Annex A

Crew induction proforma

Crew Induction form

The location and use of safety equipment and fire equipment:			
Liferaft Location		Life jackets & lights & whistles	
Lifebuoy and light		Pyrotechnics	
EPIRB		First aid equipment	
Portable fire equipment		Fixed fire equipment & detection	
Deck / fire pump & hose/s		Vent closures / fuel shut offs	
Fire buckets with lanyards		Wear and use of PFD`s.	
The routine operation, procedure or general knowledge of:			
Windlass / anchoring		Preparing vessel for sea	
Watch keeping responsibilities		LPG system	
Berthing mooring lines		Fishing equipment & safety	
Helm / engine controls & pilot		Electrical & emergency electrical	
Communication equipment		Refuelling	
Bilge & tank pumping		Hatches and closures	
Garbage / oil / sewage disposal		Record keeping	
Incident reporting		Navigational equipment	
The response in the event of an emergency:			
General alarm signal		Medical / injury	
Fire on board / E/R alarms		Escape routes	
Person overboard		Abandon vessel / remain with vessel	
Flooding / grounding / bilge alarm		Fixed fire equipment & detection	
Deck / fire pump & hose/s		Vent closures / fuel shut offs	
Metal buckets with lanyards			

Acknowledgement of instruction provided by the master / owner and received by the crew for those items initialled above			
Name of Crew	[redacted]	Signature & Date	
Name of Owner / Skipper		Signature & Date	
Name of Emergency Contact for crew	[redacted]	Phone	[redacted]

Olivia Jean's risk assessments

Beam trawling/dredging

Last edited / reviewed on: 20/12/2017

Risk Id	Hazard Area/Activity	Risk	Controls in place	Risk Outcomes	Risk Level
Version - 3 20/12/2017	Shooting the gear	Becoming entangled in gear and being pulled into the water leading to death or serious injury Being struck by weights leading to death or serious injury Lifting heavy equipment leading to back injuries The sudden movement of sweeps and chains leading to to death or serious injury Gear snagging vesse	vessel automated so crew well clear of moving parts when shooting	serious injury, going overboard	Medium Risk
Version - 2 03/06/2014	Beam	Being struck by beam leading to death or serious injury. Being crushed by dredge leading to death or serious injury	crew are well clear of gear time of hauling as vessel fitted with automatic system ppe and hard hats provided	head injuries crushing	Medium Risk
Version - 2 03/06/2014	New crew members	Inexperience of crew leading to mistakes and injuries	crew have been to basic safety courses before joining vessel	serious injury	Medium Risk
Version - 2 03/06/2014	Vessel openings	Falling into the water leading to hypothermia or drowning	vessel has high rails crew given ppe and PDF's when on deck	drowning	Medium Risk
Version - 2 03/06/2014	Winches	Becoming caught in winch mechanism leading to serious injury Becoming caught in wire/rope entering the winch leading to leading to serious injury Lines parting leading to death or serious injury	vessel has winch room which is un manned	serious injury ,snagging limbs	Low Risk
Version - 2	Beam retrieval	Being banged by gear on retrieval	vessel fitted with cctv cameras	head injuries, crushing	Medium

Risk Id	Hazard Area/Activity	Risk	Controls in place	Risk Outcomes	Risk Level
03/06/2014		leading to major injuries Gear snagging vessel propulsion system leading to vessel loss, death or serious injury Poor communication leading to lack of awareness of work being undertaken leading to possible injuries Poor lifting and anual handling leading to possibl	which skipper has full view of deck, only qualified crew can haul the derricks	capsizing	Risk
Version - 1 30/11/-0001	Bag lifting	Poor communication leading to lack of awareness of work being undertaken leading to possible injuries Being stuck by swing net leading to possible injuries Overloading causing equipment failure leading to possible serious injuries Equipment failure leading to serious injury			Level not set
Version - 2 03/06/2014	Stowage of gear	Gear falling on crew leading to serious injury Shifts in loading leading to vessel instability and loss	gear stowed in channels and made fast with chains	crushing	Low Risk

MAIB Safety Flyer to the Fishing Industry

MAIB

MARINE ACCIDENT INVESTIGATION BRANCH

SAFETY FLYER TO THE FISHING INDUSTRY

Fatal accident to a crewman on board the scallop dredger *Olivia Jean* (TN35), north-east of Aberdeen, Scotland on 28 June 2019

Olivia Jean

Narrative

At about 2200 on 28 June 2019, an Indonesian crewman on board the scallop dredger *Olivia Jean* was fatally injured after being struck on the head by one of the vessel's scallop dredge towing bars while working on deck.

The crewman had replaced two worn dredges on the towing bar and stood clear as the skipper used the winches and derrick to lift and realign the gear against the vessel's tipping door. Unfortunately, one of the towing bar's securing chains had not been released and the dredge gear became snagged. Although the skipper shouted instructions to the crewman to remain clear as he attempted to free the gear, the crewman stepped between the snagged bar and the accommodation superstructure just as the snagged bar released and swung inboard.

The crewman suffered crush injuries to his head and was airlifted from the vessel and taken to hospital for emergency treatment. He died 12 days later.

The dredge gear winches and the two crew members working on deck were being controlled by the skipper from the wheelhouse. The location of the accident was out of the skipper's line of site and he was reliant on a CCTV screen that was positioned behind him to monitor the area. The deck crew's level of English comprehension was poor, and they did not speak a common language.

In August 2020, a British crewman on the *Olivia Jean* was struck by a towing bar during a dredge gear shooting operation. He moved out of the designated safe zone before being given the clearance to leave, stepped into an unsafe area and was struck by the towing bar when it unexpectedly moved. The injured fisherman was taken to hospital for emergency treatment.

Safety lessons

1. The shooting, hauling, and moving of dredge gear are extremely hazardous activities that need to be tightly controlled. No matter how experienced the crew on deck might be, they need to be properly supervised and their safety closely monitored.

2. The crew on deck may not be visible to the winch or machinery operator, so clear, explicit and easily understood communications are vital to the avoidance of dangerous situations from developing. This is particularly the case where the crew do not share the same first language.

3. Learning lessons from previous accidents can prevent injuries and save lives. In this case, the lessons learned and corrective action implemented did not prevent a near identical accident from occurring to the crew on board in August 2020. It was very fortunate that it did not result in another fatality.

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

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

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

NOTE

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