# Shipping: safety on the River Thames and the Marchioness disaster

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Author: Louise Butcher
Section Business and Transport

This note looks at the safety issues on the River Thames that came to light as a result of the Marchioness disaster in 1989 and measures taken to deal with them.

The passenger launch *Marchioness* and the aggregate dredger *Bowbelle* collided on the River Thames on 20 August 1989 resulting in the sinking of the *Marchioness* and the loss of 51 lives. The accident was investigated by the Marine Accident Investigation Branch (MAIB), and following its 1991 report a number of its safety recommendations were implemented. Further recommendations were made in the 1992 Hayes Report and by the inquest jury in 1995. There followed a public inquiry into safety on the River Thames and the circumstances surrounding the sinking of the *Marchioness*, this reported in 1999 and 2000. Lord Justice Clarke recommended a further formal inquiry into the accident and further recommendations were made in the inquiry's March 2001 report. The same day a non-statutory investigation into the identification of victims was published.

Following his various inquiries Lord Justice Clarke made a total of 74 recommendations on Thames safety. The Labour Government published three reports between November 2001 and February 2003 on the progress made on implementing those recommendations.

Safety on the River Thames returned as an issue of concern in early 2007 when the Thames Watermen campaigned against a new National Boatmasters' Licence, derived from the European Directive on the harmonisation of national boatmasters' certificates. The Marchioness Action Group appeared before the Transport Select Committee to voice its concerns at possible safety issues surrounding the new licences.

Information on other shipping and inland waterways matters can be found on the Shipping Topical Page of the Parliament website.

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# 1 The Marchioness disaster

## 1.1 The incident and its immediate aftermath

The passenger launch *Marchioness* and the aggregate dredger *Bowbelle*, both bound down river, collided on the River Thames just upstream of Cannon Street Railway Bridge on 20 August 1989 at about 2 a.m. As a result, the *Marchioness* sank and 51 of those on board lost their lives. There were 80 survivors.

On 21 August 1989 the then Secretary of State for Transport, Cecil Parkinson, announced two measures to improve passenger safety - passenger numbers for all charter vessels were to be recorded before sailing and all passengers should be given proper instructions on the emergency equipment and how to use it.[1] Regulations to make both measures mandatory came into force on 12 April 1990.[2]

The Director of Public Prosecutions announced on 26 April 1990 that the master of the *Bowbelle* was to be prosecuted for failing to ensure a proper lookout was kept and therefore causing damage to another ship and death or injury to another person.[3] As a result of this it was decided not to publish the report of the Chief Inspector of Marine Accidents until the prosecution was concluded. On 13 April 1991 Captain Henderson's trial ended after the jury failed to reach a verdict. A second jury failed to reach a verdict and was dismissed by the judge on 31 July 1991. A verdict of not guilty was entered on the charge as the Crown decided to abandon the prosecution.[4]

Mr Ivor Glogg, who lost his wife in the disaster, took out a private prosecution for alleged manslaughter against South Coast Shipping, owners of the *Bowbelle*, and four senior managers of the company. The manslaughter charges were dismissed on 24 June 1992 on

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1 "River safety clampdown by Parkinson", *The Times*, 22 August 1989

2 the *Merchant shipping (passenger counting and recording systems) regulations 1990* (SI 1990/659) and the *Merchant shipping (emergency information for passengers) regulations 1990* (SI 1990/660) were made under what are now sections 85 and 86 of the *Merchant Shipping Act 1995*; SI 1990/659 was subsequently repealed and replaced by the *Merchant Shipping (Counting and Registration of Persons on Board Passenger Ships) Regulations 1999* (SI 1999/1869)

3 at the time this was an offence under section 27 of the *Merchant Shipping Act 1970*; now section 58 of the *Merchant Shipping Act 1995*

4 see, for example: "Bowbelle case abandoned after second jury dismissed, *The Independent*, 1 August 1991; and "Survivors press for enquiry in final appeal to Rifkind", *The Times*, 8 August 1991

the grounds that there was insufficient evidence against any of the defendants to commit them for trial.[5]

### 1.2 Marine Accident Investigation Branch report, 1991

The Marine Accident Investigation Branch (MAIB) prepared an interim report on the accident within two weeks of it taking place. The then Conservative Government published the report's six recommendations for immediate action, though the full report was not published. Two of the recommendations were implemented on 18 September 1989 by amendments to the *General Directions for Navigation in the Port of London*.[6] These were:

> In all vessels of more than 40 metres in length with wheelhouse aft navigating in River Thames, a look-out should be stationed forward at all times,. He should have telephone or UHF communication with the wheelhouse and should be instructed to report all sightings.
>
> Vessels of more than 40 metres in length navigating in River Thames by night should carry a light illuminating the bow, or, alternatively, a light on each side illuminating the bow but shielded so as not to impair visibility. This should be in addition to the lights at present required.[7]

The findings of the interim report were incorporated in the report of the Chief Inspector of Marine Accidents published in 1991.

The official MAIB inquiry was a private one, not a public one. As a result of the prosecution of the master of the *Bowbelle*, is it was decided not to publish the report of the Chief Inspector until the case was concluded. However, on 24 July 1990 the Secretary of State, Cecil Parkinson, accepted all 27 recommendations in the report and decided that they should be published.[8] The report was eventually published in August 1991.[9]

The Chief Inspector allotted much of the immediate blame for the collision to the captains of the two vessels but he also castigated the 25-year long "malaise" that he said had afflicted the UK maritime industry and the Department of Transport. The document was particularly critical of the failure of the regulators to ensure that river boats were designed in such a manner that enabled the crew to keep "an efficient watch and lookout". Although it was critical of individuals, the report stated that no one should be singled out as responsible for the tragedy and recommended that no disciplinary action be taken.

The report contained 27 recommendations, which were first released in July 1990, including compulsory lookouts on larger vessels, extra insulation to block out disco music and the installation of extra navigating lights. When the report was published the Department of Transport sought to deflect any criticism by announcing it had already implemented 20 of the 27 recommendations.[10] The statement also commented on some matters that were the subject of concern to correspondents but only touched upon briefly in the report - namely

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5 see, for example: "Bereaved husband loses private case over Marchioness Disaster", *The Guardian*, 24 June 1992

6 the latest version of the *General Directions*, published in 2009, is available on the Port of London website

7 DoT press notice, "Loss of the Marchioness: Cecil Parkinson acts on interim report", 31 August 1989 [PN 89/380]

8 HC Deb 24 July 1990, cc141-42W; and: DoT press notice, "Marchioness – safety recommendations published", 24 July 1990 [PN 90/274]

9 MAIB, *Report of the collision between the passenger launch Marchioness and MV Bowbelle*, August 1991

10 DoT press notice, "Action taken on the recommendations in the MAIB Marchioness/Bowbelle report", 15 August 1991 [PN 91/247]

why all survivors were not interviewed by the Inspectors and why rescue services were initially sent to the wrong bridge.

Of the seven outstanding recommendations, four were subject to consultation and legislation was consequently introduced in 1992 and 1993; one depended on international developments agreed by the IMO Maritime Safety Committee; and consideration of the remaining two recommendations, relating to the involvement of military helicopters in civil search and rescue, resulted in agreement on the first and a decision being taken on the second that infrared heat-seeking equipment would not be necessary as night vision devices worked just as well.

### 1.3 Hayes Report, 1992

Following criticism of the Department of Transport the then Secretary of State for Transport, Malcolm Rifkind, asked Mr John Hayes, the Secretary of the Law Society, to carry out an inquiry into the Department's handling of its responsibility for the safety of vessels on rivers and inland waterways.[11] The Hayes report was published in July 1992 and concluded that the Department showed "technical competence and dedication but lacked the vision and drive to lead the river marine industry into accepting that high safety standards and commercial success were compatible".[12]

The report's 22 recommendations included:

- The Department for Transport should take a much higher profile in promoting safety;
- There should be more river safety spot checks;
- There should be an early review of the rescue arrangements and equipment on the Thames; it should take account of the views of the witnesses to the Marchioness/Bowbelle accident;
- The Merchant Shipping Acts should be rationalised;
- There should be new legislation to permit breath testing of skippers and crew; and
- There should be an annual report, by the Government, of its performance against implementing the recommendations that follow the reports on all major disasters.[13]

The Government's initial response was published on 7 July 1992.[14] The then Secretary of State, John MacGregor, refused a further review of rescue procedures and equipment on the Thames but did state that action was being taken to ensure that the lessons of the *Marchioness* disaster were being fully assimilated. A series of district marine safety committees were established throughout the country to review the way in which responsibilities for safety, rescue and accident prevention were distributed. The Secretary of State also accepted the recommendation to publish annually the progress being made on the implementation of recommendations made after any major disaster. Consequently, the first annual summary of the progress made on the recommendations of the official enquiry into

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11 HC Deb 19 December 1991, c237W

12 DoT, *Report of the Enquiry into River Safety*, Cm 1991, July 1992, para 2.2

13 ibid., paras 2.5.1-2.5.22

14 DoT, *Report of the Enquiry into River Safety conducted by John Hayes: recommendation & Government initial response*, 7 July 1992 [HC DEP 8182]; a summary of the Government's view on the report was given by the Minister for Transport in London, Steve Norris, in response to a debate later the same month, see: HC Deb 9 July 1992, cc700-04

the Marchioness collision was published in July 1993 and showed that by that date actions had been completed in all cases.[15]

### 1.4 Coroner's inquest, 1990-1996

The coroner's inquest into the deaths was adjourned in April 1990 after four days because of the criminal proceedings involving Captain Henderson.[16] In July 1992 the Westminster coroner, Dr Paul Knapman, decided not to reopen the inquest.[17] There followed a successful legal challenge by the relatives of some of the victims and in October 1994 the West London coroner, Dr John Burton, agreed to hold a new inquest.[18] On 10 March 1995 the Lord Chancellor granted legal aid to the families of the 51 people who died, allowing them to be represented by counsel at the inquest that opened 13 March. Legal aid is not normally available for inquests but Lord Mackay agreed their case was "wholly exceptional in terms of the number of deaths, the number of parties involved and, most crucially of all, the fact this is a second inquest". Families had paid their own legal costs at the first inquest. Government and the owners of both vessels would be legally represented at the second and it was agreed that the families should also be.[19]

The inquest jury decided on 8 April 1995, by a nine to one majority, that the 51 people who had died as a result of the collision were unlawfully killed. The jury also called for tougher safety laws to prevent a repeat of the accident and made twelve recommendations, including legislation on maximum blood alcohol levels for seamen on duty. During his summing up the coroner had said that a verdict of unlawful killing could not apply to anyone cleared by a court, presumably referring to Captain Henderson and South Coast Shipping, the operator of the dredger. Despite this, the jury insisted on their verdict.[20]

The Crown Prosecution Service considered the transcripts but decided not to institute further criminal proceedings on the ground that there was insufficient evidence.[21] The Government considered the twelve safety recommendations put forward by the jury but did not believe a public inquiry was necessary. In January 1996 the Transport Minister, Steve Norris, stated that:

> The Department agrees with the majority of the jury's 12 recommendations. In many cases, existing rules and guidelines already meet the jury's proposals [...] The jury endorsed the earlier recommendations of the marine accident investigation branch report into the Marchioness sinking, together with the recommendations of the report of the inquiry into river safety by Mr. John Hayes. All of the recommendations in the MAIB's report have since been implemented. Action has also been taken on the recommendations of the Hayes report [...][22]

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15 DoT, *Progress on MAIB recommendations in Marchioness report, June 1993; Recommendations from the Hayes report on river safety: follow up action*, 19 July 1993 [HC DEP 9520]

16 “Captain of Thames dredger to face charge in Marchioness boat disaster inquiry”, *The Times*, 27 April 1990

17 “Coroner will not reopen Marchioness inquest”, *The Guardian*, 25 July 1992

18 “Marchioness families win new inquest into collision”, *The Times*, 19 October 1994

19 "Marchioness families win inquest aid", *The Guardian*, 11 March 1995

20 “Thames deaths ‘unlawful’”, *The Guardian*, 8 April 1995; “Marchioness victims ‘killed unlawfully’, *The Times*, 8 April 1995

21 "File closed on Thames tragedy", *The Guardian*, 27 July 1996

22 HC Deb 31 January 1996, c803W; the Government’s views in detail were set out in a report appended to a press notice published the same day, see: DoT press notice, “DoT responds to Marchioness jury recommendations”, 31 January 1996 [PN 96/24]

### 1.5 Public inquiry, 1999-2003

Demands for a public inquiry persisted throughout the early 1990s, although they had to be curtailed during the time of the trial of the captain of the *Bowbelle*. The victims and the relations of those who died saw a public inquiry as the only means of obtaining a full and open examination of the facts surrounding the disaster. They wanted an opportunity to have their say and to have legal representation to ask the questions they wanted answered. They also argued that most transport disasters on this scale had been the subject of public inquiries. Certainly in the cases of Zeebrugge ferry disaster and the Clapham rail crash, public inquiries were ordered under high court judges. The Conservative Government's view was that nothing new would be gained by a public inquiry. For example, the then Transport Minister, Steve Norris, said:

> When the then Secretary of State considered the need for a public inquiry he concluded that the holding of a formal investigation was unnecessary given that a full, thorough and comprehensive inquiry had been carried out by the marine accident investigation branch MAIB. Subsequently, the view has remained that a formal investigation would be unlikely to add to the inspector's findings, or to the 27 safety recommendations made in the MAIB report. The position was not changed by anything said in the Hayes report, which made no suggestion that a further inquiry into the accident was needed. I therefore remain of the view that the case for a formal inquiry has not been made. [23]

And the Minister for Aviation and Shipping, Lord Goschen said:

> My Lords, the Government do not believe that a public inquiry is needed. The circumstances of the tragedy were established by the Marine Accident Investigation Branch whose findings were accepted by the inquest jury. We have acted on the recommendations in the MAIB report and on those of the later Hayes inquiry into river safety. The inquest jury welcomed this and put forward 12 further safety recommendations to which we are giving urgent and careful consideration. [24]

In 1991 the Labour Party's Transport Spokesman, John Prescott, said that the Labour Party, were it in Government, would hold a public inquiry.[25] On coming to office in May 1997, the Labour Government reviewed the case for a public inquiry and on 18 August 1999 Mr Prescott, then Deputy Prime Minister, ordered a wide-ranging public inquiry into safety on the River Thames and the circumstances surrounding the Marchioness disaster. The terms of reference for the inquiry were:

> To review the responsibilities of Government Departments, the Port of London Authority and any other persons or bodies for promoting safety on the River Thames ("the River") and advise:
>
> - Whether they are sufficient for the purpose and are properly allocated;
> - Whether they are properly discharged;- Whether there are in place effective arrangements to ensure that all relevant persons and bodies co-operate effectively;
> - Whether the safety measures applied to vessels on the River are sufficient and are adequately enforced; and

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23 HC Deb 9 December 1993, c337W

24 HL Deb 10 May 1995, c64

25 Simon Hughes on behalf of the Liberal Democrats also called for a public inquiry at the time, see: "Rifkind rejects inquiry call over pleasure boat disaster", *The Independent*, 1 August 1991

- Whether the safety procedures and rescue facilities on the River are sufficient to respond to emergencies arising from collision or otherwise; and

- To advise whether there is a case for a further investigation or inquiry into the circumstances surrounding the Marchioness disaster and its causes on 20 August 1989. [26]

Lord Justice Clarke was appointed on 20 September to conduct the inquiry.[27] Mr Prescott asked the judge to make interim recommendations on arrangements for safety on the River Thames by December 1999 but recognised that the recommendations on the Marchioness would take longer.

Lord Clarke's interim report was published on 2 December 1999 along with a written statement from Mr Prescott.[28] The Government accepted all 44 of Lord Justice Clarke's recommendations. An action plan on river safety was then published, explaining how the Department for the Environment, Transport and the Regions (DETR), working with the Maritime and Coastguard Agency (MCA) and the Port of London Authority (PLA), intended to implement the recommendations. These included:

- consultation on the consumption of alcohol by people in charge of vessels;

- funding for a formal safety assessment of search-and-rescue facilities on the Thames; and

- funding for experimental life-saving equipment at locations along the Thames.

The intention was to pursue the recommendations on a UK-wide basis.

Lord Justice Clarke said in the introduction to the interim report that in his opinion, "the safety regime on the river today is very different from that which obtained in 1989".[29] Later on in the report he said that "it is clear from the Department report on the Hayes recommendations, prepared in October 1999, that matters have come on a long way since the Hayes Report, although there is still work to be done in some areas".[30] In his second report, published on 14 February 2000, Lord Justice Clarke added a few points to the matters dealt with in his first report and corrected some errors.[31] On the question of a public inquiry, Lord Justice Clarke concluded that "... in this case the facts have at no time been open to the kind of public scrutiny which would be appropriate" and that, therefore, "The secretary of State should exercise his power ... to cause a formal investigation to be held" into the incident and its immediate aftermath, including the search and rescue operation.[32]

Consequently, Mr Prescott announced that that he had ordered a judicial inquiry, under section 268 of the *Merchant Shipping Act 1995*, into the collision between the Marchioness and the Bowbelle, and the search and rescue operations that followed the collision.[33] He appointed Lord Justice Clarke to act as Wreck Commissioner to the investigation. Oral

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26 DETR press notice, "Prescott orders new probe following Marchioness disaster", 18 August 1999
27 DETR press notice, "John Prescott appoints judge for Thames safety inquiry", 20 September 1999
28 *Thames safety inquiry: interim report by Lord Justice Clarke*, Cm 4530, December 1999
29 ibid., para 2.5
30 ibid., para 24.26
31 *Thames safety inquiry: final report by Lord Justice Clarke*, Cm 4558, February 2000
32 ibid., paras 7.18 and 13.53
33 HC Deb 14 February 2000, cc603-615

hearings for the Formal Investigation took place from 2 October to 23 November 2000 in Westminster Central Hall and the report was published on 23 March 2001.[34]

The report of the Formal Investigation is in two volumes and contains a detailed account of the causes of and responsibility for the accident. The main findings were:

- The basic cause of the collision was poor lookout on both vessels;
- The Bowbelle owners and managers failed to properly instruct or monitor crews;
- The Marchioness owners failed to issue proper instructions about keeping lookouts and did not properly supervise their skipper;
- The Department of Transport had known for years about the problems posed by the limited visibility from the steering positions on the Marchioness and the Bowbelle;
- Captain Henderson drank more than he should have on the afternoon of 19 August, but by the time of the collision early on 20 August he had no alcohol in his bloodstream;
- The Metropolitan Police were ill-prepared in that there was no specific contingency plan to deal with a major disaster on the river;
- No one considered the possibility of a deceased person being identified by dental records before the decision to remove the hands was taken; and
- In the case of three victims, the removed hands were not released with the body.[35]

The report gave an update on the many recommendations that had been made over the years since August 1989, notably by the MAIB, the Hayes Report, the inquest report and the reports in the Thames Safety Inquiry. Mr Prescott made a statement in the House indicating the progress made on these issues.[36]

Taking all of his inquiries together, Lord Justice Clarke made a total of 74 recommendations on Thames safety. The Government published three progress reports, in November 2001, July 2002 and February 2003 on progress made against the recommendations. The then Minister for Transport, David Jamieson, indicated that the third would be the final report of its kind. He said that, since Lord Justice Clark's inquiry the following had been achieved:

> manning and training on passenger ships has been reviewed and guidance prepared on safety training for crew and support staff on passenger vessels;
>
> the Safety Management Code for domestic passenger ships has been introduced, and we believe this is supporting a more focussed safety culture in the industry;
>
> the London Coastguard now co-ordinates all Search and Rescue activities on the tidal River Thames, and the five RNLI lifeboats installed in January 2002 have proved their value by attending 679 incidents in their first 12 months;

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34 *Marchioness/ Bowbelle: Formal Investigation under the Merchant Shipping Act 1995*, March 2001
35 ibid., part 6, paras 40.1-40.73
36 HC Deb 23 March 2001, cc599-611

> MCA continues to work with other Member States to ensure that the introduction of European standards for passenger ships on inland waterways does not compromise passenger safety in the UK;
>
> a Formal Safety Assessment, carried out since the introduction of many recommendations from the Thames Safety Inquiry and Marchioness Formal Investigation has shown that the overall level of safety on the River Thames falls within acceptable limits, judged against HSE criteria. Work is continuing to identify areas where additional safety measures could bring the most significant safety benefits. This work will be completed by the end of this year.
>
> recommendations in respect of alcohol are being implemented through the Railways and Transport Safety Bill which is currently before the House.[37]

Mr Jamieson concluded:

> We believe that the safety measures put in place immediately after the Marchioness disaster and again more recently following the Thames safety inquiry and Marchioness formal investigation, substantially reduce the risk of a further tragedy and would significantly improve the response to such an incident. However, we continue to look for ways to improve safety on all passenger ships through education, proportionate regulation and enforcement.[38]

By February 2003 action on 40 of the 74 recommendations had been completed. A further 29 recommendations had action in hand but had not then been completed. The proposals on alcohol legislation were subsequently included in Part IV of the *Railways and Transport Safety Act 2003.* The Act provides for the creation of statutory alcohol limits for mariners, and the creation of alcohol and drug-testing regimes. These provisions largely mirror provisions for road users and safety-critical staff on railways and related transport systems.

Although no further inquiries were conducted into the Marchioness following the publication of the Clarke Report in March 2001, there were a number of reviews commissioned. For example, the Director of Public Prosecutions was due to report on whether it would be appropriate to take action against Captain Henderson or any other party and the MCA was tasked to undertake an urgent review of Captain Henderson's fitness to hold a British Masters Certificate of Competency. Further, the then Secretary of State for Health agreed that the review of the *Human Tissue Act 1961*, following the Alder Hey inquiry report, would be widened to cover Lord Justice Clark's recommendations.[39] The Home Office Minister, Paul Boateng also announced that the fundamental review of the coroner system would also reflect the recommendations.[40]

### 1.6 Inquiry into identification of the victims, 2000-2001

Following the completion of hearings for the Formal Investigation, a non-statutory inquiry into the identification of victims following major transport accidents began on 30 November 2000. The Inquiry was conducted in two parts: The first part dealt with the identification procedures used in relation to the Marchioness/Bowbelle disaster, while Part 2 dealt with identification

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37 HC Deb 26 February 2003, cc21-22WS
38 ibid., c22WS
39 for more information, see section I.B.1 of HC Library research paper RP 01/23
40 Home Office press notice, "Fundamental review of the coroner system - terms of reference", 23 March 2001

procedures used generally following any major transport accident. The report into the identification of the victims was also published on 23 March 2001.[41]

The terms of reference were:

1. To consider and to report on the procedures followed to establish the identity of the victims of the collision between the Bowbelle and the Marchioness;

2. To review and to report on the procedures currently followed when establishing the identity of victims following similar accidents;

3. In the interests of minimizing distress to the families of the victims;

   - to advise on what additional procedures should be followed, if any, when the need to identify victims arises following similar accidents; and

   - to consider and advise on procedures for the notification and involvement of the next of kin in cases when it is necessary to establish the identity of such victims.[42]

The report attempted to address particular concerns highlighted by the families in a number of areas, including:

- The removal of hands for identification purposes when non-evasive means were likely to be available in the near future;

- The failure of anyone in authority to inform the relatives that this had been done;

- The refusal to allow the relatives to view the body;

- In some cases, the return of the body without the hands;

- The failure thereafter to return the hands to the body;

- In one case the disposal of hands which were discovered much later without informing the relatives and without their authority;

- The issue of inaccurate and insensitive interim death certificates;

- A lack of detailed information available to families; and

- The lack of over-all co-ordination of the identification procedures.[43]

The report analysed the events of 1989 and considered responsibility for what occurred. It also considered the systems in place at the time of the report and listed the general principles which should be kept in mind throughout the identification process after a major disaster. These include honesty, accuracy, and respect.[44] The report made 36 main recommendations, the most important of which was that a detailed review should be

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41 *Public inquiry into the identification of victims following major transport accidents*, Cm 5012, March 2001
42 ibid., para 1.3
43 ibid., para 4.1
44 ibid., para 34.1

undertaken as to the role of the Coroner with a code introduced laying out his powers, duties and responsibilities.[45]

## 2 New National Boatmasters' Licence, 2006-

In 2006 it was proposed that a new National Boatmasters' Licence (BML) should come into force in 2007. The BML would implement Directive 96/50/EC on the harmonisation of the conditions for obtaining national boatmasters' certificates for the carriage of goods and passengers by inland waterway in the European Community. The purpose of this Directive was to improve the facilitation of trade, and movement of labour on inland waterways within, and between, EU Member States. The *Merchant Shipping (Inland Waterway and Limited Coastal Operations) (Boatmasters' Qualifications and Hours of Work) Regulations 2006* (SI 2006/3223) came into force on 1 January 2007.[46]

The aim of the BML was to underpin safety standards within the inland waterways industry and support the carriage of freight on water, as a viable and sustainable alternative to road and rail transport. The regulations also updated and strengthened the existing licence regime for domestic passenger ships on limited coastal voyages. The BML replaced the old MCA boatmasters' licence which applied only to passenger ship operators. The new BML also applied to operators of non-passenger inland waterway vessels for whom there had previously been no national operator standards. It did not apply to owners/operators of pleasure vessels, or to hire boat users.

In addition to fulfilling the requirements of the 1996 Directive, the BML also fulfilled one of Lord Justice Clarke's recommendations in the Thames Safety Inquiry report, about a need to establish competency standards for non-passenger vessel operators. Although the Report concerned conditions on the River Thames, the Government considered that this recommendation was relevant to other waterways as well, in underpinning safety.

The main area of contention was about how the BML compared to the old licence for boatmen on the Thames. The Thames Waterman and Lightermen took their complaints to the Government, and consequently to the Transport Select Committee, which held an inquiry into the new licences in early 2007. The Marchioness Action Group also related their concerns about the new licence to the Committee. The Committee's report, published in May 2007, outlined the substance of the concerns:

> If the new licence was controversial, it became clear to us that it was also a difficult area where there was significant scope for misunderstanding on all sides. Both the new Licence and the old regimes it replaces are complex. The new licence is a modular one which permits of numerous variations, from a Tier 2 licence for use on canals to a Tier 1 licence with multiple endorsements allowing the holder to carry out a range of operations on tidal estuaries and limited coastal operations. The old system was a 'patchwork' of different qualifications relating to different types of vessel, different parts of the UK's classified waters and different types of operation. Some operations which formerly did not require a licence have been included in the new licensing requirement. Despite the amount of Parliamentary time already devoted to the subject, we felt that this was an area where a select committee inquiry could make a positive

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45 ibid., para 34.2; the coroner system was finally reformed in 2009, for more information see HC Library research paper RP 09/07

46 the MCA's two 'consultation packages' on the BML from 2005 and 2006 are available on its website; the MCA proposed an amendment to the regulations in late 2009 following numerous representations about the effect of the BML on new masters seeking to operate in a geographically restricted tidal area; for more information see: MCA, *Consultation on Amending Boatmasters' Licences Regulations 2006*, November 2009

contribution, not least by shedding light where previous activity had generated rather more heat. We resolved to investigate the new Licence, in order to establish whether or not it represented a reduction in standards, and announced our intention to do so on the day the Regulations were debated in committee.

(…)The question of standards is particularly vexed. In some areas, the new Licence has clearly raised standards by requiring some masters who did not previously need a licence to hold one. Licences to operate on the tidal Thames, which were formerly issued by the Company of Watermen and Lightermen on behalf of the Port of London Authority (PLA), were previously very difficult to obtain, requiring ten weeks' shore-based study and a five-year apprenticeship in most cases. The fact that the old PLA licence represented a particularly high standard of training and competence is reflected by the transitional arrangements, under which Thames boatmasters are entitled to convert their qualification to a higher grade of licence than the holders of other qualifications.

**The tidal Thames: a special case**

Although the Thames boatmasters are not alone in their objection to the new Licence, they have been very much at the forefront of the campaign against it. The Thames is the busiest and most complex inland waterway in the UK. Like any estuarial river, navigation can be extremely challenging. The Port of London is the second largest port in the UK, handling more than 50 million tonnes of cargo each year, some of it hazardous. It includes the world's largest sugar cane refinery, an oil refinery with a capacity of 10 million tonnes and the largest sea-dredged aggregates terminal in Europe. It is a major destination for cruise ships, accommodating around 50 each year, and passenger ships on the Thames carry more than two million people annually, including both journeys for pleasure and passenger transport services licensed by Transport for London (TfL). It is also used extensively for leisure and sporting purposes.

The new BML is a national licence and we have considered its likely impact throughout the UK's classified waters. However, the Thames is clearly a special case and we have therefore considered it separately from the rest of the inland waterway network in some contexts.

**Safety on the inland waterways**

The comparative safety of the inland waterways should not obscure the fact which was so powerfully put to us by Mr Malcolm Williams of the Marchioness Action Group, that even a single collision or contact can visit the most terrible consequences on many hundreds of people:

"In 1989 I remember walking onto the deck of the Marchioness feeling that I was going to have a good time and I was in safe hands. I anticipated that people would be knowledgeable, experienced and in a fit state to ensure my safety, but in the event … I found myself struggling for my life in the River in the middle of the night".

Even where passengers' lives are not at risk, every ship carries a crew who have the right to expect the very highest safety standards on waterways which are their places of work. Cargo can also be hazardous, and the spilling of oil, fuel or other contaminating cargoes has the potential to cause significant and widespread environmental damage.[47]

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[47] Transport Committee, *The new National Boatmasters' Licence* (sixth report of session 2006-07), HC 320, 25 May 2007, paras 4-9

In their evidence the Marchioness Action Group expanded further on their particular concerns:

> Over the past 17 years plus I have worked with Government, Watermen and other interested parties to improve practices on the River Thames to increase experience and training requirements of masters, watermen, boat owners and other agencies.
>
> To apply their trade with full knowledge of importance to safety that directly or indirectly affects thousands of people daily.
>
> It appears that the Government has reneged on the hard fought gains in safety obtained over those years.
>
> It defies logic to believe that relaxing standards will not impact on safety. Also there does not seen to be any attempt or desire to accept professional opinions of others who are experienced in navigating these waters. This closed mindedness can only lead one to assume that "Safety" comes after political or economic concerns. Certainly the value of "human life" is not "highly placed".
>
> The Department of Transport, PLA and other Departments have shown themselves to be woefully negligent in a number of areas. In one instance they resistend the placement of a rescue service on the River Thames actively denying its need. Thankfully that grossly incompetent position has now been corrected due to the campaigning of MAG. RNLI boats are now in service 24 hours a day all year round. The RNLI annually report that the Thames Stations are the most active units in its UK service. What can be concluded in this?? Only that the Minister, PLA, MCA have little knowledge or required experience of working and navigation on what is considered the most difficult Tidal River in Europe, Do they really care??
>
> Instead of relaxing standards there should be increased emphasis on "Safety Factors". Disaster preparedness requires that drills should be held on a regular basis involving multi agency emergency personnel and boat owner's. Passenger boats should be inspected more regularly to insure that "safety" measures are being complied with and crews should be drilled in evacuation procedures. Many of the boats now plying the Thames are older boats that have structural deficiences making them unstable when fully loaded with passengers. These boats should have limited licences and be replaced with craft designed to navigate tidal waters.[48]

The Committee concluded that a lack of confidence in the local knowledge requirement of the BML would undermine confidence in its suitability for the Thames. It recommended that the Government "give a firm commitment to monitor safety in the local knowledge areas and in the disputed areas—such as the lower Estuary at Fowey and the upper and lower reaches of the Thames—and to review each local knowledge area from time to time, taking account of the views of local authorities, operators and masters".[49] In its response to the Committee, published in October 2007, the Department for Transport stated that it was up to the relevant harbour authority to ensure that the local knowledge requirement for their area is rigorous and monitored adequately.[50]

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48 ibid., Ev 51

49 ibid., paras 47 and 49

50 *Government response to the Committee's sixth report of session 2006-07* (tenth special report of session 2006-07), HC 1050, 17 October 2007, pp6-7