MAIB
MARINE ACCIDENT INVESTIGATION BRANCH

ACCIDENT REPORT

VERY SERIOUS MARINE CASUALTY | REPORT NO 12/2025 | SEPTEMBER 2025

Fatal man overboard from the fishing vessel *Kingfisher* (DH 110) approximately 30 nautical miles east-north-east of Wick, Scotland on 12 July 2024

Email: maib@dft.gov.uk
Tel: +44 (0)23 8039 5500

SUMMARY

On the afternoon of 12 July 2024, the crew of the UK registered fishing vessel *Kingfisher* **(Figure 1)** were manually shooting a string of creels when a deckhand became attached to a creel's leg rope and was pulled overboard. The deckhand's personal flotation device automatically inflated but he was pulled underwater by the sinking creels. Using the hauling winch, *Kingfisher*'s crew retrieved the back rope and recovered the now submerged deckhand on board. Despite the efforts of the vessel's crew, rescue services and crew members from a nearby vessel, the deckhand could not be revived.

Figure 1: *Kingfisher*

The investigation found that:

- The lifting strop (becket) of the deckhand's personal flotation device created a snagging hazard that enabled him to inadvertently connect himself to a creel's leg rope.
- The hazard of the becket snagging had been identified by other crew members but had not been communicated to everyone on board.
- The vessel's risk assessment process had not identified the hazard posed by the becket.

In response to the accident the vessel's owner, Browse Brothers Fisheries Limited, has reviewed the type of personal flotation device used on board and updated the vessel's risk assessments. Recommendations have been made to Browse Brothers Fisheries Limited to review the compatibility of personal flotation devices with the areas of working and its risk assessment methodology, and to ensure that its crews complete all mandatory training.

The MAIB has issued a safety bulletin to highlight the importance of risk assessments and ensuring that personal protective equipment is suitable for the specific operating conditions it was intended to mitigate. A recommendation was made to UK fishing industry organisations to promulgate the safety bulletin widely among their membership.

FACTUAL INFORMATION

Narrative

On the evening of 8 July 2024, *Kingfisher* left Stromness, Scotland with six crew on board. The vessel made passage through the Pentland Firth and on to the fishing grounds to the east of the Orkney Islands. Over the following days the crew recovered and shot strings of creels, mostly during the daytime.

At about 0900[1] on 12 July, the crew restarted fishing in a water depth of about 50m. By 1500, they began shooting the fourth string of the day. One of the deckhands was standing at the shooting table, manually toggling the creels one at a time onto leg ropes connected to the back rope **(Figure 2a)**. At 1508, the deckhand inadvertently threaded the third creel's toggle through both the eye in the leg rope and the becket that was hanging loose from his personal flotation device (PFD) **(Figure 2b)**. The other crew members on deck heard a scream and saw the deckhand being rapidly dragged by the leg rope across the shooting table and over the vessel's side.

In the wheelhouse, the skipper became aware of the man overboard (MOB) and immediately set *Kingfisher*'s propulsion to full astern and the rudder to starboard. The deckhand's PFD had inflated, and the crew could initially see him with his hands aloft and waving, but he disappeared underwater within seconds.

Unaware the deckhand was connected to the fishing gear, the skipper told another crew member to cut the back rope. The skipper then manoeuvred *Kingfisher* alongside the creel string's end float and the crew recovered it. Putting the back rope around the hauler, the crew heaved in the laid creels and recovered the deckhand on board.

At about 1515, the crew cut the deckhand's PFD's becket from the leg rope, removed the PFD from him and began cardiopulmonary resuscitation. During this time, *Kingfisher*'s skipper reported the MOB emergency to His Majesty's Coastguard on very high frequency (VHF) channel 16 who in turn issued a "Mayday Relay" broadcast. The coastguard tasked the Thurso Royal National Lifeboat Institution all-weather lifeboat (ALB) to the accident and deployed a rescue helicopter from Sumburgh, Shetland Islands. A nearby windfarm guard vessel also responded and sent two crew with a defibrillator to assist.

At about 1600, the rescue helicopter lowered two paramedics onto *Kingfisher* and the ALB arrived on scene. After assessment, the deckhand was declared deceased at about 1615. The deckhand's body was taken by helicopter to a hospital on the Orkney Islands. The postmortem recorded his cause of death as drowning.

Kingfisher

Kingfisher was a purpose-built potting vessel operated by a crew of six. The vessel was primarily operated from Stromness during the summer and from either Fraserburgh or Peterhead in the winter months. *Kingfisher* had a partially open working deck forward of the wheelhouse on the starboard side, from where the deck crew shot and recovered the creels.

Shooting method

Kingfisher operated with 40 strings of 120 creels. Each creel weighed between 20kg and 25kg. The creels were individually connected to a back rope **(Figure 3)** via 2m long leg ropes, which were spaced approximately every 30m along the back rope. Each end of a string had an anchor weight attached to hold the creels in position on the seabed, and riser lines leading to end floats to identify the location of the string and to aid recovery. After recovery, each creel was stripped of catch and then stowed aft of the working area before being rebaited, connected to the leg rope and shot away from the shooting table.

The creel shooting table on the starboard side of the open working deck was 0.95m high and was separated from the creel recovery position by stainless steel vertical barriers to prevent the crew member shooting the creel becoming entangled in the back rope.

[1] All times are universal time coordinated (UTC) unless otherwise stated.

For illustrative purposes only: not to scale

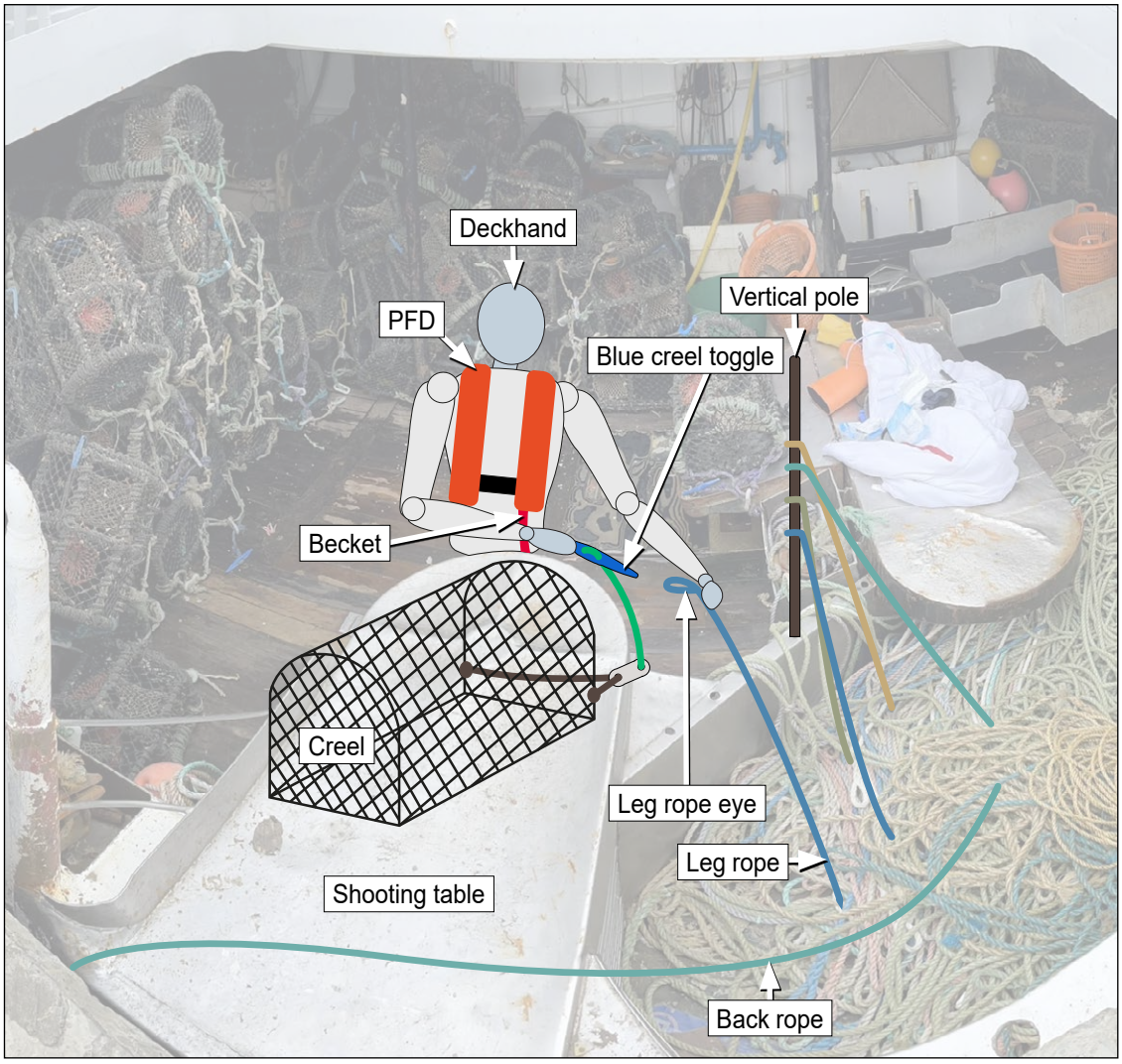

Figure 2a: Representation of the deckhand toggling creels at the shooting table

Figure 2b: Reconstruction of the deckhand inadvertently passing blue creel toggle through the lifejacket becket

For illustrative purposes only: not to scale

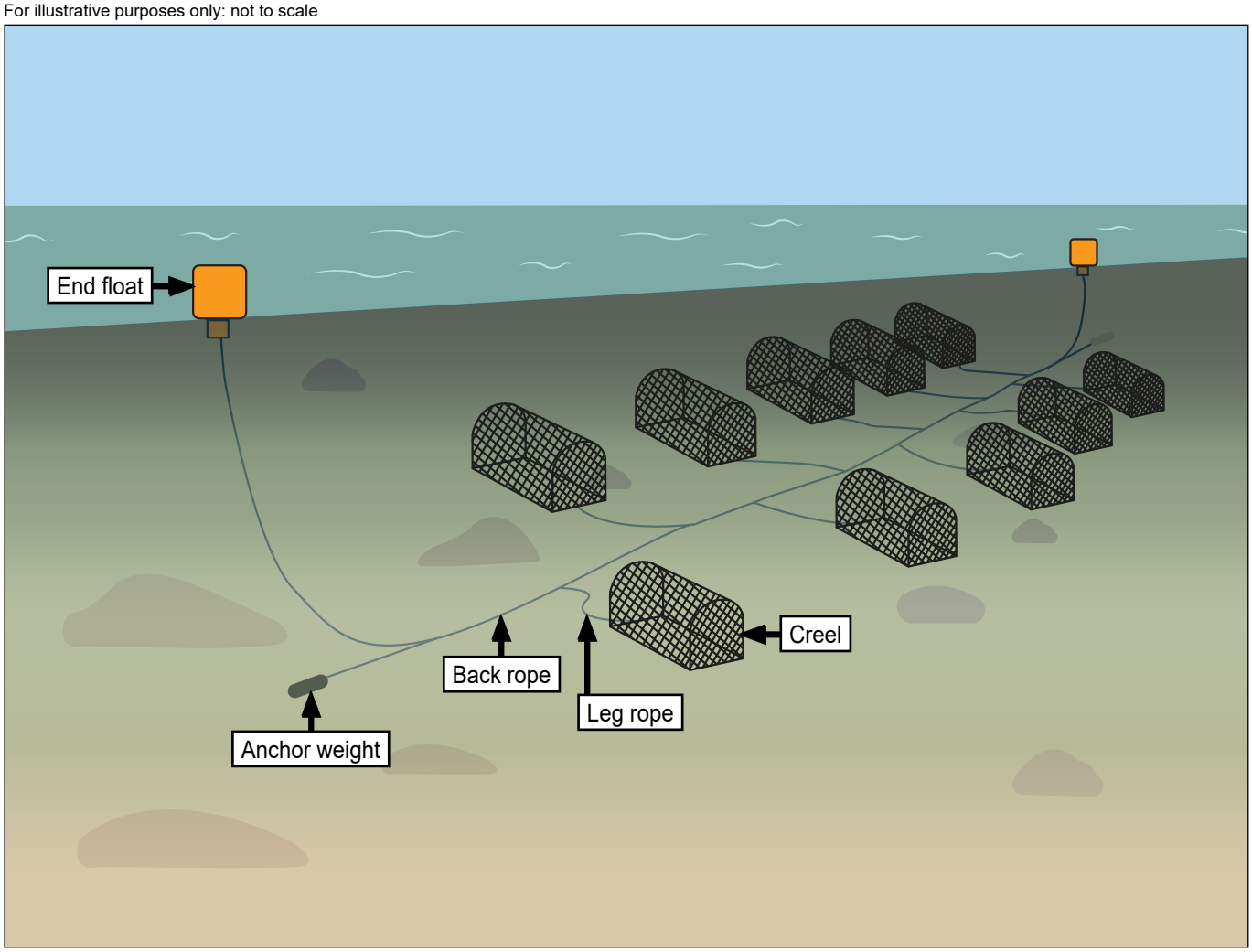

Figure 3: Creel fishing arrangement

The use of creel toggles allowed the creels to be disconnected and stored separately from the back rope until required for shooting. Baited creels would be placed on the shooting table and connected using a toggle by a crew member to the back rope via leg ropes, which were stored on a vertical pole.

Two different types of toggles were used to connect the creels to the leg ropes: approximately 90% were of an oval white plastic design; the remainder were of a blue double-ended plastic spike design about 200mm long **(Figure 4)**. The blue toggles were part of a new batch that had been purchased.

Shooting away involved the allocated crew member placing creels on the shooting table one at a time and connecting them to the back rope by pushing each creel's toggle through the eye at the free end of the next leg rope. Once connected, the weighted end of the back rope deployed at the allocated fishing location would pull the creels off the shooting table and overboard. The creels would deploy overboard every 15 seconds to 20 seconds during the shooting process.

Figure 4: Blue and white creel toggles

Kingfisher's crew

Kingfisher's crew comprised the skipper and five deckhands. The skipper and one temporary deckhand were UK nationals; of the regular deckhands, two were Filipino and two were Ghanaian. The skipper had worked on fishing vessels since 1996 and on *Kingfisher* for the last 18 years, including 6 years as one of the vessel's two skippers. The skipper had completed all their mandatory Seafish qualifications.

The deceased deckhand, Richard Fiati, was a 40-year-old Ghanaian national. He had obtained his STCW[2] certificates in 2019 and was qualified as a deckhand. He had completed six trips on board fishing vessels. He had initially sailed on board *Kingfisher* between 2 December 2020 and 28 September 2021, with a further 6-month trip beginning in early December 2021. His last contract on board *Kingfisher* began on 25 June 2024 at the port of Fraserburgh, Scotland. The deckhand was 1.77m tall, physically fit, and on the day of the accident was wearing a Seago Seaguard 300N[3] PFD over his oilskins. Several crew members were deficient in their Seafish training certification.

The crew rotated around the different deck positions at the recovery of each string to balance the workload between them.

The personal flotation device

Most of the crew, including the deceased deckhand, used Seago Seaguard 300N PFDs that were designed to automatically inflate on immersion. The PFDs were compliant with EN ISO[4] 12402-2[5] (275N[6]) and, as supplied, each had a becket sewn onto the harness that folded back on itself and was tucked into the stole, which was secured by Velcro. The becket was required by the ISO standard and was intended to facilitate manual recovery of a person from the water, though the investigation established that none of the crew were aware of the becket's purpose. Some of the crew had found that the becket on their individual PFD would drop and hang loosely below the stole **(Figure 5)** where it could snag on equipment while the wearer was working on deck. Some crew had cut the becket off their PFD, but this was not known by all those on board or the vessel's owner. It was uncommon for the crew to connect their PFD crotch straps and they were usually tied and allowed to hang freely at the wearer's back.

Onboard risk assessment

The onboard risk assessment, signed by *Kingfisher*'s crew, required them to wear a PFD in all areas of the working deck as a mitigation against drowning if they fell overboard. The risk assessments did not identify any specific snagging hazards with the fishing gear, including snagging of PFDs, but required the crew to report any they identified. Man overboard recovery drills were not conducted by *Kingfisher*'s crew.

[2] International Convention on Standards of Training, Certification and Watchkeeping for Seafarers, 1978 as amended.

[3] Newtons – 10N is equivalent to 1kg of buoyancy.

[4] European standards adopted from International Organization for Standardization (ISO) standards.

[5] Personal flotation devices Part 2: Lifejackets, performance level 275 – Safety requirements.

[6] The 275N performance level applications included offshore; extreme conditions; special protective clothing; and heavy equipment.

Figure 5: The red webbing becket on the PFD

Regulation and guidance

Published in April 2024, Marine Guidance Note (MGN) 588 (F) Amendment 2[7]: Compulsory provision and wearing of personal flotation devices on fishing vessels, provided guidance that included:

- *Where risks cannot be reduced to a safe level by other measures, personal protective equipment must be provided and used.*
- *Following risk assessment, measures should be established to reduce the risk of fishers falling overboard wherever practicable.*
- *MCA will expect to see a record of any risk assessment and measures put in place.*
- *Failure to ensure the provision and wearing of PFDs and/or fall restraint harnesses by all fishers working where there is a documented risk of falling overboard will be considered by the MCA to be a breach of health and safety legislation.*
- *PFDs must meet minimum performance standards required by MSN1870 and be worn in accordance with manufacturer's instructions* [sic]

On risk assessment, MGN 588 (F) Amendment 2 required that:

> *When developing this risk assessment, it is important that owners consider:*
>
> *a. the risks to which the crew or other worker are exposed to performing their task; …*
>
> *c. the compatibility with and risks associated with certain types of mitigating equipment, such as the increase in the risk of snagging, or damage to PFDs, so that the PFD remains effective against the risk;…*

and,

> *f. the measures that are in place to reduce the MOB event happening in the first place, such as the use of physical barriers, automated equipment, use of harnesses etc;*

Safety awareness and risk assessment

In addition to the mandatory training courses required by new entrants to the fishing industry, MGN 411 (M+F)[8] required experienced fishermen (with 2 years' experience or more) to complete the one-day Safety Awareness and Risk Assessment course. The Seafish course risk assessment section included *identification of snagging hazards which could result in a MOB situation*.

The implementation of ILO 188[9], via MGN 587 (F) Amendment 1: Health and safety: responsibilities of fishing vessel owners, managers, skippers and fishermen, required suitable and sufficient risk assessments for all work activities on board. This included:

> *5.4 The skipper and crew should be closely involved with the risk assessment, to take advantage of their practical knowledge and experience of the work, what can go wrong, and how to prevent that. But the fishing vessel owner has overall responsibility for ensuring that the risk assessment has been done and acted upon.*

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[7] In response to MAIB's investigation into the man overboard from the fishing vessel *Eder Sands* https://www.gov.uk/maib-reports/fall-overboard-from-fishing-vessel-eder-sands-with-loss-of-1-life

[8] MGN 411 (M+F) – Training and Certification Requirements for the Crew of Fishing Vessels and their Applicability to Small Commercial Vessels and Large Yachts.

[9] International Labour Organization Work in Fishing Convention, 2007 (No.188).

5.5 The assessment must be reviewed if

(a) there is reason to suspect that it is no longer valid; or

(b) there has been a significant change in any of the matters to which it relates,

It is good practice to review the risk assessment at least every year, to ensure that any changes affecting its validity are identified. If the review identifies a need to change any procedures or practices to ensure safety is maintained, those changes must be made, and recorded.

5.6 The crew should be informed of the findings of the risk assessment and any measures taken for their protection and should be involved in reviewing the risk assessment…

5.7 The risk assessment must be documented so that it is available to the skipper and crew of the vessel, and to authorised persons during inspections. A written risk assessment (hard copy or electronic) will help to ensure that when it is reviewed nothing is missed. Even if no changes are required, any documentation should be annotated to show that a review has been carried out.

MGN 588 (F) Amendment 2 included that, *unless measures are in place which eliminate the risk of fishers falling overboard, all fishers must be provided with and must wear PFDs or safety harnesses*.

Risk assessment information was also provided in the Fishermen's Safety Guide published by the MCA.

ANALYSIS

Overview

The becket on the deckhand's PFD was connected to the leg rope of the third creel being shot away. The deckhand was pulled over the shooting table and overboard by the back rope, and then under the water. Although the deckhand's PFD inflated, it did not provide enough buoyancy to counteract the weight of the deployed creels pulling him underwater. While *Kingfisher*'s crew responded promptly and the deckhand was recovered within 7 minutes, he could not be revived.

Connection to back rope

The deckhand had shot creels away many times on board *Kingfisher*. The process was relatively simple and quick and, after many repetitions, could be carried out with little focus.

The blue toggle's shape made it easier to thread through the eye of a leg rope than the white toggle design and its length improved security of the creel once threaded **(**see **Figure 4)**. It is likely the deckhand's concentration lapsed just before the accident and he inadvertently threaded the toggle through the loosely hanging becket of his PFD while connecting the third creel to the leg rope **(**see **Figure 2b)**. Of the two types of toggles used on *Kingfisher* the blue toggle design was more likely to inadvertently snag on items such as the loose becket due to its length and slim pointed shape. There was no specific reason identified for the purchase of the blue toggles other than that of availability. The different shaped toggles, the snag hazard posed by a freely hanging PFD becket, and the possibility of threading the pointed blue toggle through a becket loop appear not to have been formally recognised as a serious hazard to life. Although the chance of making such an error could be seen as unexpected and relatively unlikely, the consequences were severe.

Personal flotation device suitability

The 275N Buoyancy PFDs supplied to *Kingfisher*'s crew were intended for offshore heavy duty use. Although the crotch strap was not connected as intended, the deckhand's PFD operated correctly and initially kept him afloat. Only under the additional weight of the creels was the PFD unable to perform as intended.

The EN ISO 12402-2 (275N) standard required PFDs to be equipped with a rescue lifting becket. The becket was stored within the PFD's stole when new and was intended to deploy upon inflation. During heavy use on board *Kingfisher*, the Velcro tape securing the stole on some of the PFDs gradually degraded allowing the becket to be released and to hang down loosely from the PFD.

Some of the crew who had experienced loose PFD beckets snagging on parts of the fishing gear had cut the beckets off to prevent this. However, removal of the beckets had been done without individuals consulting between themselves or raising the snagging problem with the skipper. Had the skipper been informed about the problem with the PFD beckets, the owner or manufacturer could have been notified. Alerting the manufacturer would likely have received a rapid response to the effect that removal of the becket both invalidated the PFD's certification and reduced the wearer's rescue options.

The immediate purpose of a PFD upon immersion is to maintain the wearer's airway clear of the water to preserve life. When rescue arrives, the becket assists the rescuers to recover the individual from the water. The use of PFDs has been promoted through consistent safety messages for decades and they have proven successful in saving many lives. However, it is apparent that the PFD used in this accident, although approved and suitable when new, became deficient while in use and was not replaced nor the loose becket rectified.

Risk management

Kingfisher had risk assessments, in compliance with MGN 588 (F) Amendment 2. The risk assessment for a person drowning from falling overboard had the stated mitigation of the crew wearing PFDs when on the working deck. This was probably considered reasonable due to the risk of being washed overboard in certain areas of the working deck.

While at the shooting table the crew were separated from the back rope on deck by a physical barrier. The use of toggles meant that creels were not permanently connected to the back rope, but the process of 'toggling on' the creels placed the crew member close to the moving fishing gear in that moment and therefore at potential risk of entanglement. The wearing of a PFD mitigated the risk of drowning when the wearer was in the water, but not the risk of entanglement on board leading to someone entering the water. Crew becoming entangled in the back rope as it deployed was a risk that required mitigating. The risk of the crew standing in a bight of back rope had been reduced by physical separation, but in this accident their PFDs created a snagging risk. The wearing of a safety tether instead of a PFD by the crew standing at the shooting table could have reduced the risk of them being carried or washed overboard.

Effective risk management involves regular reviews of work activities and any changes to equipment, personal protective equipment or the working environment to ensure compatibility, and clear communication between all involved, as referenced in MGN 587 (F). The introduction of the blue toggles, which was a small change to the shooting process, was beneficial as they could be threaded more easily than the white toggles. Concurrently, some of the crew had experienced the loose beckets on their PFDs becoming snagged and had overcome their perceived danger of this by cutting off the beckets. In this accident, the easily threaded blue toggles and the loose PFD becket combined to attach the deckhand to the moving back rope with fatal consequences. Those crew who had removed the beckets from their PFDs had not thought to highlight this hazard; however, a periodic review of working practices on board might have identified that two things had changed since the risk assessments were written, and that new risks were present that required mitigating.

It is apparent that the application of the risk assessment process was not fully effective on *Kingfisher*; some of the actual risks from the shooting process were not therefore mitigated and this put the crew at risk.

Although risk assessment formed part of the Seafish training for experienced fishermen, which *Kingfisher*'s skipper had completed, it was a small element of the overall training requirements. Understanding the risk assessment process, documenting the results and implementing mitigations and

safe systems of work are subjective activities that depend on the knowledge and capabilities of those undertaking them. Those involved also need to recognise the importance of frequent reviews of risk management to ensure its effectiveness over time.

Guidance on risk management was provided in MGN 587 (F) Amendment 1, MGN 588 (F) Amendment 2 and the Fishermen's Safety Guide. However, it is possible that the extant guidance on risk management was either not accessed, misunderstood, or not trained in sufficient detail to improve safety standards on board fishing vessels. Further, mandatory training was incomplete on *Kingfisher*, which limited the crew's ability to work safely within an effective risk management system.

CONCLUSIONS

- The deckhand was dragged overboard and drowned when he inadvertently connected his PFD's becket to a leg rope of a creel as it was being shot away.
- The deckhand's inflated PFD was unable to overcome the weight of the deployed fishing gear and he was held underwater.
- The PFD's becket had become a known snagging hazard, which the deckhand may not have recognised.
- Although approved, the PFD became unsuitable for its intended purpose while in service on *Kingfisher* due to the risk of snagging.
- The onboard risk assessments did not effectively mitigate the risk of entanglement while shooting the creels.
- The risk assessments were not reviewed and updated to reflect changes in operation and hazards.
- It is possible that the extant guidance on risk management was either not accessed, is misunderstood or is not trained in sufficient detail to improve safety standards on board fishing vessels.
- Mandatory training was incomplete on *Kingfisher*, which limited the crew's ability to work safely within an effective risk management system.

ACTION TAKEN

MAIB actions

The MAIB has issued a safety bulletin[10] recommending to the Home and Dry Safety Forum that it communicate through its members the need for owners and crew of creel fishing boats to ensure that: the hazards of shooting and recovering creels are fully mitigated; working deck PFDs are fit for purpose; and, new hazards are brought to the attention of the crew as soon as possible.

Actions taken by other organisations

Browse Brothers Fisheries Limited has made amendments to *Kingfisher*'s risk assessments and changed the PFDs supplied to crew.

Seago Yachting Ltd has increased the minimum length of the PFD lifting strop (becket) from 15cm to 29cm to increase the friction fit under the cover and enhance visibility when the PFD has inflated. Additionally, the latest Seaguard model incorporates a Velcro tab to secure the becket that breaks free upon inflation and allows it to hang free. This attachment can be retrofitted to any Seago lifejacket.

[10] https://www.gov.uk/maib-reports/safety-warning-issued-following-a-man-overboard-from-potting-vessel-kingfisher-with-loss-of-1-life

RECOMMENDATIONS

Browse Brothers Fisheries Limited is recommended to:

2025/132 Review the risk assessment guidance in Marine Guidance Note 588 (F) Amendment 2 to determine and ensure the compatibility of personal flotation devices supplied with the vessel's working areas to mitigate the risk of snagging, or damage to, personal flotation devices so that they remain effective against the risk.

2025/133 Review its risk assessment methodology to identify the actual risks on board and implement mitigations to reduce them to as low as reasonably practicable.

2025/134 Ensure that its crews have completed all the mandatory training courses.

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

VESSEL PARTICULARS	
Vessel's name	*Kingfisher*
Flag	UK
Classification society	Not applicable
Fishing numbers	DH 110
Type	Potter
Registered owner	Browse Brothers Fisheries Limited
Manager(s)	Browse Brothers Fisheries Limited
Year of build	1989
Construction	Steel
Length overall	18.35m
Registered length	16.40m
Gross tonnage	122
Minimum safe manning	Not applicable
Authorised cargo	Crabs/lobsters

VOYAGE PARTICULARS	
Port of departure	Stromness, Orkney Islands
Port of arrival	Kirkwall, Orkney Islands
Type of voyage	Fishing
Cargo information	Crabs
Manning	6

MARINE CASUALTY INFORMATION	
Date and time	12 July 2024 at 1508
Type of marine casualty or incident	Very Serious Marine Casualty
Location of incident	30nm east-north-east of Wick, Orkney Islands
Place on board	Main deck
Injuries/fatalities	1 fatality
Damage/environmental impact	None
Vessel operation	Underway
Voyage segment	Mid-water
External & internal environment	North to north-westerly 4kts to 6kts; low cloud; fair visibility; 0.5m swell; 1.25m to 2.5m moderate choppy waves.
Persons on board	6