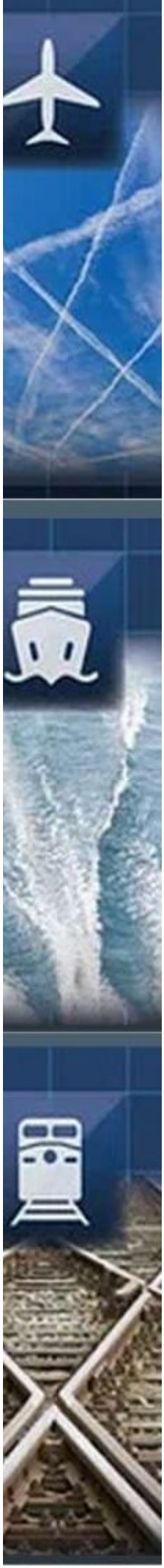

Transporta nelaimes
gadījumu un incidentu
izmeklēšanas birojs

Simplified report Nr. 2-2026

Occupational accident (leg trauma) onboard of Latvian flagged vessel CAPELLA in port of Vasteras (Sweden) on 21th January 2026

2026

Content

1. Preamble

The sole objective of the investigation of an accident shall be the prevention of future accidents through the ascertainment of its causes and circumstances. It shall not be the purpose of an investigation to determine liability nor to apportion blame. The information provided in the report is not intended to be used in legal proceedings.

Latvian TAIIB has received an initial notification about occupational accident onboard if Latvian flagged vessel CAPELLA from Swedish maritime accidents investigation authority on 21 January 2026 by email. A seaman (AB) sustained a leg injury during cargo operations.

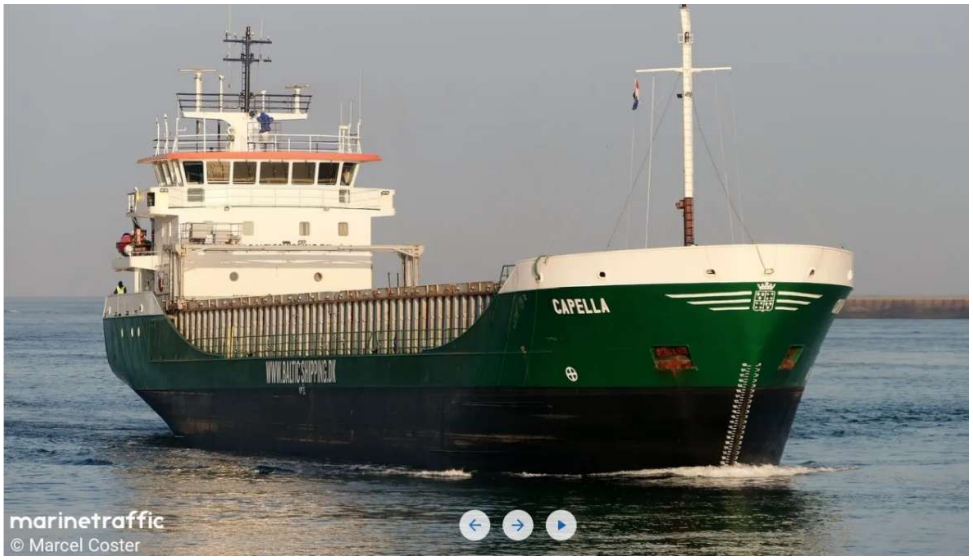

Image 1. Vessel CAPELLA (IMO 9190171)

List of abbreviations

AB	Able Seaman
ISM	International Safety Management (Code)
OS	Ordinary Seaman
SMS	Safety management system
TAIIB	Transport accidents and incidents investigation Bureau

2. Short description of an accident

On 21 January 2026, CAPELLA has finished cargo unloading operation in port of Vasteras, being in process of preparation for next voyage. Cargo hold hatch was in process of closing using vessel's gantry crane at 14.30, OS has been operated crane's control console while his colleague AB was accidentally struck on the leg by the crane on portside of crane's driving mechanism at vessel's fore. Leg has been factually trapped between crane's rail and moving

part, resulted by injury. AB has shouted and waived to operator (OS), who stopped movement immediately and switched out electric power. After freeing of leg from crane's mechanism injured person was taken to hospital. Later AB was released from the vessel due to inability to continue contract.

3. Facts

Accident basic data are shown in Table 1

Table 1

Vessel's name	CAPELLA
IMO number	9190171
Call sign	YLRB
Flag state	Latvia
General measurements	Gross Tonnage 2780 tons; Length 89 meters; Width 13.30 meters, Draft 4.2 meters;
Ship owner/operator	REEDEREI HEINZ CORLEIS KG
Vessel built /hull materiel	1999/steel
Minimum safety crewing	7 persons
Vessel's type	Dry cargo bulker
Voyage from-to	Vasteras
Voyage segment	Cargo operations in port
Cargo	None
Crew	7 persons
Accident data	
Accident severity/description	Serious, leg trauma, person's inability 72h+
Date and time of accident	20.01.2026; 14:30 local time
Accident coordinates	Port of Vasteras
Weather conditions:	Calm weather/slight wind; -3 degrees Celsius; daylight;
Location onboard	Portside vessel's fore, gantry crane's rail
Vessel's operational activities during the accident	Cargo hatch closing after completion of cargo unloading operations
Human factors data	Possible factors: 1. Insufficient awareness on bridge about crew members movements during gantry crane's operations 2. Insufficient awareness of two persons involved in hutch closing operation.
Consequences (for people, ship, cargo, environment, other)	Crew member's serious leg trauma
Shore authority involvement and emergency response	
Involved authorities	N/A
Involved units and resources	N/A
Speed of response	N/A
Actions taken	N/A

Results achieved	N/A

4. Narrative

Vessel has completed cargo unloading operations in port of Vasteras on 21 January 2026 at afternoon. Crew has started standard hutch closing operation before 14:30. During operation one crew member (OS) was on control of gantry crane with the task of moving it forward and back for closing sections of hatch one by one, while another crew member was with the task of general control of smooth crane's power cable as well as proper locking of hatch cleats in stowage position (see Image 2.)

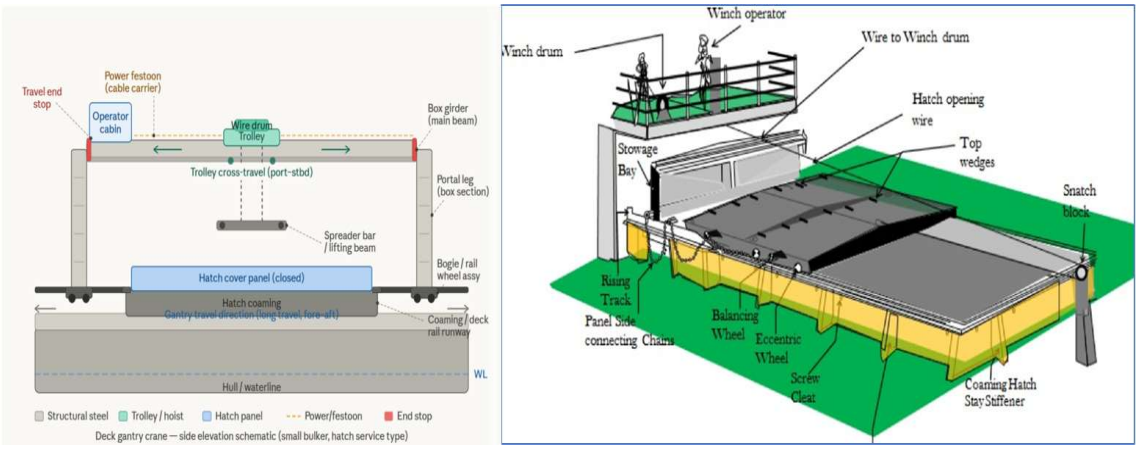

Image 2. Generic parts and elements of vessel's gantry crane and cargo hold hutch


Image 3. Location onboard (by red dot, view from bridge) and visualisation of trapped leg at moving part of gantry crane at vessel's fore deck

During crane's movement at vessel's foredeck in forward direction AB has been walking hereaway, assumingly for visual control of hatch cleats to be closed properly. Stepping on fore

deck's gangway AB's leg got stuck between moving wheels (travelling mechanism) of gantry crane and rail, assumingly it has happened due to momentarily distracted attention from moving parts in vicinity, and general narrowness of the walking path at gangway. After leg being stocked in wheels, AB has shouted in order to draw attention of crane's operator, who acted rapidly, arresting movement of crane and switching out electric supply. Two crew members appeared immediately, it has taken several minutes to release leg safely. Injured crew member has been evacuated to local hospital (paramedics arrived onboard within 30 minutes). Leg injury has been qualified as serious.

Remark: within the framework of the investigation conducted onboard the vessel CAPELLA, it has been established that all crew members held valid certification in compliance with the Standards of Training, Certification and Watchkeeping (STCW) as prescribed by the International Maritime Organization. The certification records reviewed during the course of the investigation confirm that the crew met the applicable regulatory requirements with respect to training, qualification, and certification for their assigned duties.

5. Analysis

5.1. Gantry crane and cargo hold hatch

The vessel is equipped with the mounted gantry crane, named Hatch Crane 15kw, fitted specifically to open and close the folding hatch covers without shore assistance or port crane dependency. The crane does not normally handle cargo — its primary function is hatching panel handling only (see Image 2.).

Image 4. Hatch closing cleat onboard

A folding cargo hatch onboard of CAPELLA serves several interconnected functions, each critical to the safe and efficient operation of the vessel. Primary structural function is to close and seal the cargo hold opening against the sea and weather. Weathertight sealing is achieved by compression bar system running around the full perimeter of each panel at the coaming top. When the cleats are dogged down, they press the panel flanges firmly against packing strip, preventing any ingress of seawater or rainwater into the cargo. On a bulk carrier this is especially important because bulk cargoes can shift, spoil, or in some cases liquefy if they become wet, with potentially catastrophic consequences for stability.

Cargo access is an operational function. When the hatch is opened, the panels fold and stow compactly at the coaming ends, leaving the full clear opening of the hold available for loading and discharging via grabs, conveyor belts, or pneumatic systems. The folding mechanism is designed specifically to minimise the footprint of the stowed panels. On CAPELLA hatch opening may span most of the beam, maximising that clear opening, directly affecting cargo handling speed and port turnaround time.

In summary, the folding hatch is simultaneously a watertight door, a structural beam, a cargo access platform, and a safety barrier, all packaged into a mechanism compact enough to open and close quickly in port under hydraulic power.

Normally the process of hatch closing/opening procedures ae being executed by two crew members under supervision of duty officer. One crew member operates gantry crane console, controlling crane’s movement, while another is visually controlling power supply cable proper laying/drumming when winding it along crane movement, as well as smooth locking of cleats

on hatch folding panels (see Image 4.) There are only visual/verbal means of communication between those involved in hatch closing/opening operations. During movement of crane on rails there is permanent warning flashing light and bell sound.

5.2. Human erroneous actions and omissions

The most significant individual erroneous action possibly is AB (injured crew member) positioning of himself on the side of the hatch cover while the crane was still in operation and the closing sequence was ongoing. This placed him directly within the crane's danger zone without authorisation or awareness of the machine's movement path. According to his statement he was distracted and forgot to listen for the crane's audible warning signal, even though he was aware such a signal existed. He turned his back to the moving crane, thus losing visual situational awareness. He also acknowledged that the red warning light on the crane was active at the time, meaning two simultaneous warning systems — audible and visual — were present and functioning but were not heeded. His leg entered the area of the wheel mechanism on the crane, suggesting he was standing closer to the machinery than any safe working procedure would permit.

Possible omissions of Crane operator: OS was operating the crane to close the hatch cover, and he was unaware his colleague had moved into the adjacent danger zone. Possibly, OS did not know his colleague would approach that side of the crane, suggesting there was no communication protocol or toolbox talk conducted before the operation began. He became aware of the accident only when he heard a screaming and then shut down the crane.

Possible omissions of a Duty Officer. Vessel's "Table of shipboard working arrangements" states quote*…" Port watchkeeping. During cargo operations-duty officer & duty deck hand must be available on deck, including hatch cover opening and closing" …* unquote. The line of events during accident did not include factual activities of a duty officer in matter of control and supervision.

5.3. Analysis of vessel's SMS

In framework of investigation company has submitted set of SMS documents that are directly and or indirectly related with the accident. Titles of those documents are presented in Table 2.

Table 2. Vessel's SMS documents

Title of document	Description	Signatures /marks of involved crew members	Possible relation to hatch opening/closing procedures
Familiarisation of newly assigned crew members (folders ISM)	Questionnaire for all newcomers onboard regarding emergency procedures, safety routes, mustering, life rafts etc.	Signed	Questions as follows: 1.Which areas onboard are declared as restricted? 2.Who is authorised to enter restricted area? 3.What are Your watch duties at port? *Remark: there are none written data about underlying content of those questions*
Drill exercise matrix (ISM Folder3)	List of completed and planned calendar drills and exercises for different topics: mustering, oil spill management, lifesaving equipment management, search and rescue etc.	Calendar datums of completed /planned drill	Training "Bunkering" (planned to be conducted on 25.02.26) *Remark: there are none written data about underlying content of those trainings*
Training report (ISM folder 3) executed 27.12.25	Mustering, Man overboard, grounding, etc.	Signed by all crew members	None
Monthly meeting of safety committee (25.12.25)	Safety measures and procedures in different aspects	Signed by all crew members	Safe practise onboard during ship's operations: handling of hatch, gantry crane *Remark: detailed analysis of the document is in chapter 5.3.1.*
Risk asessment document: DAMAGE ON SHIPs CONSTRUCTION / PERSONAL INJURY. H/C OPENING-CLOSING / GANTRY	Mitigation measures: 1.Training and awareness drills 2.Access over covers only once they have been closed correctly 3.Safety protection should be available on all open hatches 4. Hatch covers should duly be secured when open 5. Maker's instructions to be followed 6.Hatch covers to be operated in the presence of the DUTY OFF. 7.Proper Maintenance	Document designates responsibility of CO/WO; is due to 17.01.26	Direct relation with gantry crane/hatch handling *Remark: detailed analysis of the document is in chapter 5.3.2.*

CRANE SAFE OPERATIO N. Low risk; good detectability	8.Emergency stops to be checked regularly 9.Hatch covers to be operated by crew trained for the job		
Instructions Hatch Crane 15 kW	Four pages		The four-page crane instruction document is technically adequate as a description of how the hatch crane 15 kW functions mechanically, hydraulically, and electrically. As an operational safety document for personnel working in the vicinity of the crane, it is not relevant. It does not merely omit safety instructions — it describes the specific components that caused the accident, the specific operating speeds that created the hazard, and the specific single-operator control arrangement that made independent safety observation necessary. No safety conclusion from any of these descriptions. A crew member who read and followed this document in its entirety would be well informed about how to operate the crane mechanically and entirely uninformed about how to protect themselves or others from it.

5.3.1 Analysis of vessel's document: Monthly meeting of the Safety Committee

This is the formal record of the Monthly Meeting of Safety Committee held on 31 December 2025, signed by four vessel's senior officers. It also was countersigned by the Designated Person Ashore, identified by the signature on the same date. This means the DPA personally reviewed and endorsed this meeting record on 31 December 2025 — three weeks before the accident. The document is therefore not merely a shipboard record. It has been seen, signed, and implicitly approved by shore management at the highest safety oversight level required by the ISM Code. Among the subjects listed as discussed at the December 2025 safety committee meeting is the following specific item: **"Safe practice on board during ship's operations (handle of gantry crane, shifting of bulkheads)".** This entry establishes that the safe handling of the gantry crane was explicitly discussed at the safety committee meeting on 31 December 2025 — twenty days before the accident. The Master, the Chief Officer, the Chief Engineer, and the Safety Officer all participated in this discussion and signed the record confirming it took place. The DPA countersigned the same day. Every person in the company's safety management chain from the vessel's officers to the shore-based designated person was therefore on record as having discussed gantry crane safe practice in December 2025.

Discussion of safe practice for the gantry crane at the December 2025 safety committee have not produced any practical outcome — any instruction, reminder, and/or verification of compliance with the procedures specified in the risk assessment — none of it was reflected in the conduct of the operation three weeks later.

5.3.1.1. The final substantive entry in the meeting record reads: **"As a whole, the condition of environment of safety for crew is of considered to be safe and satisfying the Code of Safe Working Practice."**
Statement constitutes a formal collective assessment that the safety environment on board MV Capella was satisfactory as of that date. Twenty days later, a crew member had his leg trapped in the drive of the gantry crane during an unsupervised operation, suffered a severe injury. There is possible gap between the formal collective assessment of 31 December 2025 and the reality demonstrated on 20 January 2026.

5.3.1.2. The meeting record notes that incident reports were discussed, specifically:

"202601 Near disaster in fog" and **"202603 Big bags cause big trouble"** These reference codes suggest that at least two prior incidents or near misses had been formally recorded and were being reviewed at the December 2025 safety meeting. The existence of a near-miss reporting system that was generating reports is not in itself a finding of non-compliance —it is a positive indicator that the reporting culture was functioning to some degree. However, the specific content of these incidents is not recorded in this document, and their relevance to the accident cannot be fully assessed without the underlying reports. The question raised by the accident is whether that activity was translating into genuine operational improvement or whether it remained at the level of discussion without behavioural change.

5.3.1.3. Training and drills: January 2026 plan discussed

The meeting record states: "Drills and Trainings plan for January 2026 discussed."

This entry is directly relevant to the risk assessment which showed training and awareness drills ticked as done and existing on 17 January 2026. If the January 2026 drills and training plan was discussed at the December 2025 safety committee, it was presumably a planned and scheduled programme. The risk assessment three days before (see Para 5.3.2) the accident confirmed these drills as having been completed. Yet the behaviour of both crew members operating crane on 20 January 2026 — AB ignoring audible warnings and OS operating without positional awareness of his colleague — is inconsistent with effective crane safety training having been conducted shortly before the accident. This raises the question of what the drills actually comprised and whether they included any specific component addressing crane operation safety and personnel exclusion.

5.3.1.4. The DPA's countersignature. The countersignature of the DPA on 31 December 2025 is the element of this document that most significantly affects the company's legal and regulatory position. Under ISM Code section 4, the DPA's role is to monitor the safety aspects of the operation of each ship and ensure that adequate resources and shore-based support are provided. By countersigning this meeting record, the DPA confirmed personal awareness of the following facts simultaneously: that gantry crane safe practice had been discussed on board, that the January 2026 training and maintenance plans had been reviewed, that prior incidents had been examined, and that the overall safety environment was assessed as satisfactory. The DPA therefore had personal knowledge, three weeks before the accident, of the specific operational area in which the accident occurred, and endorsed a finding that safety in that area was satisfactory.

5.3.1.5. Summary of the document

Monthly meeting of the Safety Committee establishes that gantry crane safe practice was a known and specifically discussed safety topic at the highest level of the vessel's safety management system three weeks before the accident. It establishes that all senior officers on board participated in that discussion and signed the record. It establishes that the DPA personally endorsed the conclusion that safety conditions on board were satisfactory twenty days before a serious personal injury occurred during the exact operation that had been discussed. And it establishes that a training and maintenance programme for January 2026 had been planned and discussed, making the subsequent confirmation in the risk assessment that these measures were done and existing: a matter that must be examined against the actual evidence of what training was conducted and, also, what maintenance was performed. The gap between the documented safety management activity of December 2025 and the operational reality of 20 January 2026 is the definitive finding.

5.3.2. Analysis of document: “Risk Assessment Capella RA-004-2026” in the context of the accident

This risk assessment was completed and closed by the Chief Officer on 17 January 2026 — three days before the accident. **Its existence proves beyond any reasonable doubt that the company and the vessel's officers were explicitly aware that hatch cover opening and closing using the gantry crane was a hazardous operation carrying risks of personal injury and damage to ship's construction**. The company had a formal risk assessment template for this exact operation. The Chief Officer completed it, signed it, and closed it three days before the accident occurred. The risk was known, documented, assessed, and mitigation measures were listed and ticked as existing and done. The accident then happened anyway. Mitigations procedures, safeguards are being analysed as follows, line-by-line:

5.3.2.1. "Training and awareness drills — Done: 17-01-26 — Existing: X"

The accident occurred because AB stood with his back to a moving crane, ignored an audible warning signal, and walked into the wheeling mechanism/transmission zone. In turn operator OS did not know his colleague was approaching. Neither man had any shared operational awareness of the other's position or intentions. If training and awareness drills had genuinely been conducted three days earlier and were confirmed as existing, these two fundamental behavioural failures would not have occurred. The tick in the "Done" and "Existing" had no operational effect.

5.3.2.2. "Access over covers only once they have been closed correctly — Done: 17-01-26 — Existing: X"

This measure addresses access to hatch panels after closure — a different hazard from the one that caused the accident. It does not address the hazard of personnel proximity to the moving crane during the closing operation itself. Its presence on the list without any equivalent measure addressing personnel exclusion during crane travel reveals a gap in the risk assessment's hazard identification that is directly relevant to the accident mechanism.

5.3.2.3. "Safety protection should be available on all open hatches — Done: 17-01-26 — Existing: X"

This measure appears to address fall protection at open hatch openings, not machinery guarding. It does not address the wheeling transmissions hazard. Its confirmation as existing and done is therefore irrelevant to the specific mechanism of the accident.

5.3.2.4. "Hatch covers should duly be secured when open — Done: 17-01-26 — Existing: X"

This addresses a different hazard — uncontrolled movement of open hatch panels. It has no bearing on the accident mechanism and its confirmation as existing provides no protection against the hazard that caused the injury.

5.3.2.5. "Maker's instructions to be followed — Done: 17-01-26 — Existing: X"

This is the most revealing entry on the entire document in the context of the crane manual analysis. The maker's instructions — the four-page document contain no personnel safety instructions whatsoever. Confirming that maker's instructions are being followed therefore provides zero protection against personnel injury from the crane wheeling transmission, because the maker's instructions never addressed that hazard. The tick in the "Existing" column here is not simply inadequate — it creates a false sense of security by implying that following the maker's instructions constitutes adequate risk mitigation for personal injury, when those instructions say nothing about keeping people away from moving machinery.

5.3.2.6. "Hatch covers to be operated in the presence of the DUTY OFF. — Done: 17-01-26 — Existing: X"

The risk assessment explicitly identifies, as a mitigation measure for personal injury during hatch crane operations, that the operation must be conducted in the presence of the Duty Officer. This measure was confirmed as done and existing on 17 January 2026. On 20 January 2026, three days later, the hatch cover closing operation was conducted with no duty officer

present. The gap between what was documented on paper and what happened in practice on the day of the accident is absolute and total on this specific point. This entry transforms the absent duty officer from a contributing cause into a documented, pre-identified, explicitly required control measure.

5.3.2.7. "Proper Maintenance — Done: 17-01-26 — Existing: X"

The wheeling transmission assembly and the surrounding structure show advanced deterioration. Confirming proper maintenance as existing on 17 January 2026 while the crane was in the condition visible in the photographs three days later constitutes either a false certification or evidence that the assessment was completed without physical inspection of the equipment.

5.3.2.8. "Emergency stops to be checked regularly — Done: 17-01-26 — Existing: X"

The accident sequence does not indicate that emergency stop functionality contributed to the injury — OS stopped the crane when he heard the shouting. However, the confirmation that emergency stops are checked regularly as an existing measure raises the question of what checking procedure was used and whether it was documented? If no record exists of emergency stop checks prior to 17 January 2026, the confirmation in this document is not supported by evidence.

5.3.2.8. "Hatch covers to be operated by crew trained for the job — Done: 17-01-26 — Existing: X"

OS was operating the crane. AB was approaching it without awareness of the wheeling transmission hazard. Neither man demonstrated behaviour consistent with having received adequate training for this specific operation three days earlier. The confirmation of this measure as done and existing is contradicted by the behavioural evidence of both men on the day of the accident.

5.3.3. The risk scoring: a possible methodological failure

The document **RA-004-2026** assigns a consequence rating of low, a likelihood rating of low, and a detectability rating of good, producing a composite score of 1.00 — Acceptable. This scoring is the most methodologically significant in the document.

A crane operating at 20 metres per minute with an unguarded drive transmission at leg height, in a confined working area with no exclusion zone, operated by a single person with no

lookout, should not rationally be assessed as having a low consequence potential for personal injury. Crush injuries, traumatic limb entrapment, and in the worst-case fatality are the foreseeable consequences of contact with this type of machinery. The actual outcome of the 20 January accident — an open wound to the lower leg requiring emergency surgery, and a period of hospitalisation — is not a low-consequence event.

The likelihood rating of low is equally questionable. The crane operates in a confined deck area where other crew members are routinely present during the same operation. The audible and visual warning systems are passive — they alert but do not prevent approach. There is no physical exclusion barrier. The operator's field of view during driving does not cover the full perimeter of the crane. These conditions, taken together, create conditions where personnel proximity to the moving crane during operation is not a low-likelihood event — it is the normal working environment in which the operation is conducted.

The composite score of 1.00 — Acceptable, reached through these three ratings, represents a risk assessment methodology that produced the wrong answer for every parameter evaluated. A risk assessment that identifies the correct hazard, lists the correct mitigation measures, but then scores the residual risk as acceptable through systematically underestimated inputs, provides no genuine protection.

The form itself is dated 31 January 2012 as the original template creation date, Revision 0. The assessment was opened and closed on 17 January 2026. This means the company has been using the same risk assessment template, at Revision 0, for fourteen years without amendment. The fact that this document was completed and closed on the same day — opened 17-01-26, closed 17-01-26 — with all mitigation measures confirmed as done and existing on the same date, raises a serious question about whether this was a genuine prospective risk assessment or a retrospective paper exercise conducted to satisfy a documentary requirement.

The document's role in the broader legal picture: under the ISM Code, the existence of a risk assessment that correctly identifies a hazard and specifies mitigation measures, followed by an accident caused by the non-implementation of those exact measures three days later, might be treated as aggravated negligence rather than as evidence of good faith compliance. It demonstrates that the company had the knowledge, the system, and the specific written instructions to prevent this accident, and that none of them were applied when it mattered.

Image5. Location of nipped leg at wheeling mechanism of the crane

6. Conclusions

1. **The accident and its immediate causes**: at approximately 15:00 on 20 January 2026, crew member, Able Seaman sustained a serious crush injury to his lower right leg while the hatch crane was being used to close hatch cover number one aboard MV Capella, berthed at port of Vasteras. His leg became entrapped (nipped) in the wheeling transmission assembly of one of the crane's four hydraulic wheel-drive units while the crane was travelling along the track rail at approximately 20 metres per minute. The injury resulted in an open crush wound to the lower leg requiring immediate emergency surgery. The accident was caused by AB positioning himself adjacent to the moving crane with his back turned toward it while distracted, and by his failure to respond to the active audible and visual warning signals. The crane operator, Ordinary Seaman, stopped the crane upon hearing the shouting. No duty officer was present at the scene at any point during the operation.

2. **The physical condition of the crane**: photographic evidence obtained by the attending local police patrol demonstrates that the hatch crane was in a condition of advanced deterioration at the time of the accident (as per police protocol, that states extensive corrosion, degraded paint, mechanical wear, and accumulated contamination are visible across the crane's structural and mechanical components). The transmission assembly that caused the injury shows evidence of prolonged inadequate maintenance. This condition is inconsistent with the annual thorough examination required by SOLAS regulation II-1/3-13 and MSC.1/Circ.1663.

3. **The crane operational documentation**: the crane's operational documentation consists of four pages of manufacturer's instructions describing the mechanical, hydraulic, and electrical systems of the crane and specifying two monthly lubrication tasks. Across all four pages, the documentation contains no personnel safety instructions of any kind. The wheeling transmission assembly that caused the injury is referenced four times in the document as a mechanical component but is never identified as a hazard to personnel. No exclusion zone is defined. No area clearance procedure is specified. No instruction addresses the meaning or required response to the audible and visual warning systems. No emergency stop procedure for personnel contact exists. The document satisfies the formal existence requirement of an operations manual under MSC.1/Circ.1663 section 3.6.2.1 while not covering the mandatory minimum content requirements of section 3.6.2.2 regarding safety instructions.

5. **The risk assessment**: Risk assessment Capella RA-004-2026, completed and signed by Chief Officer on 17 January 2026 — three days before the accident — identifies hatch cover opening and closing using the gantry crane as a operation carrying risks of personal injury and damage to the ship's construction. The assessment lists nine mitigation measures including duty officer presence at all crane operations, training and awareness drills, proper maintenance, and crew trained for the job, and confirms all nine measures as done and existing on the same date the assessment was opened and closed. The assessment assigns consequence, likelihood, and detectability ratings that produce a composite risk score of 1.00 — Acceptable. The accident three days later demonstrated that none of the nine mitigation measures was functioning in practice, that the consequence rating was substantially underestimated, and that the risk score of acceptable was not supported by the operational reality on board.

6. **The safety committee meeting**: the Monthly Safety Committee Meeting record for December 2025, signed by the Master, Chief Officer, Chief Engineer, and Safety Officer on 31 December 2025 and countersigned by the Designated Person Ashore on the same date, records that safe practice during gantry crane operations was specifically discussed at the meeting. The record concludes that the overall condition of safety for the crew was considered safe and satisfying all requirements. The DPA's countersignature on this document twenty days before the accident establishes that shore management at the highest ISM Code oversight level was personally aware that gantry crane safe practice had been discussed on board, had endorsed the

conclusion that safety conditions were satisfactory, and had taken no independent action to verify that the measures discussed were being implemented in practice.

7. **The absence of precautions:** the risk assessment signed three days before the accident explicitly identifies duty officer presence as a mandatory mitigation measure for personal injury during crane operations. The December 2025 safety committee meeting record confirms that safe practice during crane operations was a known and discussed topic among the vessel's senior officers. The hatch cover closing operation on 20 January 2026 was conducted by two ratings without any officer present, without a pre-operation briefing, without an exclusion zone, and without any communication protocol between the crane operator and the deck worker. The absence of the duty officer is the non-fulfilment of a control measure that the company's own safety management system had identified as essential three days earlier.

8. **The summary of the documentary evidence** — the risk assessment, the safety committee meeting record, the crane operations manual, the maintenance documentation, and the accident itself — presents a consistent picture of a safety management system that was producing the required documents without generating the operational behaviours those documents were designed to require. Risk assessments were completed and closed on the same day. Safety committee meetings were held and concluded with positive findings. Mitigation measures were ticked as done and existing without verification. The DPA countersigned records without independent inspection. The result was a vessel whose paper safety record was formally compliant and whose operational safety reality was fundamentally deficient. This gap between documented compliance and operational reality is the defining systemic finding of this investigation and the condition that made the January 2026 accident not merely possible but, given sufficient time and opportunity, inevitable.

9. **General safety culture onboard**: The investigation has identified the presence of an assumption within the vessel’s operational practices that personnel holding certification in accordance with the IMO Standards of Training, Certification and Watchkeeping (STCW), do not require additional ad hoc or task-specific safety training related to lifting appliances and/or, possibly, other machinery. This assumption is inconsistent with the principles of an effective safety management system and constitutes a deficiency in the vessel’s overall safety culture. STCW certification provides a standardized baseline of competence; however, it does not encompass the specific characteristics, operational limitations, and risk factors associated with

individual lifting appliances installed onboard a particular vessel. Safe operation of lifting equipment requires not only general competence but also familiarization with equipment-specific procedures, hazard controls, and operational constraints. The absence of such targeted training increases the risk of improper operation, particularly in non-routine or high-risk lifting scenarios.

Accordingly, the reliance solely on STCW certification as a substitute for additional, situation-dependent safety instruction demonstrates a gap in risk awareness and a failure to implement continuous and adaptive safety practices.

9. **Summary conclusion**: the accident aboard MV Capella on 20 January 2026 was not caused by an unforeseeable event or an unavoidable combination of circumstances. It was caused by the systematic failure or non-existence of every layer of — physical guarding, operational supervision, pre-operation briefing, personnel training, maintenance regime, and management oversight.

7. Safety recommendations

To company REEDEREI HEINZ CORLEIS KG

1. To revise SMS and make all lifting appliances onboard of CAPELLA and fleet fully compliant with SOLAS regulation II-1/3-13.2.4 and MSC.1/Circ.1663 requirements (hereinafter Ref.A) in all aspects, and *inter-alia:*

   - Annual examination programmes (Ref.A section 3.2.2.1).

   - Physical guarding of possible nip points in compliance with machinery safety standards (Ref.A section 3.5.1.4.2, section 3.6.1.9)

   - Personnel qualification, authorisation, and familiarisation for crane operations (Ref.A sections 3.6.1.1, 3.6.1.2, and 3.6.1.3)

   - Lifting operations planning, supervision, and risk minimisation (Ref. A sections 3.6.1.8, 3.6.1.9).

To Latvian Maritime Administration:

2. To establish and implement a targeted flag state supervision regime specifically addressing compliance with SOLAS regulation II-1/3-13 and MSC.1/Circ.1663 across all vessels registered under the Latvian flag, with immediate priority given to vessels operated by Reederei Heinz Corleis KG and to all vessels of comparable age, type, and operational profile carrying rail-mounted or deck-installed lifting appliances.

TAIIB Maritime Investigator Aleksandrs Pavlovičs

(signed)