SYNOPSIS

At about 1839 (UTC) on 26 November 2001, a fatal accident occurred on board the twin-rig trawler *Ocean Star*, while she was recovering her fishing gear. The coastguard at MRSC Shetland informed the MAIB of the accident at 2045 that day.

While fishing to the north of the Shetland Islands, the skipper received a coastguard weather forecast to the effect that the wind was due to increase to force 9. He decided to suspend fishing operations and heaved in the gear until there was 130m of warp still remaining.

In preparation for bringing the cod ends inboard with the gilson hook, a deckhand threw a heaving line up from the poop deck around the base of the gallows, and forward, to a second deckhand, who was on the top deck. The two deckhands were able to do this out of sight of each other. When the deckhand on the poop deck turned away, he heard a loud noise and thought that one of the main warp wires had parted. He looked up and saw that the starboard main warp block had broken and that the heaving line was trailing astern of the vessel. He retrieved the line and threw it back up to the other deckhand. The line was not caught. He called a warning to him and then to the skipper, that the block had come apart.

From the wheelhouse, the skipper saw the deckhand lying limp over the hand-rail on the top deck. The crew carried him into the wheelhouse, and started CPR. This was stopped when they realised the deckhand's ribs were broken. The skipper called the coastguard and informed them of the situation and told them the vessel would proceed to Lerwick.

Having described the symptoms, by radio, to a doctor at the Aberdeen Royal Infirmary, the skipper was told that the deckhand was dead.

An analysis of the block showed that it had failed under load because of progressive wear of a cheek plate caused by the outward movement of a bearing sleeve. A full inspection of this block by a registered body for the purpose of certifying it safe, might well have detected the use of thin sleeving and have caused the block to be withdrawn from service as a result.

Actions since, and intended to be, taken by the Maritime and Coastguard Agency (MCA) with regard to the testing, inspection and maintenance of hauling gear, will contribute to preventing similar accidents in future. Therefore, the MAIB has recommended that the intended regulations and guidance are implemented as soon as possible.