Fishing 2003 Safety Digest

Contents

Marine Accident Investigation Branch

The Marine Accident Investigation Branch(MAIB) is an independent part of theDepartment for Transport, (DfT) and iscompletely separate from the Maritimeand Coastguard Agency (MCA). The ChiefInspector of Marine Accidents isresponsible to the Secretary of State forTransport. The offices of the Branch arelocated at Carlton House, Carlton Place,Southampton, SO15 2DZ.

This *Safety Digest* draws the attention ofthe marine community to some of thelessons arising from investigations intorecent accidents. It contains facts whichhave been determined up to thetime of issue.

This information is published to inform thefishing industry, and the public of thegeneral circumstances of marineaccidents and to draw out the lessons to belearned. The sole purpose of the *SafetyDigest* is to prevent similar accidentshappening again. The content mustnecessarily be regarded as tentative andsubject to alteration or correction ifadditional evidence becomes available. The articles do not assign fault or blame nor dothey determine liability. The lessons oftenextend beyond the events of the incidentsthemselves to ensure the maximum valuecan be achieved.

The *Safety Digest* is only available from theDepartment for Transport, and can beobtained by applying to the MAIB. Otherpublications are available from the MAIB.

If you wish to report an accident orincident please call our 24 hourreporting line 023 8023 2527.

The telephone number for general use is023 8039 5500.

The Branch fax number is 023 8023 2459.The e-mail address is maib@dft.gsi.gov.uk

Safety Digests are available on theInternet: www.maib.gov.uk

Extract from

The Merchant Shipping

(Accident Reporting and Investigation)

Regulations 1999

The fundamental purpose of investigating an accident under theseRegulations is to determine its circumstances and the cause with the aim ofimproving the safety of life at sea and the avoidance of accidents in thefuture. It is not the purpose to apportion liability, nor, except so far as isnecessary to achieve the fundamental purpose, to apportion blame.

CHIEF INSPECTORS FOREWORD

This digest has one simple aim: to sharewith everyone in the fishing worldsome of the key lessons that we havelearned recently from the tragicaccidents we have investigated.

Sadly, the number of accidents, anddeaths, shows no sign of reducing. Inthe first 2 months of this year alone, 6British fishing vessels have been lost atsea, and 4 British fishermen have died.I believe it is essential that wecontinue to find out why theseaccidents are happening, and pass thelessons on to everyone involved in theindustry. Awareness of the dangers weidentify may just help save otherfishermen's lives.

The role of the MAIB is to get right tothe bottom of what happened, not justto look at the superficial "obvious"causes. Our role is not to look at blame,fault or liability, and we most certainlydo not pass on any information we havebeen given to the police or any otherprosecution/enforcement organisations.

I have only recently taken over as thehead of the Marine AccidentInvestigation Branch (MAIB). I havespent most of the last 34 years at sea,but recognise that I have littleexperience of fishing, and so amwoefully ignorant of the pressuresunder which you all work. I plan tomeet as large a cross section of youas I possibly can over the next yearor so, to try to get someunderstanding of your work and itsvery real difficulties. My wish is forthe MAIB to work with the fishingindustry to find sensible andaffordable ways to reduce the currentrate of accidents.

I hope that you find the digestinteresting; we do try to write thearticles in a readable style. We do notnow identify the names of the vesselsinvolved, which I hope will makepeople less concerned aboutreporting incidents to us. Please takea moment to think about these cases- it might just save your life.

Stephen Meyer
Chief Inspector ofMarine Accidents

CASE 1
Near Misses Involving Fishing Vessels

Narrative 1

Having landed her catch, a fishing vesselwas returning to the fishing grounds. It wasdark, visibility was good, the sea moderate,and the wind south-south-west force 5. Onleaving harbour, she was steering 135° at aspeed of 7 knots and displaying sidelights,stern light and a masthead light.

When still within 2 miles of her port ofdeparture, the skipper detected a radarcontact 2 miles on his port bow, and shortlyafterwards sighted masthead and starboardsidelights along the same bearing. Heestimated this vessel, a general cargo ship,was on a southerly course at about 8.5knots, and that a risk of collision existed.

By the time the two vessels closed to within1 mile, the cargo vessel had failed to take any action as the give-way vessel. Thisprompted the skipper to call her on VHFradio, channel 16. Unable to get a response,he altered to starboard and eventually tookall way off to prevent a collision. Radiocontact was finally established when thevessels were very close and the merchantvessels OOW felt it was too late for him toalter course or stop. The OOW, who wasalone on the bridge, had been working a 6hour watch routine, and did not detect thefishing vessel by radar, or see her visually,until she was at close range.

Narrative 2

A stern trawler was south of Plymouth,towing her gear on a course of 180° atabout 3 knots. She was displaying anappropriate shape to indicate that she wasfishing. It was a clear sunny day, visibilitywas good and the sea was slight. There waslittle wind. A tanker was sighted about 6miles on the port beam, on a westerlycourse and making good about 13 knots.She was on a steady bearing.

As the tanker closed, the trawlers skipperbecame increasingly concerned and, whenthe range had closed to about 1 mile, triedcalling her on VHF channel 16. There wasno reply, and the skipper was forced toincrease to maximum speed to pass aheadof the tanker, leaving it very close astern.Her OOW, who was alone on the bridge atthe time, did not recollect being in a closequarterssituation, or hearing any calls onVHF radio.

The Lessons

These two instances are representative ofmany situations which will be familiar toanyone with extensive experience ofwatchkeeping. You find yourself the stand-onvessel, and detect another vessel on your portbow or beam closing on a steady bearing. Thequestions you find yourself asking are has heseen me? and is he going to give way? Toooften we find the answer to the first questionis No because a proper lookout is not beingkept and No to the second because he isunaware of your presence.

1. Keeping a good lookout and complyingwith the Rules of the Road are not justgood seamanship requirements, but arealso imperative to preventing very seriousaccidents. Had both fishing vessel skippersnot maintained a proper lookout, ormanoeuvred to prevent a collision, theMAIB would probably be investigating twoserious accidents rather than near misses.

2. There are no new lessons aboutmaintaining a proper and effectivelookout. The requirements are well known.Watchkeepers must be alert, look out ofthe windows, use binoculars, monitor theradar on an appropriate range scale, andlisten for sound signals and to the VHFradio. The factors which prevent keeping agood lookout will vary from vessel tovessel, but three reasons seem to featureover and over again. Too oftenwatchkeepers use the opportunity of aseemingly quiet period to do somethingother than keep an efficient watch. Itcould be anything from progressingpaperwork to reading a magazine. Thesecond reason is being distracted bysomething such as monitoring GMDSS,making a lengthy telephone call, orspending an unusually long time at thechart table. And the third is the tendencyfor either a tired or very boredwatchkeeper to fall asleep. If you areguilty of succumbing to any of these, youcould be endangering peoples lives.

3. If you feel you are under pressure to dosomething that will prevent you keepingan efficient lookout, or you are too tiredto do it properly, tell someone. The MAIBreceives a number of reports from peoplein such a predicament, and each one istreated in total confidence. It provides theBranch with the ammunition to dosomething about it.

4. When the OOW is busy, a dedicated visuallookout is an invaluable safety net. Whenall is quiet, he is a second pair of eyes and ears, and helps to keep a tired OOW alert.You are required to have a dedicatedlookout at night.

5. VHF radio is convenient, but it relies on thewatchkeeper in the other vesselmonitoring the appropriate channel,understanding what is being said, andbothering to reply. Not surprisingly, manycalls go unanswered. But there are realdangers to using VHF when the identity ofthe other vessel is unknown. There are anumber of recorded incidents when eitherthe misidentification of the other ship, ora lack of understanding, has contributedto the subsequent collision or incident.

6. If the situation allows, and you need tomake your presence known to the othervessel use the wake up signal by whistleor horn, and by flashing light. The signal isrequired by the Rules of the Road and,although an inattentive OOW may not seeor hear it, somebody else on board theother vessel might. Dont be shy; its inyour interest to be seen.

7. Navigation lights are no different to carheadlights. They accumulate grime andsalt in time. An occasional wipe doeswonders to improve their effectiveness.

CASE 2
Fatality on Board Fishing Vessel

Narrative

After a weeks break, a beam scalloper,sailed from an east coast Scottish port inthe early hours of the morning to returnto the fishing grounds. Later that day, andwhile shooting her gear for the fourthtime, one of the deckhands moved from aposition of safety and was struck on thehead by a towing bar. The sea conditionswere rough, and the bar swung in boardbecause of the vessels movement. It willnever be known why the deckhand madethe move, but the blow killed him.

The deceased was an experiencedfisherman, but had never sailed on thisvessel before. He had only been onboardfor 14 hours when he died.

Safety hats were available, but nobody onboard wore them.

The Lessons

This tragic accident will provoke a numberof reactions among fishermen. Everyonewill have the deepest possible sympathyfor the family of the deceased. Many will,rightly, want to know what happened andwhether anything could have been doneto prevent it. Others will say it was one ofthose things which happen from time totime in this most hazardous ofoccupations. The reality is that similaraccidents have occurred in the past andare likely to happen again unless measuresare taken to prevent them.

Much can be done once peopleunderstand that accidents are rarelycaused by a single event. It isnt just badweather, a particularly high wave, anunfortunate swing of the towing bar, orthat the victim was new to the vessel.Accidents happen through a combinationof things, and it is important to learn fromthe lessons of this and similar accidents inthe past.

1. No two vessels are the same. Variationsin equipment, procedures, the way askipper likes things to be done or eventhe vessels motion in a seaway, willdiffer. When joining a vessel for thefirst time, nothing should be taken forgranted. Make sure you are aware ofthe various hazards and safetyprecautions in force. Pay particularattention to anything that swings fromaloft such as towing bars and blocks,and make a mental note of how they can be avoided at all times. It is unlikelythings will be identical to your lastvessel and you must not hesitate to askquestions if you are unsure of anyprocedures. Doing this does notquestion your ability or experience; itsimply highlights your commonsense.

2. Every year a number of fishermen areeither seriously injured, or killed, bybeing hit on the head. Someone, sooneror later, wants to know whether theconsequences could have beenprevented had the victim been wearinga safety helmet. The answer is no oneknows, but even if wearing one couldhave prevented it, most people wouldbe very reluctant to try it for a numberof reasons. They are uncomfortable, getin the way, restrict vision, allow waterto drip down the back of the neck andnobody else wears one. So otherworkers have said in the past. But now,wearing safety helmets has becomesecond nature to those working onmerchant ships or in the offshore sector.It is now so much in the culture that tonot wear one feels uncomfortable. Thefact remains they provide very goodprotection, reduce injury and save life.Wear a safety helmet.

3. When hauling or shooting, orconducting any operation on deck, keepan eye on your colleagues and do nothesitate to raise the alarm or stop aprocedure if you see somethingdangerous developing. Safety is theresponsibility of everyone on board.

4. When accidents happen at sea, expertmedical assistance can often be faraway, and the well-being of a casualtyis in the hands of others on board. Inthis case, although the injuries weresevere and the efforts of the first-aidtrainedcrew were sadly unsuccessful,the need for fishermen to complete themandatory first-aid course was onceagain highlighted.

Footnote

In the past five years the MAIB hasreceived a number of reports from certainsectors of the fishing industry stating thatthe wearing of safety helmets is on theincrease. In nearly every instance, thecatalyst for change was the death of afriend and colleague through a headinjury incurred at sea. The sadness is thatit takes such an event to make peoplechange the habits of a lifetime. A farhappier solution is to do something aboutit before you become the victim.

This incident was the subject of a fullMAIB investigation. A comprehensivereport, giving details of the causes, ananalysis, and recommendations waspublished in August 2001.

CASE 3
For Appearances Sake

Narrative

Following a 12 hour search for fish, alarge, 92.04m stern trawler, with a crewof 34 was preparing to shoot her nets inthe English Channel, about 17 milessouth of the Isle of Wight.

Four of her deck crew went aft to shootthe nets under the control of the fishingskipper who was in the wheelhouse. Hewas positioned at the winch controlsoverlooking the aft working deck.Shooting began. Two of the crewattached the head line transponder andthen moved to two small pound areas atthe stern from where they were to attachtowing wires to the nets wings.

The man on the port side attached hiswire, but then noticed his colleague wasnot where he had expected to see him, inthe starboard pound. Thinking he hadgone to the toilet, he moved across tostarboard to attach the towing wire. Atalmost the same time the fishing skipperalso noticed the man was missing. Hewent aft to investigate.

When they failed to find the missingcrewman they realised he must have goneoverboard. It was dark and the wind wasforce 4 to 5.

A Pan Pan message was broadcast, andthe Solent coastguard initiated a searchand rescue operation. The vessel recoveredher nets and joined the search. Ahelicopter, a lifeboat and several merchantand fishing vessels also took part. Thecrewman was not found, but his selfinflatinglifejacket was recovered. This wasfound inflated with its light illuminatedand the buckle on its harness fastened.

Nobody saw him go over the side, but thecircumstances suggest he was standing inthe starboard pound to connect thetowing wire to the net. A feature of thepound is its proximity to the stern roller,which rotates as the nets are paid out. It isimpossible to say what happened, but thepossibility exists that he was somehowtaken overboard by the rotating roller.

The crewman had been wearing ordinaryclothing: a hard hat and the inflatablelifejacket. Only the lifejacket was foundand recovered. Once again, it is impossibleto reconstruct exactly what happened, buta properly secured lifejacket should nothave become detached. The evidencesuggests it was not being worn correctly,and it is likely the victim slipped thelifejacket over his head without passingthe harness around his waist. When heentered the water the lifejacket slippedoff. The particularly sad feature was therelative ease with which the lifejacket wassubsequently seen, but nothing was foundof the man.

The Lessons

1. The aft boundary of the two sternpounds is the stern roller. Because thisis able to rotate freely it cannot servethe same purpose as a guardrail orbulwark. Without a barrier betweenthe pound and the roller, crew caneasily come into contact with theroller. If it is turning, it might then dragthem overboard. Stern rollers should beviewed in the same way as any rotatingmachinery. They are dangerous andmust be guarded if personnel are likelyto be very close by.

2. The crew generally recognised theimportance of wearing a lifejacketwhile working on deck. The victim,however, apparently failed to don hisproperly, and did no more than slip itover his head. Perhaps he thought itwas unnecessary as he was onlyexpecting to be on deck for a fewminutes. To the casual onlooker itwould appear as if he was wearing one.

3. The value of a lifejacket is entirelydependent on it being worn properly andsecured correctly. A snug fitting model isboth comfortable and a life saver.

Accidents are no respecter of time.Dangers exist no matter how brief thestay on deck.

Footnote

This incident was the subject of a fullMAIB investigation. A comprehensivereport, giving details of the causes, ananalysis, and recommendations waspublished in August 2001

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CASE 4
Take Your Lifejacket and Phone with you

Narrative

A 5.8m Orkney fast liner open fishingvessel, which was powered by a 37.2kW(50HP) outboard, was being operatedsingle handedly. The skipper was haulingcrab pots, and had twelve on board whenthe line tightened on the hauler. A pot orline had snagged on the rocky bottom in adepth of 46 metres. A northerly force 3wind was blowing, and the sea was slightwith a chop and a southerly ebbing tide.

The normal practice in such situations wasto throw the recovered pots backoverboard, and then start the recoveryfrom the opposite end of the string. Theskipper began this process, but havingpayed out 2 fathoms of rope, found it hadcaught in the outboards propeller.Moments later, the rope came bar tightand the engine cut out. The skipper triedto raise the outboard, but the load on therope prevented this.

The boat was, in effect, anchored. It wasalso lying with the stern so low that waterhad started to come inboard over thetransom. The skipper attempted to lightenthe boat by ditching some of theembarked pots, but this made littledifference. He thought of diving down tocut the rope, but with the tide running,thought better of it and chose instead tocontact the coastguard on VHF via a localvessel.

Meanwhile, water continued to be shippedover the stern. The skipper was wearing alifejacket and, once in the water, began torecall the advice he had received insurvival training. It served him well. About10 minutes later he was recovered byanother fishing vessel.

The Lessons

This incident could have turned out sovery differently. The skipper owes his lifeto following the advice so frequently putout by the MAIB:

1. Wear a lifejacket at all times.

2. Let people know if you are in troublebefore it is too late.

3. Dont make matters worse by diving in,cutting the rope and then, perhaps,watching your craft drift gently awaybefore you can re-board it.

4. Carry a VHF radio and make sure itworks. If battery-operated, ensure the batteries are fully charged, or areconnected to a suitable power sourcesuch as the boats batteries.

When looking back on his experiencesafterwards, the skipper discussed theadvantages of carrying a liferaft for use insuch emergencies. As with many similarcraft, there was very little room onboard asthe pots took up most of the availablespace.

There is no doubt that when the chips aredown, and there is every prospect of yourvessel foundering, the existence of aliferaft could well make the difference between life and death. Skippers of smallcraft must make the choice. Take upcommercially useful space or give yourselfa good chance of survival. Friends,family and next-of-kin may haveuncompromising views about whichchoice to make. Ask them.

CASE 5
Poor Watchkeeping on Fishing Vessel

Narrative

A fishing vessel was on passage betweenfishing grounds and in the vicinity of theMallory gas field. Three crew were onboard. Two of the crew were carrying outvarious tasks including cooking breakfast,cutting up bait, pumping out the bilges andcleaning pump filters. They were alsoresponsible for maintaining the watch andkeeping a lookout. The third crew member,the skipper, was asleep on the deck of thewheelhouse. The vessel's planned trackpassed 0.35 miles from a rig, and the radaralarm was set on 13 of a mile. The vessel'sVHF was turned off, as, in the skipper'sopinion, there was too much unnecessaryand distracting radio traffic.

The stand-by safety vessel on station in thearea, received a message from her sistervessel saying that she had been plottingthe track of the fishing vessel since 0600, and she had been seen to pass close to theSanta FE Monarch rig. Despite the sistervessel putting her FRC alongside the fishingvessel, nobody could be seen on the bridgeor on deck. On receipt of the message, thestand-by safety vessel also launched herFRC and intercepted the fishing vessel. Thestand-by safety vessel and her FRCparalleled the course of the fishing vesseland, despite both sounding their horns,they failed to attract any attention. Therewas no sign of life on board.

The track of the fishing vessel wasestimated to be taking her to within 0.5mile of the Mallory platform. Both theplatform and the coastguard wereinformed, and the decision was taken to tryto board the fishing vessel. The Malloryplatform went to abandon platformstations as a precautionary measure. At 0800 the stand-by safety vessels FRC wentalongside the fishing vessel, which was stillmaking way at the time, and one crewmember transferred. He went to thewheelhouse and found the skipper asleep ina sleeping bag.

The skipper was awakened and told to slowdown and steer way from the platform. Hedid so. He then protested about beingawakened, and claimed the situation wasunder control. He said he generally slept inthe wheelhouse in order to be instantlyavailable if needed, and had two crew onwatch. Furthermore, the vessel was justarriving at her next intended fishingground, and at no time had a 500mexclusion zone around a rig been breached.He felt that the stand-by vessel had overreactedto the situation.

The Lessons

Readers can draw their own conclusions asto whether the stand-by vessel had overreactedon this occasion, and whether thewatchkeeping arrangements in thisfishing vessel were satisfactory.

1. Skippers should need no reminding thatthey have a paramount responsibilityto ensure a proper lookout ismaintained at all times. There isnothing fundamentally wrong with askipper sleeping in the wheelhouse,provided somebody else is on watchand maintaining the lookout when heis doing so. Watchkeepers employedelsewhere on deck or below, are rarelyin a position to keep a good lookout orto listen out on VHF. In some small craftit might be possible.

2. The Maritime and Coastguard Agency(MCA) has published MGN 84 (F)Keeping a Safe Navigational Watch on Fishing Vessels in which owners,operators, skippers and crews of fishingvessels are, among other things,reminded that:

A competent alert watchkeeper,keeping a proper all round lookout atall times is absolutely essential.

The wheelhouse must not be leftunattended at any time.

The lookout must give full attention tokeeping a proper lookout and no otherduties should be undertaken whichcould interfere with that task.

It goes without saying that thewatchkeeper cannot keep the requiredcontinuous all-round lookout at thesame time as cooking breakfast orcutting up bait.

3. Fishing vessels can legitimately work inthe vicinity of rigs but if they choose todo so, they should ensure they keep aconstant listening watch on Channel16 VHF. When operating in the vicinityof a gas field, VHF traffic does not fallinto the category of unnecessary.

4. Stand-by safety vessels carry outimportant guardship duties. If contactcannot be established with a vesselwhich is deemed to pose a potentialthreat, more direct action may benecessary to ensure the safety of allconcerned. In such circumstances, astand-by safety vessel cannot waituntil a vessel breaches the 500m zonebefore taking action.

CASE 6
Tiredness Can Kill

Narrative

After 3 days fishing off the west coast ofthe Shetland Islands, a fishing vessel wasreturning to Scalloway to land her catch.The skipper, who had only managed abouthours sleep during the time on thefishing grounds, was alone and seated inthe wheelhouse. From his chair he couldsee and reach all key equipment, includingthe watch alarm, which was set at a 10-minute interval. The vessel was inautopilot and the skipper was navigatingby eye. The two remaining crew weredown below; the engineer was having acoffee in the mess room, and thedeckhand was in bed.

As she passed to the north of theCheynies, at the entrance to the MiddleChannel, the skipper adjusted the vesselscourse a few degrees to starboard andreset the watch alarm. He then fell asleep.Less than 5 minutes later, the vessel washard aground.

The Lessons

1. Although tiredness can kill is a wellusedcliché, its as true as it ever was.Fishing is hard work but, on thisoccasion, the combination of fishingclose inshore for 3 days, with severaltows as short as 2.5 hours, and with acrew of only three, took its toll on theskipper. Fortunately there were noinjuries, and damage was onlysuperficial.

There are no hard and fast rulesdictating how many crew a fishingvessel should carry to operate safely. Itboils down to experience: what thevessel is doing and how long it willtake, her size, the equipment fitted,and finally but, most important of all,commonsense.

2. Every wheelhouse watchkeeper hasprobably felt tired while on watch.Many, including some of the best, haveprobably fallen asleep. Fortunately,most of these have been lucky andhave got away with it. What makessomeone fall asleep is difficult to say.

Sometimes tired people want to sleepbut cant; yet at other times, peoplewho dont think they are tired doze offat the drop of a hat. Two things,however, are certain. A watchkeeperwho is alone, sitting down, and doingnothing is more likely to fall asleep thanone who is walking around thewheelhouse, getting fresh air, and usingall the navigational aids available tohim. The second is that if you are very,very tired and sitting down withnothing to stimulate you, there isnothing whatsoever you can do to stopfalling asleep. It takes less than 10seconds to do so.

3. With many watch alarms positionedwithin easy reach of the wheelhousechair, it would not be surprising todiscover that some wheelhousewatchkeepers can literally reset a watchalarm in their sleep. Enough said. Andhaving reset it there is nothing toprevent that person falling asleep allover again.

4. The effectiveness of a watch alarm towake a watchkeeper in time to preventan accident depends on the timeinterval set. The longer the interval, thelonger the opportunity for somethingto go wrong. After this grounding, awatch alarm with a 3-minute intervalwas installed. Had this alarm beenfitted before the grounding, the vesselmight have been able to land her fish asplanned. What is the interval on yourwatch alarm?

5. Having a second person in thewheelhouse not only provides a secondpair of eyes, but it also gives a tiredwatchkeeper somebody to chat to. Thismight prevent him from falling asleep.

Footnote

This incident was the subject of a fullMAIB investigation. A comprehensivereport, giving details of the causes, ananalysis, and recommendations waspublished in February 2002.

CASE 7
Grounding of a Fishing Vessel

Narrative

A fishing vessel was heading towardsCullivoe in the Shetland Islands to landher catch when she ran aground in theapproaches to the northern entrance toBluemull Sound in the early hours of themorning.

Her skipper, who had not slept for about23 hours and had recently held a mobiletelephone conversation with a friend,attempted to alter course while in theSound. Using the joystick control, hefailed to use the correct procedure forchanging from automatic to manualsteering, and did not realise the vesselwas not turning as intended untilimmediately before the vessel grounded.By the time he did realise there was aproblem it was too late for him to doanything about it. When the tide fell, thefishing vessel was embarrassingly highand dry. She was refloated the followingday. There was no pollution, and damageto the vessel was minor.

The Lessons

1. Everybody makes mistakes, but we aremore likely to do so when weve nothad enough sleep. Tiredness makes itdifficult to concentrate, and our abilityto remain alert to what is happeningaround us is much reduced. Simpleerrors occur that would be unthinkablein normal circumstances. Drowsiness isthe obvious symptom of fatigue. Otherindicators which affect concentration,awareness and alertness are harder toidentify, but are just as dangerous.Dont assume that just because acompetent watchkeeper is awake thathe can do the job. You only have tothink what it is like to do a simple taskat home at the end of a long day toknow how difficult it can be. It is nodifferent at sea even if you think youcan do it. People who go without sleepfor more than about 18 hours are lessable to perform routine tasks than hadthey exceeded the drink drive limit.

2. A second person in the wheelhousewhen in confined waters or enteringharbour, when you have been up forover about 18 hours, will do much toprevent mistakes having unfortunateconsequences. Many accidents occurbetween the hours of 0100 and 0600.This one took place at about 0330.

3. Problems or faults with the steering,particularly when changing from autosteering to hand steering need not bedisastrous provided they are discoveredin time. An instinctive glance at therudder angle indicator each time youapply wheel, will give you early warningof a problem. If you find the rudder isnot responding, and you are trying toalter course, the time available to doanything about it is often very limited.Taking the way off is a possibility. It isfar better, however, to reduce thechances of anything going wrong byselecting and testing manual steeringbefore you need it.

4. Mobile telephones have proved to bevery beneficial at sea, and are widelyused for both commercial and privatereasons. As when driving a car, their useat certain times can be a

majordistraction. Many will argue thattransiting confined waters when tiredat 0330 constitutes a certain time.

Footnote

This incident was the subject of a fullMAIB investigation. A comprehensivereport, giving details of the causes, ananalysis, and recommendations waspublished in March 2002.

CASE 8
Collision in the Dover Strait

Narrative

At 0413 UTC, CNIS Dover detected a radarcontact crossing the south-west lane ofthe Dover Strait TSS on a heading of 010°.As the axis of the lane was 230°/050°, shewas not crossing at right angles as requiredby Rule 10c of the Collision Regulations.Consequently, a preliminary broadcast wasmade on VHF channel 16, followed by afurther broadcast on VHF channel 11 at0416, warning all vessels of thecontravening vessels position.

The vessel was later identified as a Frenchstern trawler which was on passage from aFrench port to the fishing grounds in thevicinity of the South Falls Bank. A 17-yearolddeckhand was alone in the wheelhouse,and had been instructed to follow theplanned track of 010° across the DoverStrait at a speed of 11 knots. The vessel wasin autopilot and the watch alarm was setto a 10 minute interval. Both the skipperand the deckhand were aware that theintended track contravened Rule 10c ofthe Collision Regulations, but the skipperwas keen to get to the fishing groundsbefore his rivals.

CNIS Dover had previously reported thisvessel five times since 1998 to the Frenchadministration for contravening Rule 10 ofthe Collision Regulations.

Shortly after crossing into the south-westtraffic lane, the fishing vessel deckhandsaw a radar contact about 3 miles on thestarboard bow. He initially saw a vesselsport and starboard side lights, but soonafter, his vessel crossed ahead of this otherone, and only her starboard sidelightremained visible. Based on thisinformation, and by monitoring two smallradar displays, the deckhand assessed thatthe vessel would pass no closer than 1 mileto starboard. He was then either distracted,or fell asleep, and paid no furtherattention to the situation until he saw alarge ship at very close range ahead.

The ship, a product tanker on passage toWest Africa, was following the south-westlane of the Dover Strait TSS at a speed ofabout 11 knots with three other vesselsclose astern. Between 0413 and 0423 UTC,the OOW fixed the ships position andannotated the deck log. Although thebridge VHF radios were set to channels 11and 16, he did not hear the broadcastsmade by CNIS. The OOW was accompaniedby a lookout, who remained at the helm formuch of this period.

After finishing his work at the chart table,the OOW checked the radar display and sawa contact 2 miles on the port bow with aCPA of 1 cable to port. He visually identifiedthe contact as a fishing vessel, andcontinued to monitor it for several minutesuntil it became apparent that the vessel wason a steady bearing and was not taking anyaction to avoid a collision. At this point, theOOW applied 10° of starboard helm andsounded 5 short blasts on the ships whistle.On hearing the sound signal the master,who had been working in his cabin, came tothe bridge and saw the fishing vessel about1 cable on the port bow. He immediatelyordered the helm to be increased andrepeated the 5 short blasts.

At about the same time, the deckhandaboard the fishing vessel attempted toavoid a collision by turning to starboardbut, as automatic steering was selected,there was no response.

The fishing vessel collided with the shipsport bow at about 0429 causing a 6m gashin the No 1(port) tank, followed by lesserimpacts amidships and in the vicinity of theaccommodation. About 110 tonnes of oilleaked from the ruptured tank into the sea,before the contents of the tank weretransferred.

The Lessons

A feature of this incident is how late eachwatchkeeper detected the other vessel.Once again it reminds people howimportant it is to keep a very goodlookout, especially at night.

1. A fundamental purpose of a TSS is toimprove safety by requiring vessels tobehave in a predictable manner. Vesselsfollowing a traffic lane should be eitherovertaking or being overtaken, and thestatus of crossing vessels should beunambiguous. When vessels disregardthe requirements of Rule 10, thebenefits of a TSS, including those of theprecautions of radar coverage andreporting schemes, are jeopardised.Familiarity, or regular use of waters,does not carry any particular rights orexceptions from complying with theRules at all times. They are there for allships to follow.

2. Maintaining an effective lookout inareas such as the Dover Strait, whichare navigationally demanding, andhave a high traffic density, is not easyand requires efficient time and bridgeresource management. Remember, thatwith a closing speed of 20 knots, it onlytakes 3 minutes for vessels to close 1mile, and an OOW cannot afford totake his eye off the ball for longperiods. An OOW quickly checking theradar display, and looking out of thewindow between plotting a fix andwriting up the deck log, can be thedifference between detecting a rapidlydeveloping close quarters situation ingood time, and panic stations. When anOOW cannot maintain a lookouthimself, it is good practice to make thelookout aware of what he is doing and,in any event, must ensure the lookoutkeeps a good watch, particularly ahead.

3. Dedicated lookouts are required atnight. Keeping a lookout from the helmis not the way to meet the requirement.

4. When there are several vessels ofdifferent sizes in close proximity, it canbe difficult to correctly associate radarechoes with the vessels sighted, particularly when there is no compassrepeater available to take bearings. Insuch situations it is essential that allvessels are continuously monitored,both visually and by radar. Be aware ofremaining in the same position on thebridge or in the wheelhouse for toolong, as a vessel on a steady bearing canremain hidden behind a windowmullion from the horizon until justbefore it hits you.

5. Bridge watchkeepers are frequentlytired, but precautions can be taken tokeep them alert. These include drinkingfresh water; ensuring they are wellrested before taking over; that twopeople are always on the bridge or inthe wheelhouse; that the frequency seton the watch alarm is appropriate tothe situation and that watchkeepers arediscouraged from remaining seated forlong periods.

6. The MAIB is aware that recreationalequipment, such as CD players, featureas aids to relieve boredom in somevessels. If a master or skipper sanctionstheir use, so be it, but they are a majordistraction in confined waters, and canprevent the OOW monitoring VHFtransmissions. Switch them off,especially in the Dover Strait TSS.

7. A warning broadcast via VHF radio isworthless if it is not heard orunderstood. Always ensure that aproper listening watch is maintained onthe VHF radio.

8. A competent master would prefer to becalled to arrive on the bridge to find avessel at a distance of 2 miles andclosing, rather than a vessel at 1 cablewith collision imminent.

9. Vessels transitting the Dover TSS shouldbe aware that the fishing vessel theysee crossing the lane in front of themmight well be in the charge of a 17 yearold who may be well trained, but isunlikely to have much experience.

10. Whether or not the belief that fishingvessels often wait until the last possiblemoment before taking action to avoid acollision is true, this should notinfluence the application of Rule 17 ofthe Collision Regulations. This ruleallows a stand-on vessel to manoeuvreas soon as it becomes apparent that thegive-way vessel is not takingappropriate action to avoid a collision.It is better to use this rule to goodeffect, and remain clear of give-wayvessels bent on maintaining theircourse and speed, rather than getinvolved in what could be a risky gameof chicken. It is dangerous to assumeanother vessel is aware of yourpresence we might be right, but wedont want to be dead right!

11. When appropriate, use the wake upsignal as soon as possible and asfrequently as needed. The use of theships whistle, and any associated light,costs nothing and, if another vessel isnot aware of your presence, the soonerit is used, the more time the othervessel may have to take appropriateaction.

12. When at close quarters, and takingavoiding action, dont nibble. By thetime it is realised that more helm isneeded to avoid a collision, it is oftentoo late to be effective. The helm canalways be eased once the risk ofcollision has passed.

Footnote

The BEAmer also investigated the accidentand cooperated with the MAIB with goodeffect.

This incident was the subject of a fullMAIB investigation. A comprehensivereport, giving details of the causes, ananalysis, and recommendations waspublished in February 2002.

CASE 9
EPIRB Saves Two Lives

Narrative

A 15.73m-long wooden vessel wastrawling about 35 miles off the coast ofnorth Yorkshire one night in April, whenshe became fast. A crew of two was onboard. The wind was from the south-eastforce 3 and the sea was slight.

While trying to release the trawl byheaving with the winch, a hydraulic pipeburst. An attempt to repair it failed, butshortly afterwards they came free.Because the winch was not working, thetrawl could not be recovered. Not wantingto lose their gear, the crew decided toleave the gear out and make for port atslow speed.

After they had been steaming for a while,the skipper told the deckhand to go belowand get some rest. When the deckhandopened the hatch to the cabin hediscovered flooding. The skipper turned onthe electric bilge pumps, but didnt thinkit necessary to contact the coastguard.After about half an hour the floodwaterdisabled the electrical supply which, inturn, stopped the electric bilge pumps.Realising the situation was becoming critical, the skipper tried to contact thecoastguard using the fixed radios, butthere was no electricity supply, so wasunable to do so. The skipper did not thinkto use the portable VHF radio carried onboard.

Soon afterwards, the fishing vesselcapsized and foundered. The crew foundthemselves in the water where thetemperature was between 8°C and 9°C.The liferaft went down with the sinkingvessel, but two lifebuoys, a gas bottle andthree or four pound boards floated to thesurface. The survivors managed to grabthe lifebuoys.

One further item had also broken free, theEPIRB. It started to transmit once on thesurface and alerted the SAR authorities.The crew were in the sea for over an hourbefore a rescue helicopter arrived, havinghomed in on the EPIRB signal.

The crew were successfully rescued, andowe their lives to the coastguard, thehelicopter crew, many others in supportand, above all, the EPIRB.

The Lessons

1. This is a classic example of how theEPIRB can save lives! Fishing vesselowners often complain about the costof safety equipment, but thisdemonstrates how valuable aninvestment the EPIRB can be.

2. If flooding is discovered, always call thecoastguard. You will not be disturbingthem unnecessarily. They much preferto be informed at an early stage, thanlater when things get desperate.

3. Fishing vessels of this size are requiredto have a portable VHF radio. If thecrew abandon to the liferaft, theyshould take the portable VHF radiowith them; this is its primary purpose.The portable VHF radio can also be usedif all other radios have failed.

4. There is little point in speculating whythe liferaft didnt float free, but thenext time you walk along the jettylooking at your fellow fishing vessels,count the number of times you seeliferafts so firmly secured that they willnever break free. Then go away andthink about it.

Footnote

This incident was the subject of a fullMAIB investigation. A comprehensivereport, giving details of the causes, ananalysis, and recommendations waspublished in February 2002.

CASE 10
The Thinking Man!

Narrative 1

A 251gt fishing vessel had recentlyundergone routine maintenance, duringwhich time the turbo charger on themain engine had been overhauled andrefitted. Once the maintenance wascomplete, the vessel prepared to return tothe fishing grounds. She sailed, and hadbeen on passage for only a short timewhen the turbo charger bearings seized,and a small fire broke out in the area ofthe exhaust manifold. The fire was quicklyput out and arrangements made to towthe vessel back to port.

On investigation, it was found that theturbo charger failed because of a basicerror during re-assembly:

a. The bearing oil supply pipe had beenconnected to the casing cooling waterinlet;

b. The cooling water supply had beenconnected to the bearing oil inlet.

Narrative 2

A ro-ro ferry was on passage toPortsmouth, and the opportunity wastaken to install a new security box in theemergency generator room for the Halonrelease lever and alarm. The release wirehad been disconnected while the workwas being carried out to give easy access.With the job nearing completion, it wasdecided to re-connect the release wirebefore the final electrical connectionswere made. In doing so, the crewmanmoved the operating lever to one side,causing the release lever of the 60kghalon bottle to activate, discharging thegas into the emergency generator room.

The crewman left immediately, the spacewas ventilated, and the work wascompleted once the area was safe toenter. There were no injuries to eitherpassengers or crew.

Narrative 3

A cruise ship was in dry dock, in the USAwhen her crew were alerted to thepresence of heavy smoke in the vicinity ofthe frozen meat room. The alert wassounded, with contractors and nonessentialcrew being told to muster ashore.Preparations were made for boundarycooling, while the deck fire party enteredthe store room wearing breathingapparatus. After reporting that they hadfound smouldering wiring on thedeckhead, they withdrew, leaving thesecond fire party from the engine room toinvestigate the surrounding area. Thisparty entered the void space outside thestore room, and found no evidence of thefire having spread to, or having originatedin, an adjacent space.

The local fire brigade was now inattendance, and entered the store room. AClass A fire was put out. Smouldering andfire-damaged goods were removed, andthe fire confirmed as being out shortlyafterwards.

The cause of the fire was put down toboxes of meat being stowed in contactwith hot unprotected compressorpipework. This resulted in the cardboardcontainers drying out, heating up andsmouldering to start a chain reaction.Nobody was injured.

The Lessons

A common theme links these three events.They happened in very differentcircumstances, and on differing types ofvessel, but they each demonstrated whatcan happen when a course of action is notthought through to its logical conclusion.If you dont think things through YOU willprobably be the one who suffers.

1. After any machinery overhaul, CHECKthat all connections are both made andtightened. Ideally, water and oilconnections should be either differentcolours, type of connections or markedin some way. ALWAYS check the workof contractors. If something is set upincorrectly, it is highly likely that YOU will be the one who eventually has tosort it out.

2. When undertaking work on a gasrelease mechanism, ALWAYS fit safetydevices to prevent accidental release.But remember to remove and CONFIRMthat it has been removed once the workhas been completed.

3. When loading stores, look at the spacefirst so that you know what accessdifficulties there are in the spaceallocated, and what problems could beencountered. If there are areas such asexposed and unprotected hot pipes, getthem insulated and protected.

No matter what vessel you are on, spendtime checking out the pitfalls that you oryour fellow seafarers are likely to meetduring the course of your job. RISKASSESSMENT, as it is now called, can saveyou a lot of time and worry.

CASE 11
I Will if you Wont!

Narrative

A fishing vessel was trawling north-westat 2.2 knots. A coaster was steamingnorth-east at 10 knots. It was daylight andthe fishing vessel was displaying anappropriate shape for a vessel engaged infishing. The weather was calm and thevisibility was good.

The fishing vessels sole watchkeepersighted the coaster when she was 4 milesaway, and determined that a closequarters situation was developing. Whenthe coasters range had closed to half amile, and she hadnt taken any action, thewatchkeeper altered course hard to portand increased to full speed.

The report is based solely on evidenceprovided by the fishing vessel, since thecoasters evidence is that no such incidentoccurred.

The Lessons

There can be few fishing vessel skippers orshort sea traders who do not recogniseincidents such as this. There is often atendency to blame the other vessel for notdoing more to keep out of the way.

1. In the fishing vessel skippers experience,approaching vessels tend not to altercourse until the last minute. This has ledfishermen to delay taking actionthemselves until it becomes apparentthat the give-way vessel has no intentionof doing so. The reluctance of fishermento take action themselves is compoundedby the restrictions imposed by their trawlgear. Although a stand-on vessel is notrequired to take action until collisioncannot be avoided by the action of thegive-way vessel alone, it may do so assoon as it becomes apparent that theother vessel is not giving way. In view oftheir restricted nature, and the reducedmargin of safety in taking late action,vessels engaged in trawling should beprepared to act much earlier than theywould do otherwise.

2. It was the coasters masters experiencethat fishing vessels tend to display afishing shape when they are not engagedin fishing. The assumption is justified, asanyone who has seen a fishing vessel in harbour can testify. The practice ofhaving shapes permanently displayeddoes undermine the value of beingrecognised as a burdened vessel, and canlead to dangerous assumptions beingmade by other, give-way vessels. Havingsaid that, it is totally wrong to assume afishing vessel showing shapes is notengaged in fishing. In this particularincident, the coaster was still the givewayvessel because she apparently hadthe fishing vessel on her own starboardside and was crossing. As a give-wayvessel, she was required to take early andsubstantial avoiding action.

3. We have here a skipper and a master who,fundamentally, do not entirely trust theother because of their past experiences.It is a sad reflection of how thetraditional manners of the sea havedeclined. Shipping must keep an eyeopen for fishermen, and must take earlyavoiding action so that trawlers andothers are not forced to manoeuvre withtheir gear still out. Fishermen, for theirpart, must realise that flouting theregulations, and having their daytimeshapes permanently rigged, underminesthe trust that other seafarers have intheir actions.

4. There are a couple of other points. TheCollision Regulations require a vesselwhich fails to understand the intentionsor actions of another, or is in doubt as towhether sufficient action is being takenby the other, to sound a warning signalof at least five short and rapid blasts. Hadthe fisherman done so in this instance, itmight have alerted the coaster. Althoughthe minimum audible range

required fora vessel the size of the fishing vessel is0.5 mile, the distance at which thewatchkeeper decided to take actionhimself, making a sound signal might,just might, be the difference between acollision and a near miss.

5. This article has focussed, in part, onshippings interpretation of fishingvessels shapes. It is an old debate, withevery prospect of continuing. The factremains that any experienced mariner inreasonable visibility can tell by looking ata fishing vessel, using binoculars ifnecessary, whether it is actually engagedin fishing. The watchkeeper glued to theradar cannot. The moral of the story: lookout of the window. Please.

CASE 12
He Who Hesitates

Narrative

A French fishing vessel collided with a UKaggregates dredger in the north-easttraffic lane of the Dover TSS. The fishingvessel was not fishing and had been thegive-way vessel under the CollisionRegulations. Both vessels suffered minordamage.

The fishing vessel had been crossing thenorth-east traffic lane on a southerlyheading making 9 knots. The dredger wassteering 050° in the traffic lane andmaking a speed of 11.7 knots. She hadbeen overhauling two vessels which wereclose ahead of her. The headings andspeeds of both vessels had been steadyfor 10 to 12 minutes before the collision.

The second officer was on watch on thedredger. He was aware that the fishing vessel was approaching on a collisioncourse. Experience had taught him toexpect fishing vessels to leave it until thelast minute before altering course. Hecontinued to monitor the situation, butdid nothing at that stage to attract theattention of the fishing vesselswatchkeeper.

The fishing vessels skipper was on watch.He had seen the dredger, but did not thinkthat there was a risk of collision.

In the event, the dredger did not alter tostarboard to avoid the collision until abouta minute before the collision, when thefishing vessel was at a range of a quarterof a mile or less. At about the same time,her skipper put her engine full astern.These actions proved too little, too late.

The Lessons

Anyone reading this brief narrative willbe asking what new lessons can possiblybe learned in this oldest of all situations.Two vessels are approaching one anotherin such a way that the risk of collisionexists. The one thinks he knows that theother will delay giving way until the lastminute, while the other doesnt think arisk of collision exists. Ancient marinersthe world over will be thinking Here wego again. Most will instinctively say theywould never, ever, leave things so late.These lessons are not, therefore, for thembut for that watchkeeper in a million whomight, just might, get it wrong. Theproblem is that it keeps happening, soperhaps we should never stop learning.

1. If a risk of collision exists, and you arethe officer of the watch in the standonvessel, never assume that the give- way vessel has seen you. Until sheshows, by positive action, that she hasthe situation under control, it is safer toassume she has not.

2. Rule 17 permits the stand-on vessel toact as soon as it becomes apparent toher that the vessel required to keep outof the way is not taking appropriateaction in compliance with these rules.In this case it was apparent, when therange between the two vessels wasabout 1 mile, that the fishing vesselwas not taking early and substantialaction to keep well clear as she wasobliged to do under Rule 16. At thistime the dredger should have used hersignalling light and whistle to alert thefishing vessel. If this did not promptimmediate action from her, the dredgershould have made a broad alteration tostarboard to avoid the collision. Shewas permitted to do this under Rule 17a (ii) and, it could be argued, requiredto do it under Rule 2.

3. If the fishing vessels skipper reallythought there was no risk of collision,he was demonstrably wrong. It doesntmatter who you are, or in what type ofvessel, the person in charge has

afundamental responsibility todetermine whether a risk of collisionexists and do something about it whenit does. Radar, the compass,commonsense, seamans eye, andknowledge of the Rules are the toolsavailable to achieve this. The oldestguidance of all is still the best. If thecompass bearing of the approachingvessel does not appreciably change,then risk of collision exists.

Footnote

This incident was the subject of a fullMAIB investigation. A comprehensivereport, giving details of the causes, ananalysis, and recommendations waspublished in April 2002.

CASE 13
Ideas for Tackling Flooding

Narrative

A 21.9m wooden vessel fishing vessel washeading north-north-east from her homeport to pair trawl with her partner. The windwas south, force 4 and the visibility wasmoderate to good. A crew of six was onboard.

While on passage, the main enginetemperature was seen to be rising. Aninvestigation revealed the problem to be ablocked sea water inlet. The mate closed theseacock as best he could before taking thecover plate off the adjacent strum box. Onlooking inside, he saw a black plastic bagjammed in the valve. He opened it andpulled the bag out but, no sooner had he done so, when water started to pourthrough. The mate did his best to shut theseacock, but the linkage came off. Despitefrantic efforts to contain the flooding, allattempts failed. Bilge pumps were used topump out the floodwater, but couldnt keeppace. The hand pump was hardly effective.

The only power-driven bilge pump used, wasthe one fitted to the auxiliary engine. Asecond one, driven by the main engine, wasavailable but not used. The main engine drewits cooling water from the open seacock, andboth skipper and mate assumed they couldnot start the main engine because there wasno cooling available. There was a pipe from the bilge system capable of feeding seawater direct to the main engine for cooling.The mate was aware of this but, because hehad never used it before, thought it shouldnot be used as it would damage the engine.The nature of the emergency left little scopefor lateral thinking.

A coastguard helicopter flew out to thevessel with two portable salvage pumps, butbefore these could be put into action, theposition on board deteriorated to the extentthat the decision to abandon ship was taken.The crew evacuated to the partner trawler,leaving the flooding vessel to sink aboutthree hours later.

The Lessons

An incident like this demonstrates thatflooding can occur at any time, in any placeand is no respecter of a vessels age. Thelessons focus on two aspects: preventing theflooding in the first place, and containing itto prevent the vessel sinking.

It is also sobering to think that the origin ofthis loss was a plastic bag.

1. Opening up a seacock when afloat is notadvisable. Unless there is some way ofisolating an inlet safely at sea, remedialwork should only be attempted inharbour. Apart from the obvious solutionof slipping the vessel to ensure there is noway for flooding to take place, it ispossible to open up a seacock by berthingin a tidal harbour and waiting for the tideto go out. Once it is safe to do so, theseacock can be opened up and theblockage cleared. Should there then be aproblem restoring the system to normal,there should be sufficient time to dealwith the situation.

2. The US coast guard trains repair teams sothat ships can be kept operational afterlimited damage. A large softwood wedgeis driven into an open pipe. Those doingso will confront an even greater quantityof spurting water initially, but smallersoftwood wedges are then driven inbetween the main wedge and the pipeuntil the flow is choked off. The tops ofthe wedges are trimmed with a saw,before a wood shore is placed between the tops of the wedges and the nearestpart of the ships

structure. The US coastguard encourages fishing vessel skippersto carry softwood wedges and shores forthis purpose. Why not do the same?

3. In extremes, it might just be possible tocontain the flooding by resorting to thetraditional option of fitting an emergencytingle. By lowering a weighted canvas orplastic sheet over the side in the vicinityof the inlet, it is possible it will cover thehole and substantially reduce the rate offlooding. This in turn might provideadditional time for other actions to bemore effective. It might sound farfetched,but in days gone by was triedwith conspicuous success.

4. The main engine could have been startedonce the flooding had developed. Thecooling water was available and plenty ofit; the floodwater inside the vessel. Thiswould have helped to pump the vesselout since the cooling water wasdischarged overboard once it had beencycled through the heat exchanger.Starting the main engine would also havemeant that the second bilge pump couldbe used.

5. The sea water pipe from the bilge systemcould also have been used for mainengine cooling. Seawater fed directly toan engine, rather than through a heatexchanger, can cause damage by blockingpassages with salt deposits. However, in situations such as this, the risk of anyproblems is minimal. In an emergency, itis a perfectly acceptable step to take.

6. Had a portable salvage pump beencarried on board, it could have helpedsave the fishing vessel. Consider it.

Footnote

The MAIB receives a number of reports offlooding incidents to fishing vessels. Thereasons are not always identified, but whatdoes become evident, is how often it seemsthat more could have been done to preventthe vessel from sinking had damage controlactions been better handled. The instinctivereaction is, invariably, to request additionalpumps. This is right and proper, but far moreneeds to be done to contain, or even stop,the flooding using alternative means.

This article is largely directed at stimulatingdiscussion on how this might be achieved.One final thought. Next time you allow inadvertently of course a plastic bagto drop overboard in harbour, dont. It couldbe the one to jam someones seacock.The really sobering thought is it mightbe yours!

This incident was the subject of a full MAIBinvestigation. A comprehensive report,giving details of the causes, an analysis,and recommendations was published inJune 2002.

CASE 14
Engine Room Flooding causes Another Fishing Vessel Loss

Narrative

A 23.99m twin-rig steel trawler wasfishing off the Yorkshire coast when hernets became fast on the seabed.

While trying to haul back the starboardnet, a hydraulic pipe, from the winch tothe hydraulic motor burst. All three crewthen spent the next several hours on deckreplacing the burst section of pipe.

While they were on deck, the vesselsuffered substantial flooding to theengine room. The flooding was notdiscovered until one of the crewmen went down the engine room for a sectionof hydraulic hose. Because thewheelhouse was left unattended, the bilgealarm went unnoticed.

By the time the flooding was discovered,the level of floodwater was well above theengine room floor plates. With the engineroom in virtual darkness, because of thefailure of the 24V electrical system, it wasnot possible to locate and open the valvechest to operate the engine-driven bilgepumps.

After unsuccessful attempts were made toregain power to the 24V electrical system,and to transmit a Mayday, the crewabandoned the vessel in the liferaft. Thevessel capsized soon after.

Shortly after boarding the liferaft, thecrew managed to activate the EPIRB,which they had taken with them. Threehours later they were rescued by acoastguard helicopter.

The Lessons

1. The investigation of this accidentrevealed that the vessels loss was one,or a combination of, the followingfactors:

- a breach in the hull plating,
- failure of a non-return valve in anoverboard discharge resulting in backflooding, or
- engine room seawater piping failurecaused by erosion or corrosion.

2. The condition of the hull plating shouldbe checked on a regular basis, inaddition to the 4-yearly ultrasonictesting required under survey. This isespecially important if the vessel hassuffered any kind of impact damage,no matter how slight.

3. Non-return valves should also bechecked regularly, to ensure they arefunctioning correctly.

4. The failure of engine room seawaterpiping is a common occurrence onfishing vessels, and has accounted formany flooding incidents. This has, insome cases, led to the actual loss of thevessel. In light of this, it is wise to carryout simple regular checks on allpipework, especially in the engine roomand in places which may at first appear to be inaccessible. A simple check forsigns of corrosion or weepingpipework, culminating in the repair orreplacement of the piping, may wellprevent the vessel from being lost.

5. While at sea, the wheelhouse shouldnever be left unattended. Had it beenmanned, the bilge alarm would havebeen heard, and would have given thecrew sufficient time to deal with theproblem and

contain the flooding. Inall probability, it would have beenpossible to prevent the vessel fromfoundering.

The ingredients of this incident are notuntypical. There have been a number ofrecent founderings in which thecircumstances have been very similar.There is a late discovery of flooding, andthe crew have insufficient time to containit. The vessel then fills with water andsinks. The saving grace in many of themore recent incidents is that the crew hasusually been rescued, thanks to the skilland dedication of the search and rescueorganisations.

Yet the fact remains that in all probability,the loss was caused by a relatively smallhole, perhaps measuring no more than 5to 10cm across, through which theflooding was taking place. If it is possibleto stop the water coming in at the pointwhere the pipe penetrates the hull, it isvery likely the vessel, and perhaps its crew,can be saved. The fact remains, that withforethought and the sharing ofexperiences, it is possible to reduce or evenstop the flooding by a number of ways,providing you know how to do it.

By adopting the oldest technique in thebook, lowering a weighted canvas sheetover the position of the engine room inletson the affected side, the rate of floodingcan be substantially reduced.

Footnote

This incident was the subject of a fullMAIB investigation. A comprehensivereport, giving details of the causes, ananalysis, and recommendations waspublished in November 2001.

CASE 15
Fisherman Saved by Lifejacket

Narrative

A 4.95m GRP vessel was being used forcreeling off the coast of Northern Irelandon an April afternoon. The wind was fromthe south-west force 4, the sea and swellwere slight, and the visibility was good.She was being operated single-handedly.

While hauling creels about half a mileoffshore, the skipper heard a thump andrealised that a rope was caught aroundthe vessels propeller. He attempted to cutthe rope free and, in the process, noticedfloodwater coming up through thefloorboards.

Alarmed at how quickly his vessel wastaking on water, the skipper pulled therelease toggle to inflate his lifejacket. Lessthan five minutes later the vesseldisappeared beneath the surface. Theskipper had had no time to call for help orfire distress flares. Buoyed by his lifejacket,he slowly drifted inshore and, about anhour later, was able to stagger ashore. Hewalked home, took a hot bath and thennotified the coastguard of his experience.

The vessel was subsequently recovered.When examined, it became apparent thatthe rope had wrenched the propeller away,along with a section of the hull.

The Lessons

1. This skipper had a very lucky escapeindeed, especially given that the sea isextremely cold in April, and there can beno doubt that the lifejacket saved hislife. The MAIB has consistently advisedfishermen to wear inflatable lifejacketswhen working, and this case illustratesvery well that by doing so, you willgreatly increase your chances of survival.

An EN 396 inflatable lifejacket can costas little as £60, a worthwhile investment.One of this type satisfies the regulatoryrequirement for vessels of less than 12min length (an inherently buoyantlifejacket is not required if a selfinflatinglifejacket is carried).

2. The risks multiply when sailing alone, soit is particularly important to wear aself-inflatable lifejacket when doing so.This skipper owes his life to the fact thathe took this most basic of safetyprecautions.

3. The skipper should have paid a little moreattention to communication. Had thedrift been offshore, the outcome mighthave been very different. Mobile phonesare not ideal; they arent waterproof anda signal isnt always available offshore.Lone fishermen should always carry awaterproof portable VHF radio, the costof which is about £300. Although thismay seem a little pricey, few wouldargue that if it saves your life, it ismoney very well spent.

CASE 16
See No Vessel, Hear No Vessel!

Narrative

A potter of 10m registered length washauling a fleet of pots in thick fog. Shewas exhibiting navigation lights and wasdisplaying an appropriate shape forward.The skipper and his crew were all involvedin the operation on deck and thewheelhouse was left unattended. A radarwas operating on a 0.5 mile range scale.

A 1,441gt cargo vessel was steaming atabout 7 knots. The chief officer was onwatch with operational radar and, she,too was exhibiting navigation lights.

The fishing vessels skipper first becameaware of the cargo vessel when he heardher wash in the fog; he then saw heremerge from the fog and approach his port side. He entered the wheelhouseimmediately and applied full asternpropulsion, while his crew quickly threwthe fleet of pots overboard.

The cargo vessel passed close ahead of thefishing vessel and has no record of theincident.

The Lessons

1. Neither vessel was aware of the otherin sufficient time to prevent a closequarters situation. In the prevailingfog, the cargo vessels chief officer wasreliant on radar and sound to detectthe fishing vessel, and the fishingvessels skipper was reliant only onsound, since he had chosen to leavethe wheelhouse unattended. It isuncertain whether or not the cargovessel sounded her whistle. What isknown, however, is that the crew ofthe fishing vessel did not hear one. Inview of her length, the fishing vesselwas not required to be fitted with awhistle. She carried a bell, but didntuse it.

In the absence of radar detection,effective sound signals are essential ifclose quarters situations are to beavoided.

2. Both vessels had operational radar, buteach failed to detect the other. Thefishing vessel was placing muchreliance on the larger vessel detectingher by radar and taking theappropriate avoiding action. She didnot. In fact, she didnt even see thesmaller fishing vessel on her radar, andwas totally unaware of the entire near miss situation. If you are fishing indense fog, be aware that you may notbe seen.

It is uncertain why the cargo vesselschief officer did not observe the fishingvessel on radar, or sight her visually atclose range. Possible reasons include asub-standard lookout, and poor radarreturn caused by the fishing vesselsfibreglass construction and a possiblyineffective radar reflector.

The fishing vessels skipper has sincefitted a larger radar reflector to hisvessel, which will assist in his vesselbeing detected in the future. He willalso remember not to leave hiswheelhouse unattended, since by doingso he is removing his ability to detectapproaching vessels by radar.

3. Many seafarers will relate to thisincident, which underlines the need fora proper lookout to be kept at all times,to maintain a full appraisal of thesituation, and to enable action to betaken at an early stage. In this case,although late, the prompt emergencyaction taken by the skipper and hiscrew was effective in preventing adisaster.

CASE 17
Things that go Bump in the Night

Narrative

A wooden stern trawler landed her catchin Mallaig, then sailed in the early hoursof the next day to return to fishinggrounds to the south. The prawn fishingwas good and, accordingly, the workloadhigh. The watch alarm was not workingand had been landed ashore for repair,and the vessel was sailing one man shortof her normal complement.

The deckhand, who was alone on watch,noted another, slower outbound vessel onthe port side. Two other vessels wereinbound, and they passed by safely. Thedeckhand was feeling tired, havingmanaged only 5 hours sleep in theprevious 24 hours, and having had nosleep for 17 hours. This was in addition tohis having worked the previous 4 dayswith a similar disrupted sleep pattern. Hesat down in the wheelhouse chair.

The deckhand had known he would betaking the first watch after departureMallaig, but had, nonetheless, opted tojoin his colleagues for an evening at a barashore, rather than taking theopportunity of a well earned rest.

While ashore, he drank a moderate twopints of beer. However, given his lack ofsleep and increased workload, the alcoholprobably had a greater adverse effectthan he realised.

At around 0230, the waypoint for the nextalteration of course was reached. Owingto the close proximity of the other vesselbeing overtaken on the port side, thedeckhand altered course to port onlyabout 10°. He intended altering the fullamount once the other vessel had beenpassed safely. The other deckhand was dueto be called about 10 minutes later for hiswatch. Shortly after making the alteration,the deckhand fell asleep.

At 0320 he was awoken suddenly by aseries of bumps and bangs. The vessel hadgrounded.

The vessel was refloated at high waterlater that day, with the assistance ofMallaig lifeboat. She had sustainedsuperficial hull damage, and waterdamage to the accommodation andengine room. There were no injuries orpollution as a result of the grounding.

The vessel was later repaired andre-entered service.

The Lessons

1. The workload was high on this trip,owing to the good fishing and the factthat the vessel sailed a man short ofher normal complement. This resultedin the skipper deciding to have onlyone man on watch, instead of thenormal two. Having another person inthe wheelhouse would have not onlyprovided a second pair of eyes, but itwould also have given the deckhandcompany and kept him more alert.

2. The deckhand had chosen to go ashorein Mallaig, rather than opting to getsome much needed rest. While ashore,he had a few drinks and, later, had satdown in a comfortable chair while onwatch and feeling very tired. Thiscombination of circumstances resultedin him falling asleep and failing tomake the required alteration of course.The result, a very rude awakening.

The effects of drinking alcohol canoccur more quickly when tired, and bemore pronounced, than expected. Avoidalcohol if you are tired, and if tired dont take the watch!

3. Had the watch alarm been working, it isprobable the deckhand would haveawoken before the vessel grounded. Ithad been sent ashore previously andhad not been returned to the vessel. Thewatch alarm is a fundamental piece ofsafety equipment, especially on a vesselwith a high workload, and one that issailing short-handed.

CASE 18
A Wooden Vessel Floods and then Sinks

Narrative

A 23.99m wooden fishing vessel, built in1982, was trawling about 75 miles fromher home port. The wind was from thenorth-north-east, force 5 and visibility wasmoderate to good. A crew of four wason board.

At about midday, the port net becamesnagged on a seabed obstruction. The crewspent the next few hours trying to haul thenet, sometime during which the vesselstarted to flood. Damage caused by acontact between the port trawl door andthe hull is considered to be the most likelysource of the ingress, although floodingvia the pipework cannot be ruled out.

The two main bilge pumps wereelectrically-driven and both were disabledwhen the floodwater reached thetransformer box. Both pumps receivedelectricity from the same source, which meant that if one was disabled, both pumpswere lost. They should have beenindependently-driven, but they were not.

Although the flooding filled the engineroom, the bilge alarm didnt alert the crewbecause the audible signal was not workingat the time. By the time the floodwater wasdiscovered, it was too deep for its source tobe identified.

The crew were unable to contain theflooding, so were forced to abandon thevessel. The batteries for the fixed VHF radiowere disabled by the floodwater, so theportable VHF radio was used forcommunication in the latter stage of therescue. Help arrived in the form of a fastrescue craft from an oil-rig guard ship, justseconds before the vessel sank by the stern.All crew were rescued, unhurt.

The Lessons

1. Defective bilge alarms have been a factorin the loss of many fishing vessels. TheMAIB, and others concerned with marinesafety, have repeatedly emphasised theimportance of a correctly functioningbilge alarm. Ensure that yours is workingbefore sailing, since without it, you andyour crews lives are at risk. Consider thetime it would take to repair one which isdefective often minutes the time ittook for this vessel to sink.

2. The electrical supply for bilge pumpsshould be independently-driven. This willensure that if the supply to one pump islost, the other will continue functioning.

3. This article clearly demonstrates the valueof the portable VHF radio. Had theskipper of this vessel lost communicationwith the guard ship, the rescue mighthave been delayed, leaving the crew onboard when the vessel sank.

CASE 19
Look After Your Tonnage Valves

Narrative

A 15.24m-long steel fishing vessel was twintrawling near an offshore platform in theNorth Sea at midday. The wind was force 5,the sea moderate with a 2m swell andvisibility was 8 miles. An experienced crew offive was on board. The fishing operation wasto be the vessels last before she returned toher home port.

When the trawl was hauled, it became clearthere was a good catch in the nets; enough tofill the hopper up to the shelter deckhead. Thefull hopper caused an angle of list of about 9degrees to starboard. While gutting the catch,the crew became alarmed at the sight offloodwater starting to build up inside theshelter. This floodwater caused the vessel toslowly capsize to starboard. She sank in 140mdeepwater and has not been recovered.

All crew members were rescued by the fastrescue craft from a nearby stand-by vessel.

A tonnage valve had been fitted either sideof the vessels shelter, to discharge deckwater. These were freeing ports fitted with aflap, which should have allowed water toflow out, but not in. It is possible the tonnagevalve on the starboard side became jammedopen, perhaps by a piece of fish offal. Thiswould have allowed the vessels shelter toflood if her stability had been sufficientlydegraded by the weight of the fish in thehopper, high up on the starboard side.

The deckwash supplied seawater to theshelter so that the fish could be washedbefore they were stowed in the hold. Had thetonnage valve been blocked, or seized closed,it would have taken about 30 minutes forsufficient seawater to build up to capsize thevessel, if the deckwash was on. Given eitherof these scenarios, the tonnage valve on thestarboard side malfunctioned, somethingsurveyors find all too frequently.

The Lessons

1. If your fishing vessel is fitted withtonnage valves, inspect them regularly preferably between each trip andremember to keep the spindlelubricated so that the flap moves freely.

2. When fish are being gutted, thetonnage valves should be checkedregularly to ensure they have notbecome blocked by fish offal; this isespecially important when thedeckwash is running. If water starts tobuild up in the shelter, check thedeckwash immediately to ensure that itis turned off.

3. Tonnage valves should be screwed shut,unless the deckwash is on. Never wedgethem open.

CASE 20
Skippers Last-Minute Action Saves Lives

Narrative

An 18m-long stern trawler was trawlingin the St Georges Channel in associationwith four other fishing vessels when shenoticed a container vessel approachingfrom astern. The 116m-long containervessel was on passage between Liverpooland Portugal. It was a warm summerevening, with a light breeze and excellentvisibility.

The trawler was towing a bottom trawl atabout 1.5 knots on a heading of 220°. Herskipper had first noticed the containervessel on radar at a range of about 2miles. He had monitored the approach ofthe other vessel on a collision course untilthe range between them had reduced to0.5 mile.

The container vessel was making a speedof about 15 knots on a course of about190°. The master had been alone on herbridge and had been aware of his vesselsapproach to a number of fishing vessels.The containers on deck hampered his closerange visibility from the wheelhouse. Ashe had neared the other vessels he alteredcourse to avoid them, but found that closepassing was inevitable.

The trawlers skipper considered the othervessel was not going to alter coursesufficiently, and that his vessel was at risk.He therefore immediately instructed hiscrew to come out from the cabin to thecomparative safety of the deck. Theskipper released the fishing gear and, atthe same time, put the helm hard tostarboard.

The container vessel passed about 6mclear on the trawlers port side.

The Lessons

1. We are all taught to drive a motorvehicle defensively, and to beprepared for the unexpected. Fishingvessel skippers are also advised to heedthis sound advice. Consider thepossibility that give-way vessels justmight not have seen you, or thatperhaps they have been hampered byother vessels or for a myriad of otherreasons. Prepare a contingency plan,just in case the other vessel doesnttake appropriate anti-collision action.

2. This skipper did well, and saved the day.He is particularly commended forcalling his crew out on deck. Herealised the situation was potentiallydangerous, and he addressed the issueimmediately. Failing to take such actionunder similar circumstances hasresulted in many fishermen beingtrapped on board their vessels, andlosing their lives as a consequence.

3. The container vessels master had beenaware of his vessels approach to anumber of fishing vessels. He was alsoaware that the cargo on deck posedlimitations to his visibility. Given theseconditions, he should have taken earlyaction to keep well clear of the groupof fishing vessels, or slowed his vesseland navigated with extreme cautionuntil clear of them.

CASE 21
No Redundancy!

Narrative

A fishing vessel was leaving port. It wasdark and the weather was calm. The skipperwas alone in the wheelhouse. Once clear ofimmediate dangers, he engaged theautopilot, forgetting that it had anunresolved fault, and then studied hisfishing charts. The vessel deviated from theintended track and grounded.

The Lessons

1. The departure followed a regular routine.The skipper was alone in thewheelhouse, while his crew cleared awaythe ropes and fenders on deck. It was tobe a normal days fishing.

Having operated satisfactorily for 14years, the autopilot had developed afault prior to arriving at the port, andalthough the skipper had attempted tohave it repaired, the fault remainedunresolved. He was aware of the wisdomof checking the autopilot against thecompass heading, but apparently failedto do so on this occasion. With noobvious indication to remind him thatthe autopilot was not working, heengaged it with misplaced confidence,based on its 14 years of good service.

Apart from monitoring the compass, theskipper had no means fitted to alert himto the fact that the vessel was deviatingfrom the intended heading. Relevantand necessary check procedures shouldbe followed at all times to guard againstcomplacency.

2. In deciding to look at his fishing charts,the skipper was unable to rely on anyoneelse to maintain a proper lookout. Asecond person on watch would haveenabled the autopilot malfunction to beidentified, and remedial action to betaken. With no redundancy, the skipperwas reliant on the correct operation ofthe navigational equipment and hisability to maintain a proper lookout. Ameasure of built-in redundancy isrequired in any navigational operationso as to ensure that an error by oneperson, or the failure of a single item ofequipment, does not result in anirreversible dangerous situation.

CASE 22
Collision Between Fishing Vessel and aGeneral Cargo Ship

Narrative

In clear visibility, slight seas and force 4 to5 winds, a small fishing vessel began tohaul her nets while heading into awesterly wind. She had been on the samewesterly heading for about 3 hours. Beforehauling, the skipper had seen a merchantvessel on the port side, heading in anortherly direction.

When the trawling gear reached the seasurface, the crew found it to be fouledwith a large piece of timber. The skipper,therefore, kept the vessel making waythrough the water to avoid the trawlfouling the propeller, and the timbercausing damage to the vessel.

The skipper decided to help the crew and,before leaving the wheelhouse,anticipated there would be no problem inthe ship avoiding his vessel. However,while busy retrieving the gear, the skipperheard one blast from the cargo shipswhistle. The two vessels collided.

The cargo ship was on a heading of 304°and travelling at a speed of 8 knots. UsingVHF radio, the chief officer had tried invain to call the fishing vessel on his starboard bow. He then called the masterwho, on reaching the bridge, saw that thefishing vessel was on a collision course.The master reduced the ships speed andturned the helm hard to port. He thensounded the whistle, but his action failedto prevent a collision.

The fishing vessel ran along the starboardside of the cargo ship, before clearing. Theskippers first response was to call the shipon VHF radio channel 16, but he receivedno reply. He then noticed water runningacross the accommodation deck, so wentbelow to check for leaks. Water waspresent, so he moved the batteries to ahigher position.

The fishing vessel was able to reach portsafely.

The Lessons

1. The skipper thought the ship didntpose a problem, based partly on hisknowledge that it was approachingfrom his port side, and partly becausehe was fishing with the appropriatesignals displayed. An assumption thatany vessel, whether fishing ormerchant, will meet her obligation tokeep out of the way when there is riskof collision, is a dangerous one tomake. Many have made thisassumption and, when avoiding actionhas eventually been taken, it has beentoo late. Some collisions in similarcircumstances have resulted in loss oflife, sometimes considerably so. Theneed to keep a proper lookout so as tomaintain a full appraisal of thesituation is paramount.

2. The obligation of the chief officer wasclear under the InternationalRegulations for Preventing Collisions atSea. He had to keep out of the way ofthe fishing vessel, which was engagedin fishing. We dont know why the chiefofficer wasted time trying to contactthe fishing vessel by VHF radio, whythere was apparent doubt as to hisobligations, and why he felt it necessaryto call the master, whose subsequentactions were too late to prevent acollision.

CASE 23
Fishing Vessel Capsizes with Loss of Life

Narrative

A 10m-long stern trawler left port in thesouth coast of England, with three crewmembers on board. She headed forpopular grounds off Gilkicker Point,unfamiliar to her skipper and crew. Theweather was fine with a west-northwesterlywind of force 4 and goodvisibility.

During the first trawl of the day shepicked up part of a WW2 torpedo, as wellas a quantity of mud and shells. Theskipper was aware that a heavy load hadbeen caught, so he and the crew decidedto try and recover it so that they couldthen decide how to deal with thesituation. They managed to raise the netto the surface fairly easily, but when they tried to lift the cod end clear of the water,the weight was too much for the trawlwinch. As the winch struggled to lift thecod end by the gilson rope led through ablock on the A frame, at a height abovethe deck of about 4.8m, the vessel took anincreasing list to starboard. The loadsnagged on the starboard quarter and,with the winchs relief valve blowing, itcould neither be pulled inboard, norlowered back into the water.

The situation seemed to stabilise with thevessel listed to starboard, and with freeingports on the aft starboard sideunderwater. As the crew member cut thenet to release the unwanted load, thevessel encountered the wash from apassing vessel. She rolled, took water overthe starboard bulwark and capsizedrapidly. Within minutes, she inverted andfoundered.

The crew of a nearby yacht witnessed theevent. They rescued the skipper and his sonquickly from the water and raised thealarm. Other rescue craft were soon onscene. The crew member who, with theskipper, co-owned the vessel, wasdiscovered floating face-down in thewater. He was airlifted to hospital but,despite continuous attempts to resuscitatehim, was eventually pronounced dead. Hewas believed to have been a non-swimmerand had not been wearing a lifejacket.

The Lessons

1. It is essential that skippers have a goodbasic understanding of ship stability sothat they can make informed decisionswhen extraordinary events occur.

2. Once again, we are reminded of theneed for fishermen to heed the advicethe MAIB so frequently issues: alwayswear a lifejacket when working on theopen deck even in seemingly benignweather and sea conditions.

Accidents are rarely caused by a singleevent. All too often, several factorscombine and tragedy strikes; leaving abereaved relative grieving and leaving avessel without a valued crew member. Thiscase was no exception. The removal of anyone of the following four situations mighthave averted the accident:

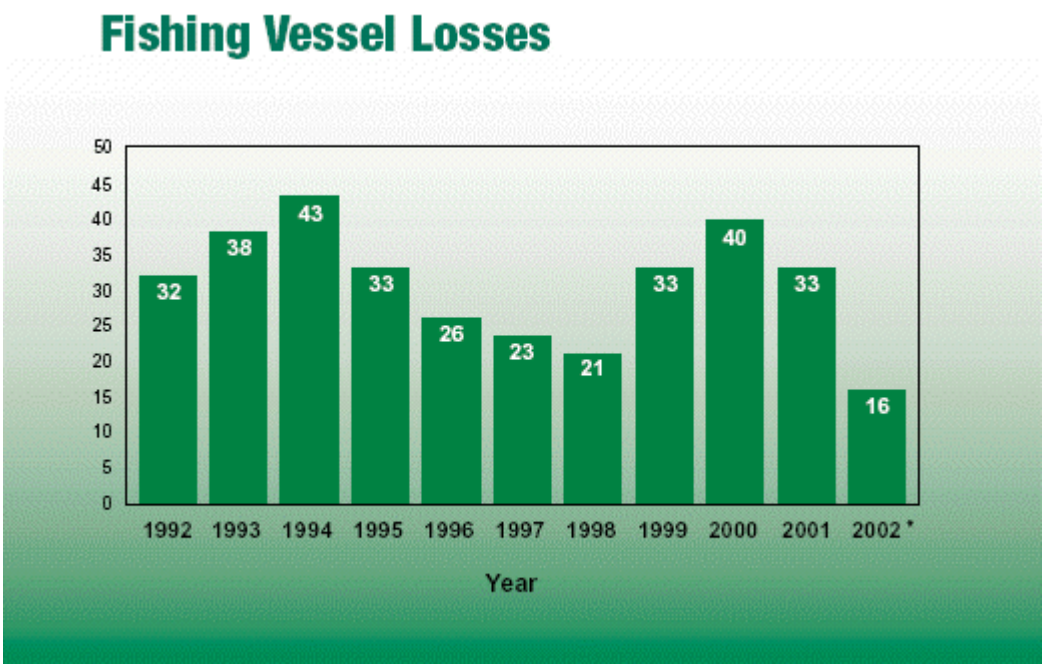
- Picking up part of a WW2 torpedowhile fishing. The area off GilkickerPoint is known to contain a substantialamount of ordnance. Anyone fishingthere should be aware of this hazardand should make contingency plans inthe event they are unlucky enough tocatch more than they bargained for.

- The decision to try and lift the load ondeck using a lifting point 4.8m abovethe deck. This action raised the vesselscentre of gravity and resulted in thecapsize. Having raised the load to thesurface, and having realised that it wasvery heavy, the skipper and crew shouldhave decided on the safer option ofreleasing the net and buoying it forrecovery by a specialist

craft.Alternatively, they could have draggedthe load into shallow water forinspection at low tide.

- The snagging of the load on the fishingvessels quarter. This left the crewunable to lower the net into the waterto reduce the list and increase thestability. The MAIB is unsure exactlyhow the net became caught.
- Finally, encountering the wash from apassing vessel. This area is close to themain routes used by many ferries, highspeedcraft and merchant vessels. It is,therefore, not unusual for a vessel toencounter wash from a passing craft.

Statistics



* Figures for 2002 are provisional at time of publication. (March 2003)

Fishing Vessel Accident Statistics 1990 2002

YEAR	LOSS OF LIFE					PERSONAL ACCIDENTS	VESSELS LOST
	Lost with	Fell	Involved	Onboard			

	vessel	overboard	Machinery	Accidents	Total		
1990	22	4	4	0	30	128	17
1991	25	5	0	2	32	165	41
1992	7	4	3	2	16	133	32
1993	9	7	0	2	18	115	38
1994	16	5	0	5	26	155	43
1995	10	8	1	0	19	108	33
1996	9	4	1	6	20	97	26
1997	16	7	0	6	29	138	23
1998	18	5	0	3	26	112	21
1999	3	4	0	2	9	89	33
2000	21	6	2	3	32	104	40
2001	0	6	0	3	9	81	33
2002*	4	4	0	0	8	50	16
TOTAL	**160**	**69**	**11**	**34**	**274**	**1475**	**396**

* Figures for 2002 are provisional at time of publication. (March 2003)

CHART

Major Accident Locations

PUBLISHED REPORTS

List of fishing vessel accident reports published since 1999

Alma C - report on death of Michael John Beedie a fishermanfrom the fv Alma C on Turbot Bank about 55 miles west-bysouthof Thyboron in Denmark on 25 January 2001

Amber Rose - foundering of fishing vessel with loss of onelife off the Isle of Man on 15 October 1998

Angela - capsize and foundering of fv in North Sea on 6February 2000

Annandale - flooding and foundering of fv 16 miles NNE ofthe Shetland Islands on 23 March 2000

Arco Arun - grounding, off Broadness Point, River Thames on13 October 1998

Arosa - grounding and total loss of UK fv on Doonguddlerock off the west coast of Ireland with the loss of 12 crewmembers 3 October 2000

Astra II - loss of two crewmen attempting to board the vesselwhile berthed at Carbost pier, Loch Harport, Isle of Skye on 2April 2000

Atlantic Princess - man overboard incident from vessel in theEnglish Channel on 23 November 2000

Aurelia - flooding and loss of fv Aurelia 78 miles west of StKilda 13 August 2001

Be Ready - fire on board the fishing vessel while fishing 30miles north-west of the Orkney Islands on 22 January 2000

Betty James - grounding and subsequent loss of fv off Isle ofRhum on 10 July 2000

fv Beverley Ann II - collision between vessels on 9 March1999 Cypress Pass

Blue Hooker - loss of the fishing vessel with two lives offBlackchurch Rock, North Devon on 12 November 1998

Catrina - capsize of the UK registered fishing vessel south ofNewhaven on 13 October 1998

Celtic King/De Bounty - collision between UK registeredfeeder container ship Celtic King and Belgian registered fv DeBounty vessels to the south of The Smalls traffic separationscheme off the south-west coast of Wales on 19 March 2000

Charisma - capsize of the fishing vessel Charisma (OB588)with the loss of one crew member Carlingford Lough 30January 2002

Christine Nielsen - flooding and foundering of fishing vessel120 miles north-east of River Tyne on 18 March 2001

Constancy - sinking of fishing vessel on 30 July 1998 withloss of one life

Constant Faith - loss of Constant Faith about 100 milesnorth-north-east of Peterhead on 30 June 2001

Crimond II - loss of vessel 30 miles north-east ofScarborough on 24 April 2001

De Kaper - fire on board trawler off Hanstholm, Denmark on12 February 1999

Donna M - capsize of fishing vessel off the Orkney Islandswith loss of two lives on 31 August 1999

Dunan Star - fatal accident on board fv 1.5 miles south-west ofthe Isle of Arran on 10 August 2000

mv Elm/mfv Suzanne - near miss incident on 11 February 1999

European Tideway and Vrouw Grietje - collision between vesselsin North Sea 16 October 2000

Fishing Vessel Safety Study 1/2002 - report on the analysis offishing vessel accident data 1992 to 2000

Fleur de Lys - explosion on board vessel which then foundered 18miles south-east of Portland Bill on 16 April 2000

Fraoch Ban - capsize of fv off coast of Shetland Islands 15 August1999

Geeske - death of one person while fishing off Beachy Head on 9December 1998

Gemma Fidelis - fatal accident on board Gemma Fidelis 9 mileseast of the River Tees on 23 October 2001

Girl Alice - loss of skipper from vessel 1.5 miles south-east ofBurnmouth 19 November 2000

Gradeley - manoverboard fatality off the west coast of the Islandof Mull on 28 October 1999

Gudermes and Saint Jacques II - collision between vessels in theDover Strait on 23 April 2001

Harbour Lights - loss of fv off Polperro, Cornwall on 8 January2000 with loss of one life

Horizonte Claro - grounding of fv vessel on Soyea Island, LochInver, 21 October 2000

Jasper III - foundering of vessel 90 miles north-east of Fraserburghon 10 September 1999

Lomur - grounding of Lomur in the approaches to Scalloway,Shetland Islands 14 June 2001

Lord Trenchard - explosion on board vessel in Poole Harbour on 30June 1999

Luc and Toisa Puffin - collision between the two vessels 8.5 milesdue east of the river Tyne on 13 June 1999

Lysfoss - grounding of Lysfoss in Sound of Mull, Scotland 7 May2001

Mariama K - carbon monoxide poisoning on vessel in Douarnenez,France 10 June 2000 - one fatality

Mathilda and Lady Hamilton of Helford - near miss incidentbetween Mathilda and Lady Hamilton of Helford, 7 miles eastsouth-east of Lizard Point, Cornwall on 28 June 2001

Opportune - man overboard fatality from mfv Opportune 35 mileseast of Wick on 23 February 2000

Osprey - fatal accident to a man overboard from the fishing vesselOsprey in Lochinver Harbour on 20 April 2002

Our Nicholas - grounding and loss of the crabber Our Nicholasnear the entrance to Stornoway Harbour on 24 July 2001

Our Sarah Jayne/Thelisis - collision between vessels in the ThamesEstuary 20 June 2001

Pescalanza - sinking of the fishing vessel with the loss of sixlives on 2 November 1998

Philomena - fatal accident on board vessel in the Moray Firthon 6 March 2001

Primrose - grounding of Primrose on the Island of Rhum on 15June 2001

Purbeck II - injury of crew member on board on 7 June 1999

Purdy - man overboard fatality from angling boat at ShipwashBank off Harwich, on 17July 1999

Rachel Harvey - grounding and loss of fishing vessel offPeninnis Head on 1 October 1999

Radiant - capsize and foundering of Radiant PD298 about 45miles north-west of the Isle of Lewis with the loss of one life on10 April 2002

Radiant Star III - foundering of fishing vessel 60 miles northeastof Fraserburgh on 6 August 1999

Random Harvest - flooding of fv south-west of Brighton on 3July 1999

Rebecca Kay - loss of fishing vessel Rebecca Kay on 20 April2001 off Bideford Bar Buoy

Resplendent - grounding of Resplendent in Bluemull SoundShetland Islands 13 June 2001

Ross Alcedo - fire on board vessel while underway about 32miles north-west of the Isles of Scilly on 16 January 2000

Sally Jane - capsize alongside in Shoreham Harbour on 27 July1998

mv Sand Heron and fv Celtit - collision between vessels NETraffic Lane, Dover TSS on 30 July 2001

Sharona - flooding and foundering of fishing vessel 80 milesnorth-east of Peterhead on 3 August 1999

Silvery Sea/Merkur - collision between Merkur/Silvery Seawhich then foundered about 35 miles west of Esbjerg, Denmarkwith the loss of five lives 14 June 1998

Solstice II - investigation of a fatal accident to a crew member,25 miles south-west of Rockall 13 May 2000

Sundance - capsize and foundering of Sundance off GilkickerPoint, East Solent with the loss of one life 10 September 2001

Suzanne - see Elm

Tullaghmurry Lass - sinking of fishing vessel Tullaghmurry Lasswith loss of three lives in the Irish Sea on 14 February 2002

Union Arbo/Philomena - collision between Bahamian cargoship Union Arbo and UK fv Philomena about 10 miles south ofNewlyn, Cornwall on 2 September 1999

Van Dijck - loss overboard of a fisherman from fishing vesselwhile fishing 30 miles south-west of Guernsey on 16 April 2001

Vertrauen - investigation of the loss of Vertrauen about 75miles north-east of Peterhead 19 July 2001

Wakil II - investigation of an accident to skipper of fv 3.5 milessouth-west of St Bees Head on 10 April 2000

SAFETY DIGEST

MAIB Safety Digest 1/2002 - Published April 2002

MAIB Safety Digest 2/2002 - Published August 2002

MAIB Safety Digest 3/2002 - Published December 2002

Copies of the Safety Digest publication can be obtained,free of charge, on application to the Marine AccidentInvestigation Branch (Mrs J Blackbourn (023 8039 5509)).

GLOSSARY of abbreviations

BEAmer Bureau Enquêtes Accidents/mer

CNIS Channel Navigation Information Service

CPA Closest Point of Approach

EPIRB Emergency Position Indicating Radio Beacon

GMDSS Global Maritime Distress Safety System

OOW Officer of the Watch

Pan Pan Urgency Call

TSS Traffic Separation Scheme

VHF Very High Frequency

MAIB Safety Digest/Report Request Form

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