

# ACCIDENT REPORT

#### VERY SERIOUS MARINE CASUALTY

**REPORT NO 26/2016** 

DECEMBER 2016

#### Extract from The United Kingdom Merchant Shipping (Accident Reporting and Investigation) Regulations 2012 – Regulation 5:

"The sole objective of the investigation of an accident under the Merchant Shipping (Accident Reporting and Investigation) Regulations 2012 shall be the prevention of future accidents through the ascertainment of its causes and circumstances. It shall not be the purpose of such an investigation to determine liability nor, except so far as is necessary to achieve its objective, to apportion blame."

#### NOTE

This report is not written with litigation in mind and, pursuant to Regulation 14(14) of the Merchant Shipping (Accident Reporting and Investigation) Regulations 2012, shall be inadmissible in any judicial proceedings whose purpose, or one of whose purposes is to attribute or apportion liability or blame.

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Email: maib@dft.gsi.gov.uk Tel: 023 8039 5500 Fax: 023 8023 2459 Loss of a crewman overboard from the potter *Our Sarah Jane* (NN710) English Channel 9 June 2016

## **SUMMARY**

On 9 June 2016, a deckhand was lost from the 9.8m potter *Our Sarah Jane* when he jumped into the sea in an attempt to cut free a rope that had fouled the boat's propeller.

*Our Sarah Jane* had been operating in the middle of the English Channel when the boat's propeller became fouled by a rope from its fishing gear. This caused the vessel to be anchored to the seabed and unable to manoeuvre. Efforts by the crew to clear the rope were unsuccessful and, after about 30 minutes, a deckhand decided to jump into the sea and try to cut the rope from the propeller. However, a strong tide swept him away from *Our Sarah Jane* and he was subsequently lost. During the attempt to rescue the deckhand, another member of the crew jumped into the sea, but quickly got into difficulty and had to be recovered back on board the boat.



Our Sarah Jane (NN710)

The MAIB investigation identified that:

- The deckhand jumped into the water despite the vessel's skipper instructing him not to do so; and the deckhand was possibly under the influence of drugs.
- Both crewmen almost certainly suffered from cold water shock.
- The attempted recovery of the deckhand from the water was impeded by the vessel being anchored by its fishing gear and because a lifebuoy attached to a buoyant lifeline was not readily available.
- The 2nd crewman's entry into the water to assist the deckhand was well intentioned but the risks involved were not properly considered.
- Emergency drills could potentially have improved the response to the fouled propeller and also identified the shortcomings in the availability of the lifebuoys.

This is the third MAIB investigation since 2014 into a fatal accident during which the use of recreational drugs among fishermen has been identified. The Chief Inspector of Marine Accidents has brought this to the attention of the Fishing Industry Safety Group, highlighting the need for vigilance.

A recommendation has been made to the vessel's owner aimed at ensuring that lifesaving equipment is readily available and improving the crew's ability to deal effectively with emergency situations.

# FACTUAL INFORMATION

#### Narrative

At 0538<sup>1</sup> on 9 June 2016, the 9.8m potter *Our Sarah Jane* (NN710) sailed from its berth in Shoreham, UK. The vessel cleared the tidal lock at 0623 and headed for fishing grounds in the English Channel **(Figure 1)**. On board were the vessel's skipper and two deckhands.

Between 1025 and 1110, *Our Sarah Jane*'s crew hauled, emptied, re-baited and shot away a string of approximately 100 whelk pots. The vessel maintained a north-westerly heading when hauling and a south-easterly heading when shooting. The predicted tidal stream was easterly at 1kt, the wind was east-north-east at 20kts and the sea was choppy.

Between 1120 and 1145, *Our Sarah Jane*'s crew hauled, emptied and re-baited a second string of pots. The pots were stacked on the port side of the working deck, forward of the wheelhouse. The vessel was then turned onto a heading of 135° at a speed of 3kts<sup>2</sup>. At 1151, the crew started to shoot the pots on deck. The skipper was in the wheelhouse, one of the deckhands was preparing bait aft of the wheelhouse, and the other deckhand, Darren Brown, was on the port side of the working deck, throwing each pot in turn towards the shooting gate on the vessel's starboard side (**Figure 2**).

At around 1158, one of the spinners (toggles) used to secure the whelk pots to its line jammed between the underside of the hinged side of the shooting gate and a rubber deck mat **(Figure 3)**. The skipper immediately reduced the speed of both engines to idle and the two deckhands then released the snagged pot. However, the 14mm backrope connecting the pots was under tension and, as it ran overboard, two of the remaining nine pots on deck were pulled into the water. The starboard engine stalled and the skipper realised that the lines attached to the pots had fouled the starboard propeller. He then put the port engine to 'neutral'.

<sup>&</sup>lt;sup>1</sup> All times are UTC+1.

<sup>&</sup>lt;sup>2</sup> All speeds are speed over the ground.

*Our Sarah Jane* remained on a south-easterly heading and the backrope between the starboard propeller and the seabed was bar taut. It was also perpendicular to the vessel's starboard side. The crew cut the backrope between the propeller and the shooting gate. They then hooked the backrope leading to the seabed with a grapple. However, the line was so taut that the crew were unable to pull it sufficiently close to cut, even with a knife cable-tied to a broom handle. During the crew's attempts to reach the backrope, Darren repeatedly volunteered to jump into the water to cut it. The skipper told Darren that the water was too cold, the tidal stream was too strong and the sea was too rough. Therefore, he was not to go into the water under any circumstances.

At 1217, *Our Sarah Jane's* skipper called the fishing vessels *Imogen Leigh* (SM 73) and *Billiris* (MT119) via very high frequency (VHF) radio channel 16, but neither vessel responded. The skipper continued to call, and *Billiris* answered at 1225. *Our Sarah Jane's* skipper advised that his vessel had a rope caught around its starboard propeller and asked *Billiris's* skipper if he could assist. During the VHF exchange, Darren was standing by the shooting gate and the other deckhand was securing equipment on the port side of the working deck.



Reproduced from Admiralty Chart BA 2450 by permission of the Controller of HMSO and the UK Hydrographic Office.

Figure 1: Extract of chart BA 2450 showing the location of fishing grounds



Figure 2: Shooting gate



Figure 3: Reconstruction of snagged whelk pot

As *Our Sarah Jane*'s skipper was confirming his vessel's position, Darren said something along the lines of *"I'll be alright, I can do it, don't worry"*. Then, with a knife in one hand, he jumped overboard through the shooting gate. Darren had taken off his oilskins, wellington boots and gloves, and was wearing a red 'T' shirt and grey jogging bottoms.

*Our Sarah Jane's* skipper immediately informed *Billiris* that Darren had jumped into the sea. He also, at 1229:30, input a mark into the Furuno Max Sea electronic chart plotter (**Figure 4**); the plotter's man overboard mark function was not used. The skipper then went to the shooting gate. By the time he arrived at the gate, Darren was 1m forward of the bow and was shouting for help. The rate of the tidal stream was now over 2kts.



Figure 4: Plot of vessel's track (1157 - 1236)

The skipper fetched a lifebuoy from the aft rails on the starboard side of the cat catcher<sup>3</sup>. He also moved the port engine control lever sited on the working deck<sup>4</sup> to 'ahead'. Meanwhile, the deckhand continued to point at Darren and encourage him to swim towards the vessel. The skipper tied a length of polysteel mooring rope to the lifebuoy with a bowline. He then threw the lifebuoy over the bow towards Darren, who was now approximately 10m ahead of *Our Sarah Jane*. The lifebuoy fell about 5m short. Darren was shouting for help and trying to swim on his back towards the lifebuoy, but his efforts appeared to be laboured and he was unable to reach the lifebuoy.

The skipper pulled the lifebuoy back on board in order to try and throw it closer to Darren. However, by the time the lifebuoy was recovered, Darren was even further away, so the skipper returned to the wheelhouse and called *Billiris*'s skipper to ask him to assist as soon as possible. He then started the starboard engine and put both engines ahead at fast speed. Seconds later, the backrope around the starboard propeller parted and *Our Sarah Jane* started to make headway. The skipper manoeuvred the vessel towards Darren, who was now about 50m ahead. He appeared to be drifting in and out of consciousness and had stopped shouting.

When Darren was about 5m off *Our Sarah Jane*'s starboard side, the remaining deckhand threw the lifebuoy with the rope attached towards him. It landed within Darren's reach but Darren was face-down in the water and motionless.

Darren passed slowly down the vessel's starboard side and the deckhand recovered the lifebuoy. He then told the skipper "*I've got to go in*". The deckhand took off his oilskins and wellington boots and went onto the cat catcher. Meanwhile, the skipper removed the rope from the lifebuoy and tied one end around the deckhand's waist and the other to a guardrail. The deckhand then jumped over the stern towards Darren, who was about 5m off the starboard quarter.

Within about 40 seconds of entering the water, the deckhand was in difficulty. He was losing his strength and the use of his limbs. He was also being hampered by the weight of the polysteel rope that was sinking, so he shouted to the skipper to pull him back in. The skipper pulled the deckhand towards the stern. The deckhand, who continued to struggle, then made his way round to the shooting gate from where the skipper assisted him back on board. By then, Darren was no longer in sight.

The skipper went to the wheelhouse and informed *Billiris*'s skipper of the situation. At 1235:45, he broadcast a "Mayday<sup>5</sup>" on VHF channel 16 stating the vessel's position and that he had lost sight of a man overboard. Dover Coastguard responded and tasked a search and rescue helicopter and the Eastbourne, Shoreham and Newhaven lifeboats. Several passing merchant vessels and a number of local fishing vessels also assisted in the search, which lasted until late evening, but Darren was not found.

*Our Sarah Jane* returned to Shoreham using its port engine only. Rope that was still entangled around its starboard propeller (**Figure 5**) was removed the following day.

#### Crew

*Our Sarah Jane*'s crew were share fishermen and UK nationals. They had all completed the mandatory Seafish<sup>6</sup> training courses<sup>7</sup> but they did not conduct emergency drills on board.

<sup>&</sup>lt;sup>3</sup> A cat catcher is a platform at a fishing vessel's stern usually used for stowing pots.

<sup>&</sup>lt;sup>4</sup> Engine control levers were sited on the working deck and in the wheelhouse

<sup>&</sup>lt;sup>5</sup> International distress message (voice)

<sup>&</sup>lt;sup>6</sup> Seafish – the Sea Fish Industry Authority works across all sectors of the UK seafood industry to promote good quality and sustainable seafood, and to improve the safety and standards of training for fishermen.

<sup>&</sup>lt;sup>7</sup> New entry fishermen must complete basic safety courses in sea survival, elementary first-aid; fire-fighting and health and safety. Fishermen with two years' experience must also complete a 1-day mandatory safety awareness course.



Figure 5: Still from video footage showing rope around starboard propeller

The skipper was 25 years of age and had been a fisherman for 9 years. He held a Seafish Under 16.5m skipper certificate<sup>a</sup> and had previously skippered *Catherine Anne* (SM700) for 18 months. He had also been relief skipper on board *Imogen Leigh* (SM73) and *Evie Mae* (SM74). The skipper had worked full time on board *Our Sarah Jane* since February 2016.

Darren Brown, nicknamed 'Spiker', was 37 years of age and was a career fisherman. He had worked on board *Imogen Leigh* from 3 March 2016 until 12 May 2016 when he transferred to *Our Sarah Jane*. During his time on board *Imogen Leigh*, Darren had clashed with its skipper over his poor timekeeping in the mornings and sleepiness at sea.

Darren did not drink alcohol and was physically fit, muscular and was reported to be a very strong swimmer. He last visited his general practitioner on 9 May 2016 and was prescribed the pain killer

<sup>&</sup>lt;sup>8</sup> The Under 16.5m skippers' certificate is a voluntary qualification administered by Seafish aimed at increasing the navigational and engineering knowledge of skippers and watchkeepers on small fishing vessels.

Tremadol to relieve pain in his shoulder together with a short course of the anti-depressant Sertraline. Darren's treatment was due for a review 2 weeks later but he had not scheduled an appointment. Darren appeared to be in good spirits and in a buoyant mood in the weeks immediately before his loss.

Darren was reported to be a recreational drug user, although the frequency and extent of his use is not known. Following the accident 18.4g (dry) of a substance containing amphetamine sulphate (15%) mixed with caffeine and dextrose, a package containing 1.06g of cannabis, and an empty packet of 'Rizla' cigarette papers were found in Darren's belongings on board *Our Sarah Jane*. Neither the skipper nor the other deckhand, who had been on board the vessel for 9 months, socialised with Darren outside of work and they were not aware of his recreational drug use. However, Darren had been reprimanded by the skippers of *Imogen Leigh* and *Our Sarah Jane* for taking Tremadol while at sea.

Darren was reported to be an emotional person who was quickly angered. Descriptions of his personality included 'impulsive', 'random' and 'spontaneous'. During the summer of 2008 or 2009, Darren had jumped overboard without prompt or warning from *Meridian* (NN757) in the English Channel and had successfully freed a rope from the vessel's propeller.

#### Vessel survey

*Our Sarah Jane* was a Gemini catamaran workboat. The vessel was built in 2006 and was purchased by its owner in 2007. It was last surveyed by the Maritime and Coastguard Agency in October 2012. The survey identified three deficiencies concerning flares, charts and the lack of a sound signal. The deficiencies were rectified.

*Our Sarah Jane* was surveyed in October 2014 by a surveyor acting on behalf of the vessel's insurer. The survey occurred as the vessel was nearing the end of a refit and the survey report identified work in progress that needed to be completed before the vessel resumed fishing. This included the marking of lifebuoys with the vessel's name and port number and the fitting of suitable lifebuoy brackets<sup>9</sup>. The survey report indicated that at least one of the lifebuoys carried was fitted with a 'throwing line'<sup>10</sup>. Following the survey, the lifebuoys were reportedly marked with the vessel's name and port number.

#### Lifesaving equipment and use

The lifesaving equipment carried on board *Our Sarah Jane* at the time of the accident included three lifebuoys, four abandon ship lifejackets, five personal flotation devices (PFD) (four adult size and one child size), and a four person liferaft.

Two lifebuoys were secured to the aft rails on the cat catcher. The lifebuoy secured on the starboard side was secured with rope using a clove hitch and the lifebuoy on the port side was secured with cable ties (Figure 6). Neither of the lifebuoys on the cat catcher had a line attached. A third lifebuoy fitted with a 10m length of 6mm polypropylene was stored in a deck locker along with two lifebuoy brackets. The skipper was not aware of the lifebuoy in the locker and none of the lifebuoys were marked.

The PFDs were stowed in a wheelhouse cupboard. The four adult size PFDs had been on board the vessel since 2007. They were unused and had not been serviced. The child's PFD had been used by the owner's son when on board. The liferaft was last inspected and serviced in January 2016.

<sup>&</sup>lt;sup>9</sup> The Fishing vessels (Safety Provisions) Rules 1975 state that lifebuoys shall be readily accessible to all persons on board and stowed so that they can be rapidly cast loose. The Rules also require lifebuoys to be marked in block letters with both the name and the port of registry, or the fishing number of the vessel in which it is carried.

<sup>&</sup>lt;sup>10</sup>The Fishing Vessels Code of Practice for the Safety of Small Fishing Vessels (MSN 1813(F) requires fishing vessels of less than 10m registered length to carry two lifebuoys (one with 18m buoyant line attached) or 1 lifebuoy (fitted with 18m buoyancy line) plus one buoyant rescue quoit.



Figure 6: Port lifebuoy

## **Vessel operation**

*Our Sarah Jane* operated from Shoreham, with each fishing trip lasting between 1 and 2 days. The vessel typically worked 800 whelk pots each day (100 pots per string, each spaced approximately 15m apart). The vessel was not equipped for overnight sleeping. A microwave oven was carried but there were no bunks or toilet facilities.

During the week commencing 6 June 2016, *Our Sarah Jane* sailed from Shoreham at 1000 on 6 June and returned the following day at about 1500. The vessel remained alongside on 8 June. The crew conducted maintenance tasks during the morning but they did not work in the afternoon.

# **ANALYSIS**

### **Decision-making**

When Darren Brown jumped into the sea, *Our Sarah Jane's* skipper was arranging external assistance to cut the rope fouling the vessel's starboard propeller. Darren was undoubtedly trying to be helpful, but his action was not necessary, and it was contrary to the skipper's instruction. In addition, although Darren took the precautions of removing his wellington boots and oilskins and alerting the skipper as he jumped in, he took no account of the relatively cool water temperature, the strong tidal stream or the sea conditions.

Darren's confidence in his action was possibly influenced by several factors, including his previous success in freeing a rope from *Meridian*'s propeller in a similar situation, his ability as a swimmer and the time of year. However, it is possible that his decision-making was also influenced by his use of amphetamine sulphate.

#### Survivability

Darren Brown was motionless and face-down in the water about 5 minutes after he had jumped in. Although he was a strong swimmer and physically fit, the sea water temperature was 13°C and it is almost certain that he suffered from cold water shock.

Cold water shock occurs when a person is suddenly immersed in water at a temperature of 15°C or below. Among other things, the cold can cause a gasp reflex, resulting in water being ingested involuntarily. Involuntary ingestion of water causes a spasm in the larynx, leading to the closure of the trachea (airway). Anoxia (lack of oxygen to the brain) quickly follows. As the person in the water then tries to inhale, water is drawn into the lungs and the spasm cycle repeats. In addition, the breathing rate increases dramatically and heart rate and blood pressure also rise, placing increased load on the heart.

Following the onset of cold water shock, without a lifejacket to keep his head clear of the water, Darren's chances of survival were dependent on him being provided with a lifebuoy to hold onto and on being quickly recovered from the water.

#### Use of recreational drugs

The effects of amphetamines vary from person to person and depend on factors such as the individual's size, weight, health and the amount of drug taken. Immediate effects on behaviour can include increased confidence and motivation, a sense of power and superiority over others and feeling more awake and alert. Lethargy and total exhaustion are also experienced when 'coming down'<sup>11</sup>.

Amphetamine sulphate and cannabis were found among Darren Brown's personal possessions on board, but it is not known whether he was under the influence of either of these drugs on 9 June 2016. Although Darren's decision to jump into the water and his reported periods of extreme tiredness were possibly consistent with the effects of amphetamine, his use of this drug cannot be confirmed. However, as some of the physiological effects of amphetamine include the same cardiovascular responses as cold water shock (increased breathing rate, heart rate and blood pressure), if Darren had recently taken the drug, the likelihood of cardiac problems could potentially have increased on his immersion.

The behavioural effects of amphetamine and other recreational drugs are hazardous in any environment, but their use in the demanding working environments on board fishing vessels is particularly dangerous. The extent to which fishermen use recreational drugs is unknown. However, in view of the long and unsociable hours fishermen work, in very arduous conditions, the use of stimulants inevitably appeals to some. The circumstances of this case and the MAIB investigations into the losses of *Diamond* (LK6)<sup>12</sup> in 2014 and *JMT* (M99)<sup>13</sup> in 2015 indicate that owners and skippers should be alert to recreational drug use by their crews.

#### **Crew response**

*Our Sarah Jane*'s skipper and the remaining deckhand responded positively and tried their hardest to recover their crew mate from the water. However, the interval between Darren jumping into the sea (plotter marked) and when he was no longer in sight ("Mayday") was only about 6 minutes. There was little time to act and no margin for error.

*Our Sarah Jane* was anchored to the seabed by its fishing gear. Consequently, as soon as Darren entered the water he was swept away by the 2kts tidal stream and was already forward of the bow by the time the skipper arrived at the shooting gate. The skipper quickly recognised that a lifebuoy with a lifeline attached was the only means available to support Darren in the water and to recover him back on board.

<sup>&</sup>lt;sup>11</sup> The reaction of the body as a drug's effects start to wear off.

<sup>&</sup>lt;sup>12</sup> MAIB investigation report 5/2015.

<sup>&</sup>lt;sup>13</sup> MAIB investigation report 15/2016.

However, the lifebuoys secured on the cat catcher were not fitted with lifelines and the skipper was unaware of the lifebuoy and lifeline in the deck locker. Although it would have taken only seconds to tie the polysteel rope to the lifebuoy, Darren was being carried away at a rate of about 3m every 6 seconds. Consequently, when the lifebuoy was eventually thrown into the 20kts wind, it landed too far from Darren for him to reach. In hindsight, Darren's likelihood of survival might have been increased by the immediate deployment of a free floating lifebuoy without a lifeline attached. However, it is likely that the skipper was concerned at the rate at which Darren was being carried away from his vessel.

As Darren weakened and his distance from *Our Sarah Jane* increased, the skipper recognised the danger and risked damage to the starboard engine gearbox and shaft by putting the engine 'ahead' to try and part the backrope. The backrope parted, probably due to the action of the propeller's rope cutter, but by the time *Our Sarah Jane* was manoeuvred close to Darren, he was already motionless.

In such desperate circumstances, the other deckhand's decision to jump into the water to help his crew mate was undoubtedly influenced by the stress of the situation. His action was well-intended and similar to the actions taken by a number of other fishermen who also have put themselves at risk trying to assist a man overboard. Nonetheless, the use of a buoyant lifeline and a lifejacket would have been prudent precautions to have taken. On entering the water the deckhand experienced cold water shock and, although the use of a polysteel mooring line as a lifeline enabled him to be recovered back on board, its lack of buoyancy not only reduced his chances of reaching Darren, it also increased the risk to the deckhand of drowning.

### **Equipment availability**

The carriage and maintenance of appropriate lifesaving equipment is pivotal to the success of man overboard recoveries, in which speed is crucial. *Our Sarah Jane*'s owner had demonstrated a positive commitment to safety through his provision of the liferaft, which was not required by the applicable regulation. However, there was no lifebuoy with 18m of buoyant line attached, readily available, which was required. Neither of the lifebuoys on the cat catcher were attached to a buoyant line, and the lifebuoy with a 10m polypropylene line attached was stowed in a deck locker. In addition, it is evident that, since the vessel's survey in October 2014, none of the deficiencies related to the lifebuoys had been addressed effectively. On most vessels the deployment of lifebuoys is one of the first responses following a man overboard. Consequently, better consideration of the applicable regulatory requirements and the lifebuoys on board was warranted.

#### **Emergency preparedness**

It is best practice for vessels to develop plans and procedures for the crew to follow in an emergency. However, on board small fishing vessels such procedures are rarely formalised and emergency drills are not usually conducted. There is no requirement for crews of fishing vessels of less than 12m registered length to conduct emergency drills, and few do. Therefore, the approach taken towards drills by *Our Sarah Jane*'s crew was similar to that of many of their peers on other small fishing vessels. Had *Our Sarah Jane*'s crew periodically conducted emergency drills or discussions, it is possible that the responses to both the fouled propeller and the man overboard could have been more effective.

When hauling and shooting a string of pots, the risk of fouling a propeller with the backrope is considerable, even where rope cutters are fitted to propeller shafts. Therefore, it is important that vessels' crews are prepared and procedures are in place to enable the propeller to be freed as safely and expeditiously as possible. After *Our Sarah Jane*'s starboard propeller was fouled, the crew tried for about 30 minutes to cut the backrope anchoring the vessel to the seabed. The crew were quick to improvise and tie a knife to a broom handle to try and cut the line. However, had some advance thought been applied to the possibility that the propeller might become fouled, purpose-made equipment – such as a pole saw or similar – could have been provided on board. Such equipment would have been more likely to result in a successful outcome.

More significantly, emergency drills, particularly man overboard recoveries, could potentially have identified the lack of a lifebuoy with sufficient length of buoyant line attached. Drills could possibly also have prompted consideration of methods of recovery, the precautions to be taken when putting a crewman in the water to assist another, and the use of the man overboard mark on the chart plotter. The mark the skipper entered into the plotter at 1229:30 was 300 yards from the vessel's position (**Figure 4**). The reason for the discrepancy is not fully understood, but is likely to have been due to the input method used being based on the position of the plotter's cursor on the screen, rather than the vessel's actual position. Dedicated man overboard marks are based on a vessel's position.

A revision of the Small Fishing Vessel Code, which includes a requirement for all fishing vessels less than 15m length overall to conduct an emergency drill each month, is expected to be published in April 2017.

#### Wearing lifejackets

That *Our Sarah Jane*'s crew did not wear PFDs when working on the open deck, even when trying to free the snagged pot from the open shooting gate, or that the deckhand did not don a lifejacket before jumping in during the attempted rescue, is of concern. Despite the advantages of wearing a PFD when working on the open deck at sea, many fishermen still do not wear them. In 2000 the MAIB made its first recommendation about the compulsory wearing of lifejackets by fishermen working on deck. In the intervening years, there has been a succession of discussions, education programmes and research projects that have had very limited success. Since 2012, European funding has also been used by the various fishing industry associations to provide PFDs to thousands of fishermen free of charge. Despite these initiatives, the culture of the fishing industry has been slow to change, and fishermen continue to drown who might otherwise have lived had they been wearing a PFD when they entered the water.

Following a review of lifejacket wear, the MAIB concluded that the initiatives to encourage commercial fishermen to wear lifejackets had been ineffective. Consequently in Report 21/2016 into the loss of a crewman from the fishing vessel *Annie T*, the MAIB recommended that the MCA prioritise the introduction of legislation making it compulsory to wear personal flotation devices on the working decks of all fishing vessels while at sea.

# CONCLUSIONS

- The deckhand jumped into the water despite the vessel's skipper instructing him not to do so.
- As soon as the deckhand entered the water it is almost certain that he suffered from cold water shock.
- The missing deckhand's actions were possibly influenced by the effects of recreational drugs.
- The skipper's response was prompt and positive, but his ability to recover the deckhand from the water was initially impeded by the vessel being anchored by its fishing gear and not having a lifebuoy with a lifeline at hand. A need to fit lifebuoy brackets had been identified during a survey in October 2014, but this work was not completed.
- The remaining deckhand's decision to enter the water in order to assist his crew mate was well intentioned, but the risks involved were not properly considered, which put his life at risk.
- Emergency drills could potentially have improved the crew's response to the fouled propeller and also identified the shortcomings in the availability of lifebuoys.

# **ACTION TAKEN**

#### **MAIB** actions

#### The Marine Accident Investigation Branch has:

- Issued a flyer to the fishing industry highlighting the safety issues identified in this report.
- Brought to the attention of the Fishing Industry Safety Group the evidence gained during accident investigations, that highlights the increasing use of recreational drugs among fishermen.

#### Actions taken by other organisations

#### The Fishing Industry Safety Group has:

In response to this accident and other fatalities resulting from persons falling overboard, established a project group to consider and/or promulgate, among other things:

- Measures to prevent fishermen from falling overboard.
- Manoverboard recovery methods, equipment and the conduct of drills.
- Ways of raising awareness of cold water shock.

#### Our Sarah Jane's owner has:

- Introduced a policy requiring all fishermen working on the open deck on board *Our Sarah Jane* and *Imogen Leigh* to wear a PFD.
- Attached throwing lines to *Our Sarah Jane*'s lifebuoys.

# RECOMMENDATIONS

The Parker Fishing Ltd is recommended to:

- **2016/154** Take action to ensure that its vessels' crews are able to respond effectively in emergency situations, taking into account, among other things:
  - The regulatory requirements regarding the minimum lifesaving equipment to be carried.
  - The benefits of emergency drills.
  - The likelihood of a propeller being fouled when potting.

Safety recommendations shall in no case create a presumption of blame or liability

SHIP PARTICULARS	
Vessel's name	Our Sarah Jane
Flag	United Kingdom
Classification society	Not applicable
IMO number/fishing numbers	NN 710
Туре	Potter
Registered owner	The Parker Fishing Ltd
Manager(s)	Not applicable
Year of build	2006
Construction	Glass reinforced plastic
Length overall	9.83m
Registered length	8.9m
Gross tonnage	5.02t
Minimum safe manning	Twin Cummins Diesel (Type 6B5.9M)
Authorised cargo	172kW
VOYAGE PARTICULARS	
Port of departure	Shoreham, East Sussex, UK
Port of arrival	Shoreham, East Sussex, UK
Type of voyage	Commercial
Cargo information	Whelks
Manning	3
MARINE CASUALTY INFORMATION	
Date and time	9 June 2016, 1229 (UTC+1)
Type of marine casualty or incident	Very Serious Marine Casualty
Location of incident	50°19'6N, 000°05'8W
Place on board	Overside
Injuries/fatalities	1 fatality
Damage/environmental impact	None
Ship operation	Fishing
Voyage segment	Mid-water

3

Persons on board