In the early morning on a fine day in April 2004, a coastguard station received a “Mayday” mobile telephone call from the skipper of a wooden creel boat. The skipper reported that the engine room was on fire and that the crew were taking to the liferaft.

At the time of the accident there were about 370 creels stowed onboard the fishing vessel, with a further 90 due to be recovered. The creels were stowed in the “cat catcher” and around the wheelhouse, severely restricting personal access/egress and making movement about the boat precarious, especially in an emergency. The creels also prevented access to the deckwash pump and associated engine room water sprinkler selector valve, bilge emergency pumping arrangements and domestic gas bottle stowage.

All had been normal until a crew member reported smoke entering the accommodation from the engine room. Because the vessel was not fitted with a smoke/fire detection system there was no prior warning, and therefore there was no chance to fight the fire in the early stages.

The skipper opened the engine room hatch situated in the wheelhouse. He was confronted by thick acrid smoke that immediately filled the wheelhouse, making the area untenable, and there was no time to attack the fire. The two crew evacuated the accommodation area via the wheelhouse, but the accommodation hatch was left open, allowing the wheelhouse to continually fill with smoke. This prevented the skipper from using the VHF radio to report the emergency to the coastguard, and from using the emergency flares that were stowed in the wheelhouse.
Unclear of the extent of the fire, the skipper believed it to be beyond his control. His fears worsened because he could not move flammable gas bottles that were stowed on deck above the fire, this was due to the number of the creels in the area. He ordered the boat to be abandoned. The liferaft was launched, and the crew embarked without their lifejackets as these were stowed in an area that was now inaccessible due to the smoke.

Fortunately, a nearby trawler picked up the four crew from the liferaft. They were shocked but otherwise uninjured. The vessel was later towed safely into harbour where the local fire brigade extinguished the fire.

The crew had been together for about two weeks prior to the accident. Their knowledge of the vessel’s emergency equipment, including the engine sprinkler system, was superficial. There had been no discussions on what to do in an emergency, and no drills had been conducted and none were planned.

On this occasion the crew were extremely lucky. The outcome could so easily have been different had the weather been poor, and had the liferaft failed to inflate correctly and a mobile telephone signal not be obtained.

All the evidence suggests that the cause of the fire was an electrical defect that ignited cable insulation and, subsequently, the main electrical distribution panel and the wooden bulkhead between the engine room and accommodation area.

Recommndations

Owners and skippers of UK fishing vessels under 15 metres are recommended to:

1. Encourage the use of “constant wear” lifejackets whilst on deck. When not in use, these, and normal inflatable lifejackets, should be stowed in a location that will always be accessible on evacuation. Consideration should be given to providing an upper deck stowage close to an evacuation route.

2. Consider fitting a smoke/fire detection and alarm system in the engine room and accommodation areas to improve the chances of investigating and tackling a fire in the early stages of its development.

3. Be aware of the dangers of excessive deck loading that restricts access to:
   • evacuation routes and safe passage across deck areas.
   • lifesaving apparatus.
   • emergency equipment, including bilge pumping arrangements, remote fixed fire-fighting facilities and volatile and explosive materials that may require removal in the event of a fire.

4. Encourage the routine conduct of drills so that actions in an emergency become instinctive, thus improving the chances of survivability.

5. Carefully consider, and take into account, the above recommendations when conducting risk assessments and self certification as required by the regulations.

July 2004