

SAFETY FLYER TO FISHING INDUSTRY

Fishing vessel *Harvester* (M999), fatal man overboard accident, 28 April 2016



Figure 1: Fishing vessel *Harvester*

Narrative

At 1424 on 28 April 2016, the 11.6 metre potter *Harvester* (**Figure 1**) grounded on rocks in Abereddy Bay, North Pembrokeshire, and foundered a short time later. There was no indication of any crew on board at the time of the grounding. A large-scale search and rescue operation commenced and the body of one crew member was recovered from the water 3 miles from where *Harvester* had foundered. He was not wearing a lifejacket or other buoyancy aid. The second crew member has not been found despite an extensive search.

Harvester had been fishing grounds to the west of Ramsey Island and it is probable that an accident occurred while shooting a fleet of pots earlier in the day. It is also likely that whatever occurred caused the two crew members to go overboard in quick succession, as the engine remained in gear and no alarm was raised from the vessel.

A likely scenario is that a crew member working on deck became entangled in the back rope as a fleet was being shot. The other crew member could then have gone to his assistance, resulting in both men going overboard through the large opening (**Figure 2**) in the transom.



Figure 2: Opening in transom

Safety Lessons

1. The assumed system of work for shooting pots on *Harvester* did not sufficiently separate the crew from the running gear to prevent the accident.

Crew should ensure that they have a sharp knife to hand and are standing in a safe area during shooting operations. The danger of becoming entangled in the running gear can be reduced or eliminated by providing a physical separation from the back rope, working the gear in a controlled fashion, or adopting a system or work that requires no manual intervention.

2. Neither crew member wore a personal flotation device (PFD), significantly lowering their chances of survival.

A PFD keeps a man overboard casualty afloat and can prevent the inhalation of water both during the initial gasp reflex on entering the water and subsequently. Furthermore, a PFD allows the casualty to remain still, conserving energy and significantly reducing cardiac workload.

3. A personal locator beacon is a very useful additional means of raising the alarm particularly, as in this case, if no one is left on board and the only other means of raising the alarm remains on the vessel.
4. *Harvester's* automatic identification system unit was switched off at the time of the accident. An historical track of the vessel's movements would have been particularly valuable to those involved in the initial search and rescue operation.

This flyer and the MAIB's investigation report are posted on our website: www.gov.uk/maib

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