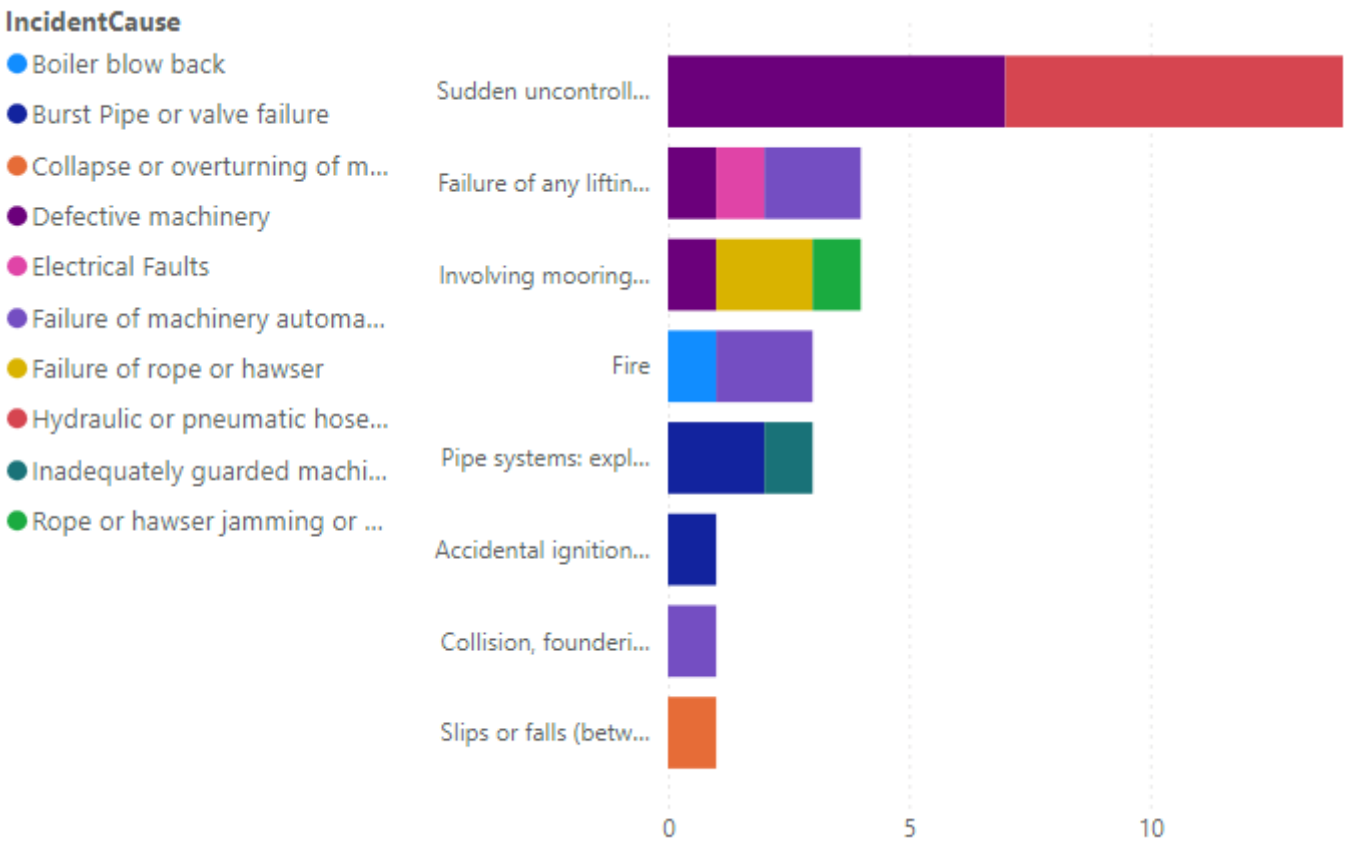

Figure 10 - Occurrences by Mechanical Factors

In 2024, the predominate cause of mechanical factors was defective machinery. Regular maintenance in line with the manufacturer's instructions are key to ensuring the long term reliability of machinery. Where there is any doubt as to the suitability of a component it should be removed and replaced prior to the job taking place. Seafarers should feel empowered to stop a job and repair or replace defective machinery rather than push through due to time constraints or commercial pressures.

6.5 Occurrences by Other Miscellaneous Causes

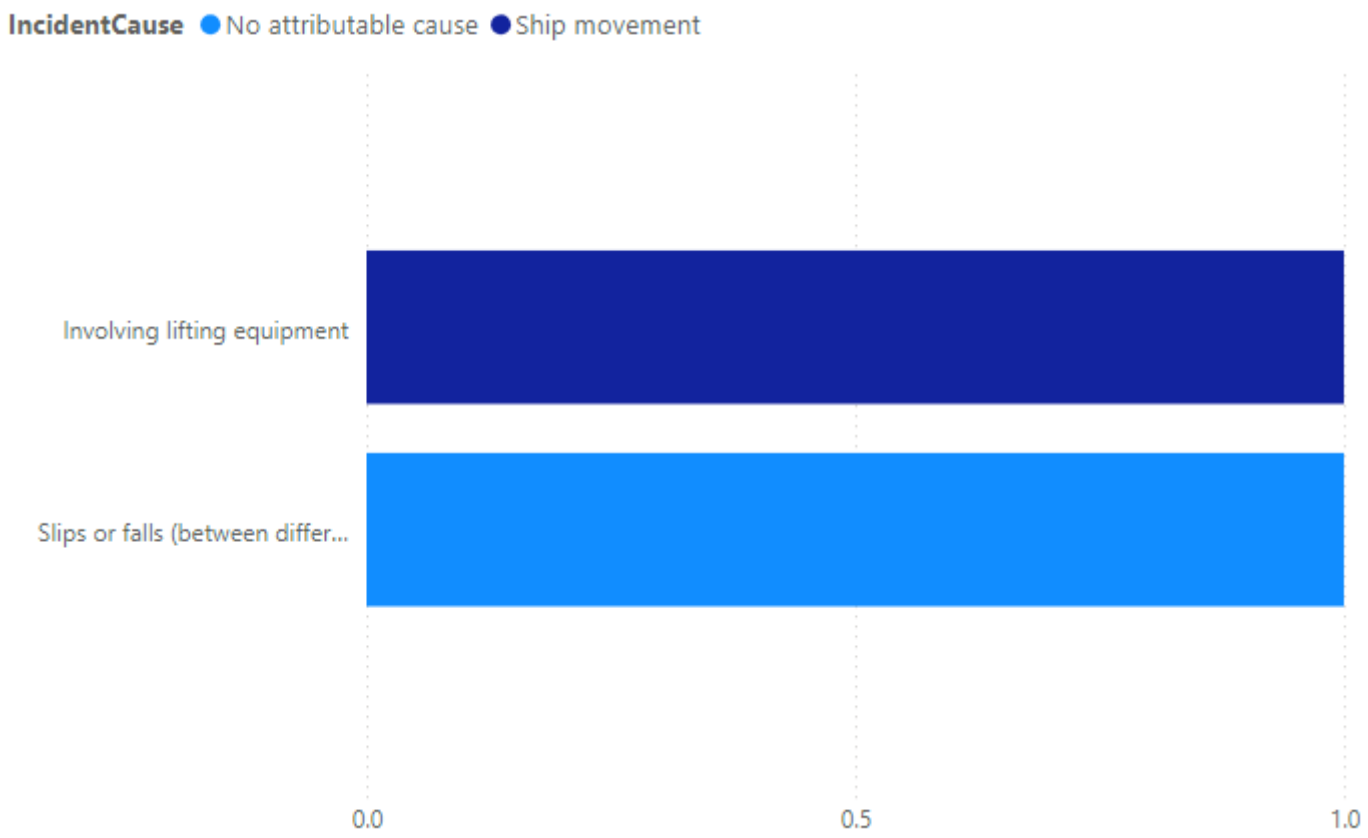

Figure 11 - Occurrences by Miscellaneous Causes

In 2024, the predominant 'other miscellaneous cause' was reported to be "ship movement". It is important to always remain aware of prevailing weather conditions and be prepared to react dynamically as a situation changes. Whilst at anchor, seafarers should be aware of other vessels within their vicinity and operate under the assumption that they may not be as aware of the weather conditions and be prepared to act accordingly.

Chapter 7 Conclusions

The most prevalent occurrences reported in 2024 were personal injuries and involving mooring.

There was 1 fatality, 8 serious injuries and 22 minor injuries to MLC seafarers reported in 2024 along with 2 minor injuries to non-MLC seafarers.

Lifting or carrying by hand and mooring operations resulted in the most severe injuries in 2024.

The ARFs received highlight the causes identified when occurrences happened. The most common causes identified for each ARF theme in 2024 were:

- Working method – Failure to comply with instructions and poor design or layout
- Mechanical and other equipment – Defective Machinery
- Human factor – Negligence or carelessness of others
- Other miscellaneous causes – Ship movement
- Movement about the ship – Slippery surfaces and unprotected openings

A significant number of the reports received could have been prevented by putting in place effective controls ahead of the work such as thorough risk assessments and toolbox talks prior to the job commencing. Seafarers should not become complacent because a job has been done many times before, the risk is still present.

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
- 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.

Appendix Summary of Select ARF Cases

Subtype	Event Description
Passenger Ship	At approximately 0900hrs the safety shutdown test as per MPM schedule was conducted. After restoring the system to running condition it was noted oil was below pressure. The boiler was immediately shutdown for investigation when it became apparent there was a fire within the unit itself. The quick closing valves were operated isolating the thermal oil and fuel oil. The air inlet was gagged and fire blankets were secured to the funnel outlet to smother. The water tight door to main engine room was shut, ventilation shutdown and dampers closed. Bridge were informed and fire hoses made ready deck 8 to drench via exhaust if needed. The fire is now extinguished and unit will be opened up and damage identified.
Oil / Chemical Tanker	Master exercising at the bridge deck twisted ankle and results in layup
Passenger Ship	During unmooring operations, a mooring line melted to a Nylacast Chock Liner at the time seafarer was attending to this mooring line. As it freed itself, it came under tension and struck the crew member
Passenger Ship	During cargo operations on the Ro-Ro deck a crew member accidently stepped into a deck recess causing a twisted knee and fall to the deck
Other Cargo Ship	Loss of deck cargo of timber. Whilst vessel anchored a period of very heavy rolling and increased gusts occurred. The stanchions gave way in a deep roll and some deck cargo (timber logs) went overboard. Logs of the incident were made in the logbook. Winds were NW'LY Force 8-9 at time of incident with approx. 4-5M swell going to the south east.
Passenger Ship	Vessel was approaching berth at slow speed. Aft spring was sent ashore as "first line ashore". Spring then parted, and stuck docker on the leg, causing what appears to be a broken leg. Vessel continued to berth and was tied up. Immediate first aid was given by shore side workers and ships staff who were waiting to board the ship. An ambulance was called and casualty was subsequently taken to hospital.
Offshore / Standby	Nuts broke off from tie rod no. 5 leg 3. As the jacking system is considered a safety critical item, reported the highest classed occurrence. A temporary repair was made and unit is now jacked up and safe.
Oil / Chemical Tanker	Vessel made contact with the jetty in port, damaged at frame 60 (4P ballast tank) about 0.5m above the waterline and is approximately 1m in length.
Passenger Ship	When letting go from berth, the aft spring mooring line was lifted off the mooring bollard but was fouled on part of the shore structure.

	The aft winch operator heaved up in an attempt to pull the line free. Shore dockers advised the rope's eye was caught and that the line should be slacked back. The winch operator slacked down the winch to allow the shore dockers to free the eye of the rope. The dockers advised that the eye had caught on a securing bolt for scaffolding. The aft mooring party were unable to sight the obstruction due to lack of lighting on the relevant mooring bollard and surrounding area.
Bulk Carrier	During watch keeping on the bridge, A/B reported to 2/O that while he was on bridge wing, a strong wind blew into his face and he felt that a foreign body got into his eye.
Gas Carrier	Vessel reported leakage from 3-way rotary SW re-circulation valve
Other Cargo Ship	The vessel was proceeding from the anchorage towards dock under pilot instruction and with single tug assistance / made fast aft. At approx. 25-30mtr from the lock gate the Pilot made the decision to abort the approach, the vessel then cleared the lock approach stern first using own power and tug. Once clear, second tug ordered to assist due to strong gusting SW 5-6 wind. Aft tug was requested to release tow and re-position Fwd as second tug was not able to enter the locks and would take up station aft. During the release of the rope towline and whilst clearing the line as it was being winched back on board by the tug the lighter line messenger became caught around the Motorman's foot, despite being witnessed by the Second Office who immediately signalled to the tug, and use of the handheld radio to the Bridge, winching continued causing the Motorman to be dragged by the foot to the fairlead where it became trapped tearing off the safety boot with the Motorman's toes becoming severed inside.
Passenger Ship	AB was stowing a trestle on the Car Deck (Dk3) at the end of the load, towards the bulkhead in Lane 7. Hand got crushed between the trestle and the bulkhead.
Other Cargo Ship	During installation of ship's portable gangway, AB was involved in the job. He was keeping in his hands rope which was tighten up to the gangway structure for adjusting position of gangway. Suddenly gangway moved from position and pull up the hand of AB toward the quay. Next moment he hit the railing by his right hand. He stopped the job and left the area. After inspection was found what his ring finger seems dislocated. Agent called ambulance. Ambulance arrived in a few minutes and brought the crewmember to the hospital. AB was wearing helmet, gloves, safety shoes and working overall during work on deck.
Bulk Carrier	Vessel was enroute for loading operation. Bilge cleaning and testing of the Water Ingress Alert System (WIAS) was planned for all cargo holds that required man entry. The daily work plan meeting and onsite toolbox safety meeting were duly completed before commencing the work. The OS was assisting Bosun and AB in carrying out the planned tasks which required opening the entrance (booby) hatch cover. While the Bosun and the AB were preparing for the assigned task, the OS proceeded to open the aft booby hatch cover of the #1 cargo hold. As the hatch cover reached 90-degree vertical position, the OS moved to the rear side of the cover to secure it using a toggle pin. During the process, the OS lost hold of the hatch cover and it unexpectedly fell making an impact against his jaw resulting in a laceration under the lower lip and broken teeth of the upper jaw.

	Initial first aid was administered onboard. As per ISOS advice, the vessel was diverted to the nearest port for further assessment and medical treatment ashore. The OS was safely disembarked and was immediately taken to the hospital.
Oil / Chemical Tanker	Chief Engineer while taking daily machinery rounds of Engine Room. He was inspecting the generator No 1, tripped on a projection on the floor plate and fell down. While falling down he used his right palm to cushion the fall and his right wrist got swollen (injured). Was wearing full PPE at the time of incident.
Passenger Ship	During bunkering the connection between the shore side hose reel and the hose failed, this caused a fine mist of fuel to start flowing from the connection.
Oil / Chemical Tanker	A wedge was forced between two flanges of a Sch 80 10" steel pipe to facilitate replacement of a gasket, the pipe was at a high level in a very awkward position, while the motorman positioned the wedge the 2nd Engineer climbed down from above the pipe level to inspect the flange gap, he started to slack a flange bolt and the wedge dropped from the flange and connected with the 2nd Engineer's forehead.
Other Cargo Ship	In the morning the engine room crew and fitter started preparing tools and materials for a hot work cutting a hole in the Engine Control Room for installing a new pipe for AC system of Engine Control Room. At 09:20 am the hot work preparations for the cutting hole in the Engine Control Room were completed. Hot Works Risk Assessment consulted and Hot Work Permit issued. When all the preparations were done fitter sparked the torch and tried to adjust the flame. At the same time the bosun was working in the workshop and heard the blast from the gas distribution box and immediately reported to the Bridge and all Engine crew were alerted. Crew on scene reported to the Bridge and started fighting the fire inside of the box. At the same time Fitter ran upstairs to close Oxygen and Acetylene cylinders at the gas station. The gas was put out with CO2 fire extinguishers (to cool down the distribution box). Situation was taken under control. Found gas hoses damaged. Company advised.
Oil / Chemical Tanker	Whilst paying out aft mooring lines, finger was caught and jarred in the rope. No visible swelling or damage at time of incident. 2/O was given cold compress to reduce any potential swelling.
Oil / Chemical Tanker	Deck operation was in progress tank cleaning with fixed machines with 63 to 65°c hot sea water. Ch. Mate was in charge of operation. Casualty was working under bosun supervision at time. In process of transferring wash hose from 6 Stbd to 1stbd. Bosun had left area temporarily to retrieve 2nd hose, leaving the OS unsupervised. Connected one end of 3 meter tank wash hose to tank wash valve 1 Stbd Aft. Other end was not secured. Attempted to flush line and hose with water. Opened valve fully in uncontrolled manner. Sprayed hot water and steam. Did not close valve back and attempted to leave area instead. Hot water and steam then caught him on the back of the legs when leaving.
Passenger Ship	Whilst vessel was manoeuvring on to berth, crewmember after sending the heaving line ashore moved position and stepped in the bight of rope that was coiled on the deck ready to go ashore. As he stepped into the bight, the rope started paying out when the dockers started pulling the heaving line. 2O on deck shouted to alert crew. Crewmember jumped out the bight as the rope was coiling around his leg, just in time to avoid injury.
Offshore / Standby	On the morning of 5/12/24 it was noticed that a redundant padeye on the stbd side of the hull was resting against the harbours hard Teflon plate fender and had been

	pushed upwards. The vessel had arrived the previous evening on a high tide with approx. 2 foot of extra tide due to low barometric pressure, tidal range around 1m. Winds on arrival were approx. 20kt with squalls gusting to 30 kts from the southwest which would have been pushing the vessel directly onto the berth. It appears that on arrival the padeye will have been above and clear of the fender then as the tide fell came to rest upon the fender however with winds overnight having further increased and been pushing the vessel hard against the quay the padeye has remained on the fender as the vessel went down with the tide. Lighting on quayside was poor and the pilot made comment on this on approach, noting that vessels didnt often berth here at night. The vessel was pulled forward on the quay to move the padeye forward of the fender and an inspection was undertaken which revealed a crack in Water ballast 20sb above the waterline. The crack had a total length of around 45cm and was in the area of frame 19. There was slight indentation to shell plating above the crack with no indentation below or on the adjacent deck level. Class and repair facilities have been informed and a repair plan is being formulated.