

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 an such 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.

© Crown copyright, 2017

You may re-use this document/publication (not including departmental or agency logos) free of charge in any format or medium. You must re-use it accurately and not in a misleading context. The material must be acknowledged as Crown copyright and you must give the title of the source publication. Where we have identified any third party copyright material you will need to obtain permission from the copyright holders concerned.

All reports can be found on our website:

www.gov.uk/maib

For all enquiries:

Email: maib@dft.gsi.gov.uk

Tel: 023 8039 5500

Fax: 023 8023 2459

Fatal man overboard from the fishing vessel *Pauline Mary* east of Hartlepool on 2 September 2016

SUMMARY

At about 1833¹ on 2 September 2016, the crewman on board the fishing vessel *Pauline Mary* was dragged overboard after becoming entangled in the gear while shooting pots at fishing grounds east of Hartlepool. When the crewman was recovered back on board about 20 minutes later, he was not breathing and, despite the efforts of *Pauline Mary*'s skipper and the emergency services, could not be resuscitated.

The skipper had been working *Pauline Mary* for only 2 days and was laying his pots for the first time when the accident happened. The skipper's 7-year-old son and a female family friend were also on board at the time.

The investigation identified that a safe method of shooting pots had not been developed on board *Pauline Mary*. The crewman was also not carrying a knife or wearing a personal flotation device, both of which could have improved his chances of survival. It was also not appropriate for the passengers, in particular a child, to be on board during this fishing operation.



Pauline Mary

¹ All times in this report are UTC+1

FACTUAL INFORMATION

Background

Pauline Mary was an 8.2m Cygnus GM27 fishing vessel. It had a glass-reinforced plastic hull and an open working deck with an enclosed wheelhouse at the bow (**Figure 1**). Built in 2005 and originally registered and operated in Jersey, *Pauline Mary* was purchased in March 2015 by a businessman based in Middlesbrough, England and then converted for use as a side shooting potter and gill netter.

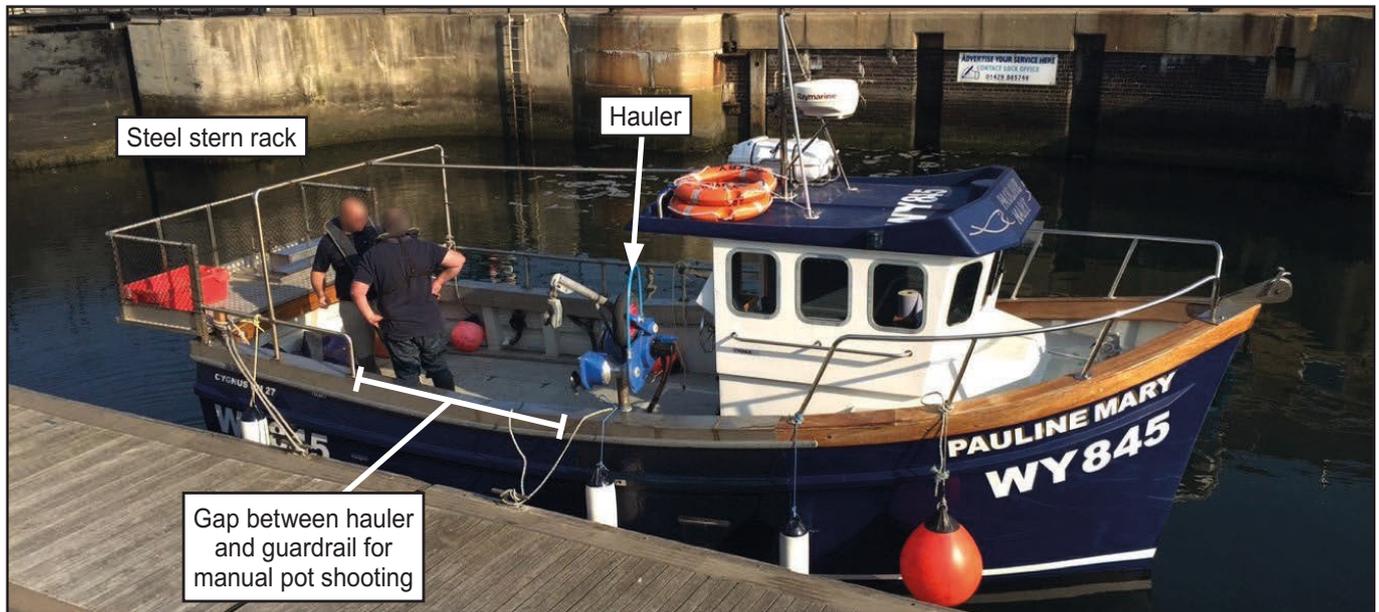


Figure 1: *Pauline Mary* showing deck layout and equipment

During the vessel's conversion, the owner fitted a hydraulic pot and net hauler on the starboard forward side of the working deck and installed steel guardrails on top of the gunwales. He also fitted a steel rack over the stern to store loose fishing gear (**Figure 1**). After registering *Pauline Mary* as a UK fishing vessel, the owner recruited a local fisherman to act as skipper and operate it.

With the assistance of a crewman, *Pauline Mary's* skipper planned to work seven strings of pots in fishing grounds about 1 nautical mile east of Hartlepool harbour (**Figure 2**). Each string had a weighted marker buoy and 30 steel framed pots. Each pot was attached to a 12mm diameter polyethylene back rope by 1.9m long leg ropes at intervals of about 12.5m (**Figure 3**).

To shoot the potting gear, the crewman released the back rope's weighted marker buoy and then manually threw one pot at a time over the starboard side in the gap between the guardrail and the hauler (**Figure 1**). The skipper controlled the vessel's course and speed from the wheelhouse. The skipper intended to employ his brother, Lee Renney, as his regular crewman.

Narrative

At 1100 on 1 September 2016, *Pauline Mary's* owner met the skipper who had been recruited to operate the vessel. The owner and skipper discussed fishing methods, safety and maintenance routines on board *Pauline Mary* as well as the commercial arrangement to share the profits. The owner and skipper then took *Pauline Mary* to sea to continue the vessel handover. At about 1400 the meeting concluded and the owner handed over *Pauline Mary's* keys to the skipper. The skipper then spent the rest of the afternoon loading pots and at about 1800, with Lee on board as the crewman, he took *Pauline Mary* to the fishing grounds to shoot the first two strings of pots, then returned back alongside.

The following morning (2 September 2016), the skipper, with a different crewman, returned to the fishing grounds and shot two more strings of pots. On his return to the Fish Quay, the skipper continued preparing the fishing gear and, at about 1630, Lee arrived to help load the pots. The vessel was loaded

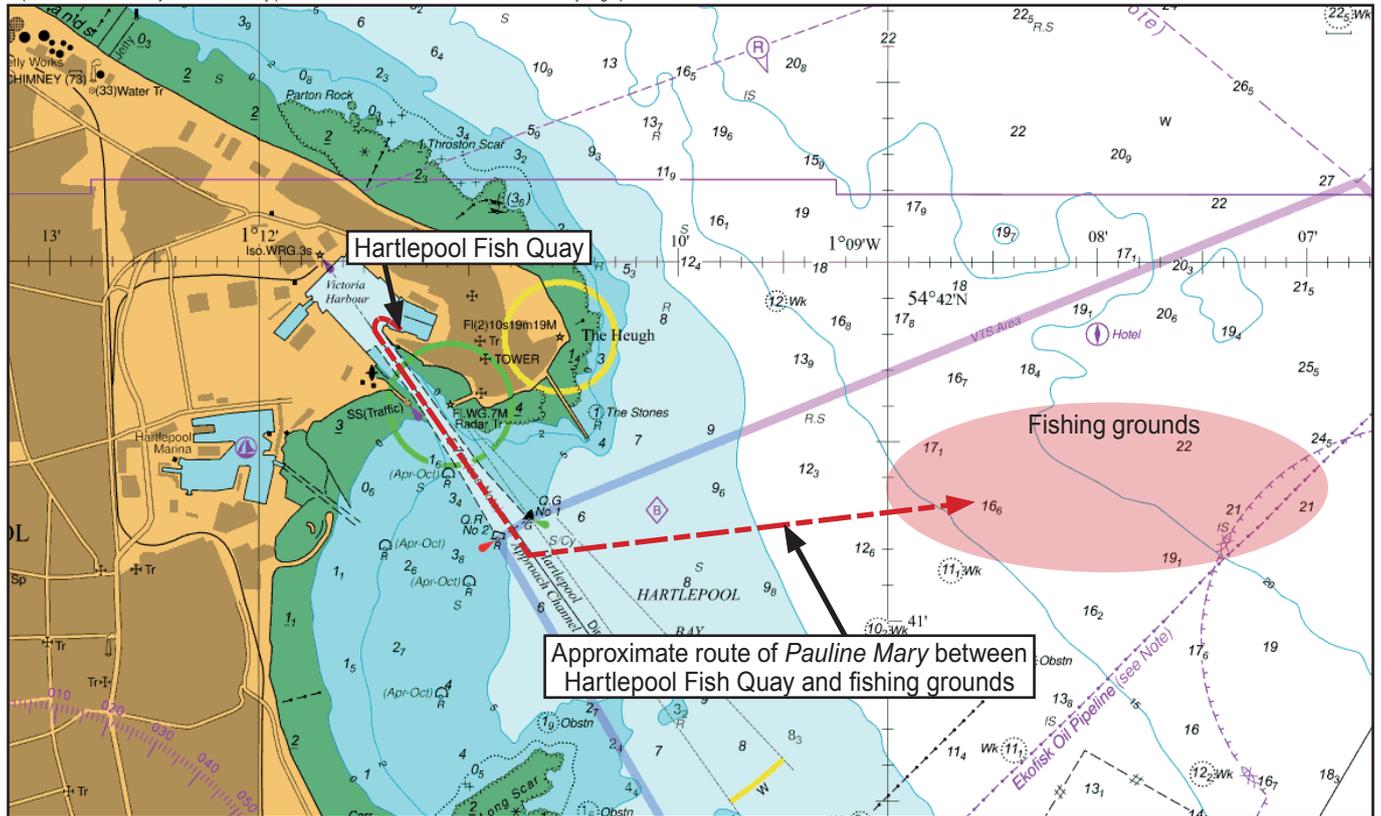


Figure 2: Chart showing Hartlepool Fish Quay, *Pauline Mary*'s route and the fishing grounds

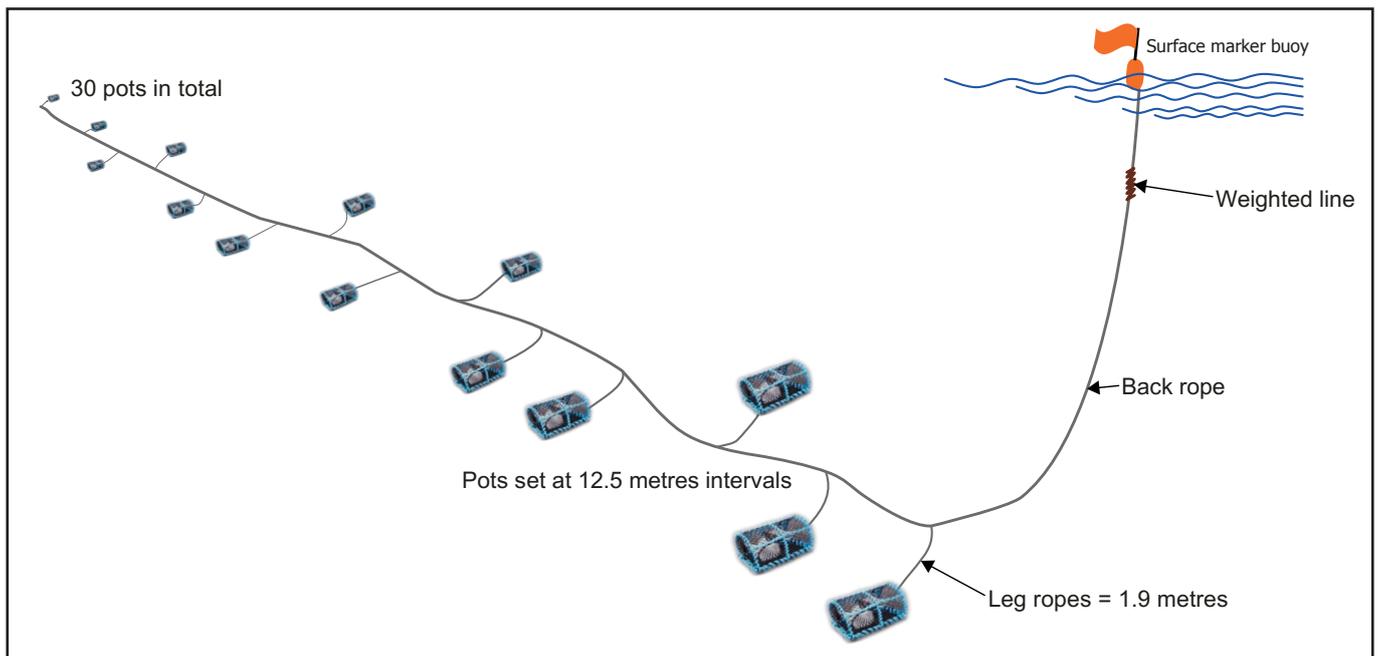


Figure 3: Arrangement of *Pauline Mary*'s potting gear

with one string of pots stacked on the forward end of the working deck and the other stacked behind. Eighteen pots from the after string were stacked on deck and 12 were stacked on the stern rack (**Figure 4**).

A female family friend and the skipper's 7-year-old son arrived at about 1810. Once they were on board, the skipper manoeuvred *Pauline Mary* out of the harbour and headed for the fishing grounds (**Figure 5**). The wind was westerly force 4², the sea state was slight and visibility was good. The skipper's plan was to shoot the two strings of pots and then spend an hour or so sea-angling with his son.

² Beaufort Force 4 equates to wind speed 11 – 16 knots, moderate breeze



Figure 4: *Pauline Mary* at Hartlepool Fish Quay fully loaded prior to departure



Figure 5: *Pauline Mary* departing Hartlepool Fish Quay at 1815

When they arrived at the fishing grounds Lee went out on to the deck; the skipper's son and the female passenger remained in the wheelhouse. The skipper then set *Pauline Mary's* course and speed and Lee began to shoot the first string of pots. Once the first string of pots had been laid, the skipper repositioned *Pauline Mary* and again set a course and speed for Lee to shoot the second string.

Lee deployed the marker buoy and then began throwing the pots over the starboard gunwale, one at a time, as the vessel moved slowly forward. At about 1833, midway through the shooting operation, Lee's right leg became entangled in the fishing gear. The skipper and the female passenger were alerted to the danger when they heard Lee shouting that he was jammed in the rope. When they looked back towards the deck, they saw Lee pressed against the starboard bulwark.

The skipper immediately put the engine lever to full astern and stopped the vessel. He then selected neutral, grabbed a knife and ran onto the deck, by which time Lee had been dragged over the side and under the water. The skipper then engaged the deck hydraulics and used the hauler to heave the back rope in until Lee, who was motionless, returned to the surface with his leg still entangled in the rope. The skipper used the hauler to pull Lee as far out of the water as he could, but Lee's head and upper torso remained submerged.

In a frantic attempt to free his brother, the skipper cut the back rope. Lee briefly came upright but his leg remained snagged in the ropes and he was pulled back beneath the surface again. Realising what had happened, the skipper jumped into the water and grabbed hold of Lee's arm. The skipper tried to reach down and cut Lee free but had to let go as they were both dragged deeper beneath the surface.

The skipper surfaced about 20m from *Pauline Mary* and swam back to the boat, where he scrambled back on board with the help of the female passenger. The skipper returned to the wheelhouse and, at 1840, used the VHF radio to alert Humber Coastguard on channel 16. At the same time, the skipper engaged *Pauline Mary's* engine and headed at full speed towards the marker buoy at the end of the string of pots.

The skipper's initial man overboard report did not include the spoken word "Mayday" or give *Pauline Mary's* position. When the skipper repeated the report, he included his location, but the quality of transmission was poor and the coastguard was unable to interpret the vessel's position. In response, Humber Coastguard requested the launch of the Hartlepool Royal National Lifeboat Institution (RNLI) inshore and all-weather lifeboats, and directed the launch of a search and rescue (SAR) helicopter. The coastguard also alerted the local ambulance and air ambulance services.

As *Pauline Mary* approached the surface marker buoy, the skipper returned to the deck, picked it up and started hauling in the pots from the seabed. At the same time, Humber Coastguard repeatedly requested the crew of *Pauline Mary* to report the vessel's position and to fire a flare to aid location. As the skipper was out on deck, the female passenger answered the radio calls and tried, with some difficulty, to read out the position from the global positioning system (GPS). After about 5 minutes, the coastguard had clarified *Pauline Mary's* position and the SAR assets were tasked accordingly. At 1849, the Teesport Vessel Traffic Service watch officer directed the pilot cutter *Coatham*, which was underway in the area, to proceed immediately to assist.

As *Pauline Mary's* skipper hauled the last of the pots to the surface, Lee re-emerged from the water with the fishing gear; the skipper and the female passenger then hauled him back on board. The skipper put the engine to full ahead, set a course for Hartlepool and told the female passenger to steer towards the harbour. He then returned to the deck and started cardiopulmonary resuscitation on his brother. At 1853, the female passenger used the VHF radio to report that Lee had been pulled out of the water.

At 1856, *Coatham* arrived alongside *Pauline Mary* and a pilot transferred across to help the skipper. Within another 3 minutes, the inshore and all-weather lifeboats had arrived on scene. A crewman from the inshore lifeboat, and a doctor with a medical kit, from the all-weather lifeboat, were transferred onto *Pauline Mary* to support the resuscitation efforts. *Pauline Mary* arrived back in Hartlepool and berthed at the RNLI's pontoon at 1911, where the vessel was met by paramedics from the North East Ambulance and Air Ambulance Services. Despite the continued efforts of the emergency services, Lee could not be resuscitated and was declared deceased at 1937.

Post-accident examination and trials

Post-accident examination of the gear identified that the skipper cut the back rope between the 18th and 19th pots on the string (**Figure 6**). Each pot weighed 21kg (dry) and 13kg when in seawater and the depth of water in the accident location was 23m. As Lee was tangled close to a pot and the distance between each pot was 12.5m, there would have been the weight of 2 pots (26kg) pulling him underwater after the back rope was cut.

Pauline Mary's owner and crew

Pauline Mary was owned by a local businessman who ran a steel fabrication company. He had some experience of commercial fishing, having operated a small, open-decked fishing boat between about 1985 and 1990. His steel fabrication business also constructed fishing vessels.

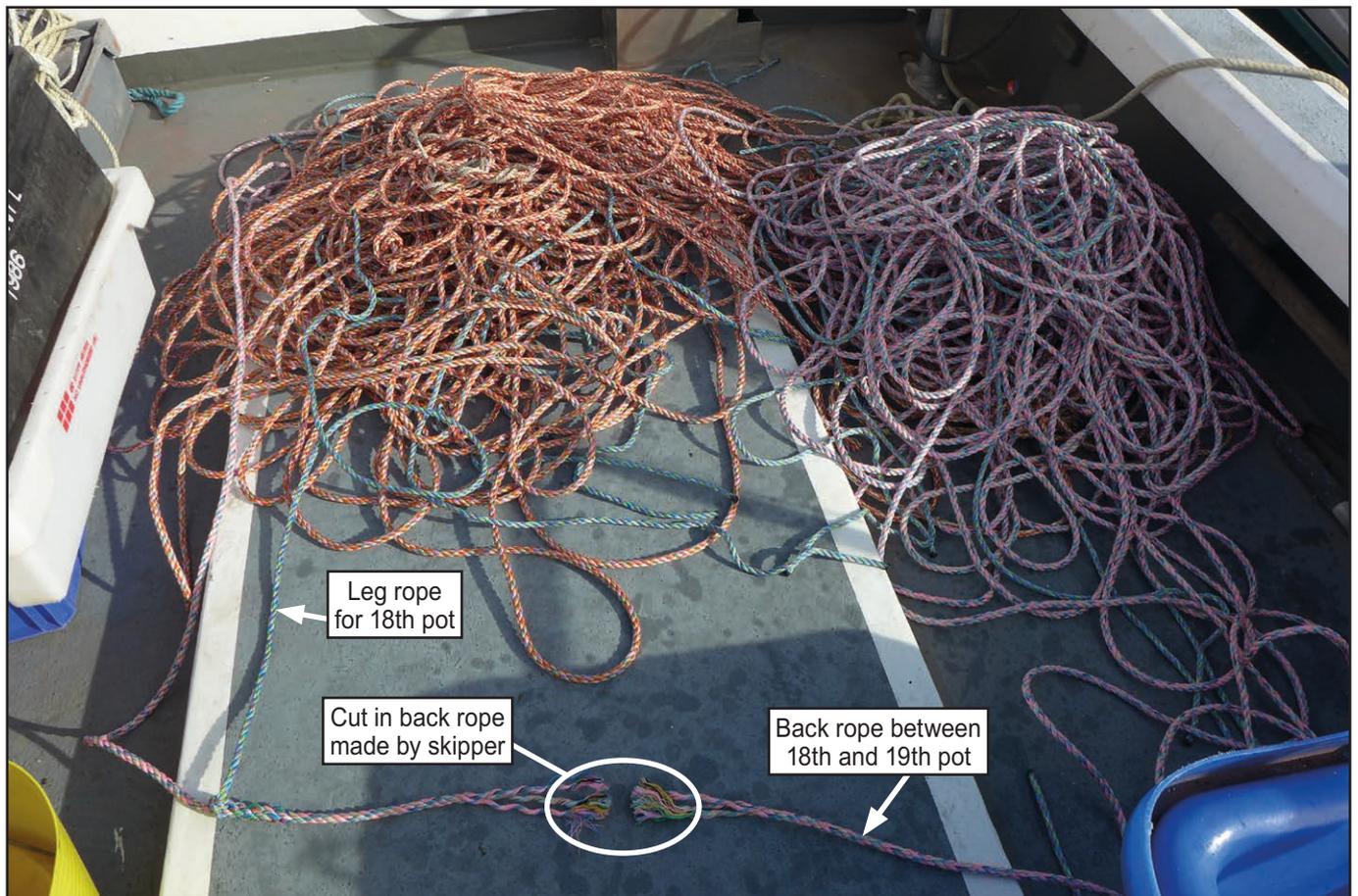


Figure 6: Post-accident examination of the fishing gear showing the cut in the back rope close to the 18th pot in the string

The skipper was a 31-year-old career fisherman. He held an unrestricted licence, issued by Seafish, to skipper fishing vessels up to 16.5m in length. The skipper had previously owned and operated both trawling and potting vessels.

Lee Renney was 22 years old; he had about 4 years' experience of commercial fishing and had completed the four mandatory safety training courses for fishermen. The autopsy report recorded Lee's cause of death as drowning and noted that he had a bruise on his right ankle that was consistent with constraint by rope.

Potting routine

Once he had initially laid the pots, the skipper intended, weather permitting, to work them on a daily basis. To haul the pots, the skipper could manoeuvre *Pauline Mary* and operate the hauler from the deck while his crewman emptied the catch, re-baited the pots and stacked them on deck. The re-baited pots would be re-shot before the next string was hauled.

Safety equipment

Pauline Mary was equipped with three Mullion 150 Newton (N) personal flotation devices (PFD), flares, a manoverboard recovery sling and a digital selective calling³ (DSC) enabled VHF radio. The vessel was not equipped with an automatic identification system (AIS) transceiver. The PFDs could be manually inflated but would also automatically inflate on entering the water.

The skipper and Lee did not wear PFDs while working on board *Pauline Mary*; Lee was wearing trainers, jogging bottoms and a t-shirt. The skipper's son was wearing a PFD, which he was made to wear at all times while on the Fish Quay and on board the vessel. The female passenger did not wear a PFD.

³ In an emergency a DSC distress call allows the operator to transmit information, including the vessel's position, to the coastguard and nearby vessels by the press of a button and without the need for voice communication.

There was a sharp knife on board *Pauline Mary*, carried in the wheelhouse and used by the skipper to cut the back rope. When fishing, neither the skipper nor Lee carried a knife and there was not a knife stored on deck.

Vessel inspection

Pauline Mary was inspected by a surveyor from the Maritime and Coastguard Agency (MCA) in January 2016. The surveyor's inspection report raised four deficiencies, one of which required the owner to produce a risk assessment. The surveyor's report also stated that PFDs should be worn during heavy weather.

In response to the deficiencies raised, the owner produced a written risk assessment. Entanglement with the potting gear was identified as a hazard in the owner's risk assessment, and being dragged overboard was listed as a potential consequence. The controls listed to mitigate the hazards included:

...Tows and anchors to be stacked to ensure that during shooting that personnel are clear of moving ropes.

All personnel to wear flotation collar, oil skins, wellingtons and gloves.

The owner's risk assessment was emailed to the MCA surveyor in February 2016 as evidence that the inspection deficiency had been addressed, but it was not passed to the skipper when the vessel was handed over in September 2016.

Safety guidance for owners and skippers of small fishing vessels

The MCA's *Code of Practice for the Safety of Small Fishing Vessels with a length overall of less than 15m* (the Code) provided guidance on safety management, risk assessments and management obligations set out in *The Merchant Shipping and Fishing Vessels (Health and Safety at Work) Regulations 1997*. Due to the numbers of fishermen who have died after falling overboard, the Code recommended that all crew wear a PFD or a safety harness while working on the open deck of a working fishing vessel⁴.

The MCA's *Fishermen's Safety Guide* contained specific guidance on potting safety. The following questions and advice were included in its *Potting and creeling* section:

Think about the layout of the vessel

Does the layout on your vessel allow the safe working of pots? Could you modify the vessel to enable the pots to be shot directly off the deck via a transom gate or a shooting ramp?

Is it possible to improve safety by installing a barrier to separate the rope from the area where the crew handle the pots?

Can the pots be securely stacked in sequence ready for shooting?

Is the number of pots in a string limited to the number that can be easily and safely worked in the deck space available on the vessel?

You should consider all aspects of the loading on the vessel, the weight of pots and rope, the catch on deck, the pull of the hauler and the effects of wind and tide.

Have a sharp knife handy.

The *Fishermen's Safety Guide's* specific advice on the dangers of standing in the bight of a rope included:

Ropes, cables, lines and chains when in use can be dangerous: they can snap, suddenly become taut, trap you, etc., so try not to step over a rope or net or a moving warp. It could pull tight and injure you, or pull you into a winch, or into the sea.

⁴ MCA Marine Guidance Notice (MGN) 502(F) amends the Code of Practice for Small Fishing vessels to include a recommendation that PFDs or lifelines are worn at all times when working on open decks.

When discussing single-handed operations and the risk of entanglement, the *Fishermen's Safety Guide* also recommended carrying a safety knife on a belt that could be used to free a fisherman from the gear.

As the national authority on seafood production, Seafish also provided guidance to fishermen on the conduct of risk assessments and the development of safe methods of working. In 2011 Seafish published a *Potting Safety Industry Advisory Notice* that specifically highlighted the risk of serious injury or death if caught in a bight of rope during shooting operations. This document also offered a range of suggested ways to reduce this risk, which included methods of physically separating the crew from the ropes.

In 2014, the MAIB published a *Potting Safety Message* that emphasised the importance of standing in a safe area when shooting pots. MAIB investigation reports into three similar accidents⁵, two of which were fatal, also highlighted the extreme hazards associated with shooting pots.

MCA guidance on carriage of passengers in fishing vessels

Paragraph 14.3.1 of the MCA's *Survey and Inspection of Fishing Vessels* (MSIS 27) stated that *nobody should go to sea in a registered Fishing Vessel unless they are suitably qualified*. The MCA's MGN 494 (M+F), *Media and Other Organisations Using Ships and Fishing Vessels* provided guidance on visitors embarking in ships for business purposes. In relation to vessels engaged in fishing, para 4.2.2 of MGN 494 (M+F) stated that:

If the registered fishing vessel is carrying passengers while it is engaged in fishing for profit (including to and from the fishing grounds), it may do so, provided that it is equipped with adequate lifesaving appliances for all onboard and no more than 12 passengers are carried.

There was no guidance on the carriage of passengers in the MCA's *Fishermen's Safety Guide*.

ANALYSIS

The accident

Lee's entanglement was not witnessed by the skipper or the female adult passenger, and therefore his position on deck when his leg was snagged could not be determined. Initially, Lee was pinned against the bulwark by the back rope, but he was unable to resist the increasing weight of the trailing pots so was soon pulled overboard into the sea.

When the skipper cut the back rope, Lee was released from the hauler and pulled back under water by the pots' weight for a second time. As the back rope was cut between pots 18 and 19 on the string (**Figure 6**), it is likely that Lee had become entangled in the back rope between pots 17 and 18, or the leg rope for the 18th pot. The 18th pot in the string would have been the last one stored on the deck, and to pick it up Lee would have had to avoid the remaining 150m of back rope (from pots 19 to 30) that would have been on the deck (**Figure 7**). With the remaining pots stacked high on the stern rack this would have been the most dangerous part of the task.

Potting methods

Although *Pauline Mary's* owner had some limited commercial fishing experience, he relied heavily on the skipper to operate the vessel safely and to develop safe methods for working the gear. However, the owner had carried out, and documented, a risk assessment for operating *Pauline Mary* as a potter or gill netter. The risk assessment did identify entanglement as a hazard and being carried overboard as a consequence, but it had not been passed to the skipper.

⁵ MAIB Report 12/2011 (man overboard from the fishing vessel *Blue Angel*), MAIB Report 22/2011 (fatal man overboard from the fishing vessel *Breadwinner*) and MAIB Report 1/2015 (fatal man overboard from the fishing vessel *Barnacle III*).



Figure 7: Illustration showing the final 12 pots on the stern rack, and the potential hazard associated with loose ropes on the deck

Potting is a particularly hazardous occupation and being carried overboard by the gear is one of the most common causes of potting vessel fatalities. This was reflected in fishing industry guidance, which clearly warned of the potentially fatal hazards on the deck of potting vessels, in particular the risk of entanglement where there is no physical separation between the crew and the ropes.

In order to minimise the risk, safe methods for working the pots need to be developed and followed. In particular, every effort should be made to separate the crew from the gear. This is often achieved by designing vessels that allow self-shooting or by installing barriers between the crew and the ropes. As *Pauline Mary* was designed for manual shooting and had an open deck, the avoidance of entanglement was entirely reliant on the tidy stacking of pots and crew vigilance.

The skipper and his brother were in the process of laying their gear for the first time when the accident happened. In order to do this, they loaded two strings of pots on the deck at a time. This required the pots to be stacked high and left very little room on deck, which made the task of shooting the pots even more dangerous. The temptation to heavily load a potting vessel when initially laying gear or when shifting grounds might be high as it saves time and therefore money; however, it significantly increases the levels of danger to the crew. In this case, the fishing grounds were very close to the harbour and therefore the financial benefits were low. Had the skipper carefully considered the risks, he might have planned to make seven trips to lay the gear, instead of four.

Safety on deck

To mitigate the consequences of becoming entangled in potting gear ropes, the *Fishermen's Safety Guide* recommended that sharp knives be kept handy or carried, particularly when working on deck alone. Lee had little time to react when he was pinned against the bulkhead, but had he been carrying a knife or able to grab one, he might have been able to cut himself free.

To mitigate the consequences of being dragged overboard, the owner's risk assessment required the crew to wear PFDs on deck. The risk assessment was not passed to the skipper, but he was an experienced fisherman and would have been fully aware of the risks associated with working on deck.

Even if Lee had been wearing a 150N PFD, this would not have provided sufficient additional buoyancy to resist the downward pull of 2 pots after the back rope was cut. However, it would have brought his head out of the water when the skipper hauled him back to the surface the first time. This would have given the skipper and the adult passenger more time to recover Lee back on board without the need to hurriedly cut the back rope. Therefore, had Lee been wearing his PFD, his prospect of survival would have been significantly increased.

The MCA surveyor's initial fishing vessel safety inspection report recommended *Pauline Mary's* crew to wear PFDs on deck in heavy weather. This was not in line with industry guidance as the MCA, along with the MAIB, strongly recommends the wearing of PFDs at all times when fishermen are working on open decks. Furthermore, the MAIB has recommended the introduction of specific regulation to make this mandatory. This accident provides yet another reminder of how things can go disastrously wrong with little or no warning regardless of the environmental conditions.

Emergency response

On hearing Lee shouting for help, the skipper's instinctive reaction was to stop the boat and try to prevent his brother from going overboard. Although this was not successful, he then acted quickly to get Lee back out of the water using the hauler. When the skipper cut the back rope and realised that Lee's leg was still entangled in the gear, he risked his own life by jumping into the sea in a desperate attempt to save his brother.

When the skipper swam back to his vessel, he needed the help of the adult passenger to get back on board. Once on board, he alerted the coastguard to the emergency using the vessel's VHF radio. The skipper's initial report was not prefixed with the words "*Mayday Mayday Mayday*" and the coastguard did not pick up the vessel's reported position. As *Pauline Mary* was not equipped with an AIS transceiver and the adult passenger was unable to interpret the vessel's GPS readings, it took a further 5 minutes for the coastguard to locate the distressed vessel.

During the confusion over the vessel's position, the coastguard asked the crew of *Pauline Mary* to fire a flare to aid position location but did not direct them to initiate a DSC alert. Had the skipper or the adult passenger pressed the distress button on the DSC VHF radio, an action that takes about 5 seconds, this confusion would have been avoided. Additionally, use of the spoken word "*Mayday*" is appropriate in any man overboard situation.

In this case, because *Pauline Mary* was so close to Hartlepool harbour, it is unlikely that the confusion over the position actually resulted in any delay in the arrival of help. However, the fact that the skipper of *Pauline Mary* did not raise the alarm using the DSC demonstrates, as has been observed in previous MAIB investigations, that this is not an instinctive reaction in an emergency.

Carriage of passengers during commercial fishing trips

The adult passenger and skipper's son were on board for a leisure fishing trip that was planned to take place after the pots had been laid. During normal shooting operations, the skipper needed to safely navigate the vessel and monitor Lee on deck. On this occasion, the skipper also had to supervise his visitors in the wheelhouse.

Once Lee had entered the water, having another adult on board proved to be beneficial, as without the female passenger's help, communications with the coastguard would have been lost for long periods and the skipper might not have been able to get himself back on board. However, the presence of the passengers in the wheelhouse, particularly the skipper's young son, was a significant distraction and

probably contributed to the fact that the skipper did not witness Lee's entanglement. Had the skipper been monitoring his brother on deck he might have foreseen the danger and intervened, or at least reacted earlier to the emergency situation.

MCA guidance on the carriage of passengers on board fishing vessels is unclear. Albeit for official organisations such as media representatives, the MCA advice states that it is acceptable to carry passengers; however, guidance for MCA surveyors suggests that only qualified personnel should be on board commercial fishing vessels during operation.

Irrespective of the guidance available, the carriage of passengers or guests on board fishing vessels during commercial operations should be subject to a thorough risk assessment. In this case, it was not appropriate for the passengers to be on board *Pauline Mary*. They were a significant and unnecessary distraction for the skipper, and a working fishing vessel was a hazardous, unsuitable environment, particularly for a child. Hartlepool Fish Quay was so close to the fishing grounds that it would have been feasible for the skipper and Lee to shoot the pots and then return alongside to collect the passengers, thus entirely separating the commercial and leisure fishing activities.

CONCLUSIONS

- Lee Renney became fatally entangled when shooting pots because a safe method of working on deck was not being followed on board *Pauline Mary*. Safer pot shooting methods, specifically where the crew and ropes are physically separated, could have been developed.
- Had Lee been carrying a knife, or if one had been readily available on deck, he might have had an opportunity to cut himself free before going overboard.
- Not wearing PFDs on an open deck is contrary to industry guidance and, had Lee been wearing one, it could have increased his prospect of survival.
- The owner's risk assessment had identified the hazards of entanglement and being dragged overboard, but it had not been passed to the skipper, who had not undertaken a risk assessment of his own.
- The skipper was not observing Lee's work on the deck and did not witness the accident, possibly because he was distracted by the presence of the passengers. Had the skipper been monitoring Lee more carefully, he might have foreseen the danger or at least reacted earlier to the emergency.
- It was inappropriate to have passengers on board during this fishing operation, and would have been straightforward to separate the commercial and leisure use of the vessel.
- Had the DSC distress alert button been pressed, the confusion over *Pauline Mary*'s position would have been avoided.

ACTION TAKEN

Following the accident, the skipper ceased operating *Pauline Mary* and the owner has disposed of the vessel.

RECOMMENDATIONS

The **Maritime and Coastguard Agency** is recommended to:

- 2017/111** Provide updated guidance on the carriage of passengers or guests on board commercial fishing vessels during operations.

SHIP PARTICULARS

Vessel's name	<i>Pauline Mary</i>
Flag	United Kingdom
Fishing Registration Number	WY845
Type	Potting fishing vessel
Registered owner	Privately owned
Year of build	2005
Construction	Glass reinforced plastic
Length overall	8.20m
Registered length	7.80m
Gross tonnage	3.86 tonnes
Minimum safe manning	Not applicable
Authorised cargo	Shellfish

VOYAGE PARTICULARS

Port of departure	Hartlepool
Port of arrival	Hartlepool
Type of voyage	Commercial fishing
Cargo information	Not applicable
Manning	Two crew and two passengers

MARINE CASUALTY INFORMATION

Date and time	1833 (UTC+1), 2 September 2016
Type of marine casualty or incident	Very Serious Marine Casualty
Location of incident	c.1.5nm east of Hartlepool
Place on board	Aft deck
Injuries/fatalities	One fatality
Damage/environmental impact	Buckling to hauler pedestal
Ship operation	Shooting pots
Voyage segment	Mid-water
External & internal environment	Wind: westerly, 11-16 knots Sea state: slight Visibility: good Weather: cloudy
Persons on board	4