MAIB SAFETY BULLETIN 2/2000

Fatal accident to a crew member

of the fishing vessel

SOLSTICE II

on 13 May 2000

Issued June 2000

MAIB SAFETY BULLETIN 2/2000

This document, containing a safety recommendation, has been produced for marine safety purposes only on the basis of information received to date.

The *Merchant Shipping (Accident Reporting and Investigation) Regulations 1999* provide for the Chief Inspector of Marine Accidents to make recommendations at any stage of an investigation if, in his opinion, it is necessary or desirable to do so.

The Marine Accident Investigation Branch (MAIB) is carrying out an investigation of the fatal accident to a crew member on board the fishing vessel *Solstice II (BF 56)* on 13 May 2000. A report will be published.

The MAIB's initial enquiries have revealed shortcomings in the implementation of specific safe standard operating procedures following health and safety risk assessments.

J S Lang
Rear Admiral
Chief Inspector of Marine Accidents

Background

At about 0500 on 13 May 2000, a crew member on board the Banff registered twin rig trawler *Solstice II* was fatally injured.

At the time of the accident the vessel was fishing the grounds off Rockall. Four members of the six man crew were aft shooting the trawl. One was forward operating the two port side sweep line winches on the main working deck, and the skipper was in the wheelhouse operating the starboard winches. It was normal practice for these to be operated locally by two crew members on either side of the deck until the double (headline and foot rope) sweeps were clear of them. This was to prevent the sweeps becoming fouled as they were being shot.

On this trip however, *Solstice II* had sailed with one man fewer than normal. The skipper was therefore operating the starboard winches from the wheelhouse where his only means of monitoring them was on closed circuit television. He was unable to see both sides.

Once the double sweeps were clear of the winches the skipper took control of all four, and continued shooting the single sweeps. The man who had been operating the port winches made his way aft to join his colleagues. As he did so, he lost his footing on a spare trawl and fell against one of the rotating winch drums. His arm caught in the space between the supporting upright and flange of the rotating drums and dragged him into the winch. Nobody saw what was happening and his injuries were fatal.

A risk assessment, which had been carried out for the vessel, identified a number of general hazards, including the dangers of rotating winches, and suggested appropriate control measures. However, these had not been implemented fully in the form of specific safe standard operating procedures.

Safety Recommendation

1. The owners of *Solstice II* are recommended to ensure that control measures identified as a result of health and safety risk assessments for this or any other owned vessel are implemented, as appropriate, in the form of safe standard operating procedures specific for each vessel.

Note

The attention of owners, skippers and crews of all fishing vessels is drawn to the dangers of ignoring any control measures that have been identified in health and safety risk assessments.

Guidance on the main elements to risk assessment and the implementation of safe working practices is contained in *Marine Guidance Note (MGN) 20 (M+F)*, which is published by the Maritime and Coastguard Agency.