ACCIDENT REPORT

Report on the investigation of

the double man overboard from the potter

# *Weston Bay* (GY123)

resulting in one fatality

approximately 12 nautical miles south-east

of Spurn Head, England

on 22 May 2024


MAIB
MARINE ACCIDENT INVESTIGATION BRANCH

VERY SERIOUS MARINE CASUALTY REPORT NO 9/2026 APRIL 2026

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**(Accident Reporting and Investigation)**

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NOTE

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# CONTENTS

## GLOSSARY OF ABBREVIATIONS AND ACRONYMS

| | | |
|---|---|---|
| ALB | - | all-weather lifeboat |
| CPR | - | cardiopulmonary resuscitation |
| CTV | - | crew transfer vessel |
| EN | - | European Norm |
| Fastline | - | Fastline Shellfish Limited |
| FISG | - | Fishing Industry Safety Group |
| HMCG | - | His Majesty's Coastguard |
| ILO 188 | - | The International Labour Organization Work in Fishing Convention No.188 |
| ISO | - | International Organization for Standardization |
| kts | - | knots |
| LSA | - | lifesaving appliance |
| MCA | - | Maritime and Coastguard Agency |
| MGN | - | Marine Guidance Note |
| MOB | - | man overboard |
| MSN | - | Merchant Shipping Notice |
| nm | - | nautical mile |
| PFD | - | personal flotation device |
| RNLI | - | Royal National Lifeboat Institution |
| safety folder | - | fishing vessel safety folder |
| Seafish | - | Sea Fish Industry Authority |
| Seafish advisory | - | Seafish FS45 Potting Safety Industry Advisory Note, published January 2011 |
| SFVC | - | Small Fishing Vessel Certificate |
| SMS | - | safety management system |
| STCW | - | International Convention on Standards of Training, Certification and Watchkeeping for Seafarers 1978, as amended |
| UTC | - | universal time coordinated |

**TIMES:** all times used in this report are UTC +1 unless otherwise stated.


*Weston Bay*

# SYNOPSIS

At about 0820 on 22 May 2024, two deckhands went overboard during deployment of the fishing gear from the UK registered potting vessel *Weston Bay* while the vessel was shooting its pots approximately 12 nautical miles south-east of Spurn Head, England. The three remaining crew were able to recover one deckhand on board, but their efforts to recover the other deckhand, James (Jimmy) Haughey, were unsuccessful. He was recovered by another vessel about 40 minutes after entering the water; he was not breathing and, despite emergency first aid efforts, could not be resuscitated. The deceased deckhand's personal flotation device became separated from him during the recovery efforts.

The investigation found that the two deckhands entered the water following an incident while manually downstacking a string of shooting pots. The first deckhand was struck, knocked onto the deck and taken overboard by the next pot in the sequence; a second deckhand entered the water as he went to assist.

The investigation established that the method of shooting pots on *Weston Bay* did not ensure the physical separation of the gear from the crew, and the vessel's risk assessments did not identify or mitigate critical hazards. The man overboard recovery system was in poor condition and was unsuitable for the recovery of an unconscious person. It was also found that regular drills were not conducted on board, and safety equipment had not been inspected and maintained.

Since the accident, *Weston Bay*'s owner, Fastline Shellfish Limited, has revised and adapted the man overboard recovery system for its vessels and implemented measures to ensure crew wear their working personal flotation devices and conduct regular manoverboard drills with a focus on the recovery of an unconscious person.

Recommendations have been made to Seafish to review its Basic Health and Safety and Safety Awareness and Risk Assessment course content and develop a safety management module for its Under 16.5m Skipper's Certificate (Restricted) and Under 16.5m Skipper's Certificate (Unrestricted) courses.

Fastline Shellfish Limited has been recommended to develop a safety management system that aligns with the principles outlined in Maritime and Coastguard Agency guidance. The company has also been recommended to develop a system of shooting pots that provides physical separation from the gear for the crew.

# SECTION 1 – FACTUAL INFORMATION

## 1.1 PARTICULARS OF *WESTON BAY* AND ACCIDENT

| **VESSEL PARTICULARS** | |
|---|---|
| Vessel's name | *Weston Bay* |
| Flag | UK |
| Classification society | Not applicable |
| IMO number/fishing numbers | GY123 |
| Type | Potting fishing vessel |
| Registered owner | Fastline Shellfish Limited |
| Manager(s) | Fastline Shellfish Limited |
| Construction | Glass reinforced plastic |
| Year of build | 1985 |
| Length overall | 11.98m |
| Registered length | 11.16m |
| Gross tonnage | 24 |
| Minimum safe manning | Not applicable |
| Authorised cargo | Shellfish |

| **VOYAGE PARTICULARS** | |
|---|---|
| Port of departure | Grimsby, England |
| Port of arrival | Grimsby, England |
| Type of voyage | Fishing |
| Cargo information | Shellfish |
| Manning | 5 |

| **MARINE CASUALTY INFORMATION** | |
|---|---|
| Date and time | 22 May 2024 at about 0820 |
| Type of marine casualty or incident | Very Serious Marine Casualty |
| Location of incident | Approximately 12nm south-east of Spurn Head, England |
| Place on board | Aft main deck |
| Injuries/fatalities | 1 fatality |
| Damage/environmental impact | Not applicable |
| Ship operation | Shooting pots |
| Voyage segment | Mid-water |
| External & internal environment | 1m wave height; wind northerly force 5; air temperature 18°C; sea temperature approximately 10°C |
| Persons on board | 5 |

## 1.2 CAVEAT

The events described in this investigation report are drawn from the evidence collected during the investigation. The recollections of the witnesses varied, and the narrative and facts presented are therefore a best representation of the information gathered.

## 1.3 NARRATIVE

At about 0500 on 22 May 2024, *Weston Bay*'s five crew arrived at the vessel's berth in Grimsby, England. A short while later, *Weston Bay* sailed for the fishing grounds south-east of Spurn Head **(Figure 1)**. At about 0740, *Weston Bay* arrived at the fishing grounds; the skipper was in the wheelhouse and had called the four deckhands (deckhand 1 to deckhand 4) to the working deck **(Figure 2)** to haul the first string of pots. All four deckhands were dressed in bib and brace oilskins, wellington boots, jumpers and protective gloves. Deckhand 1 and deckhand 2 each wore a personal flotation device (PFD).



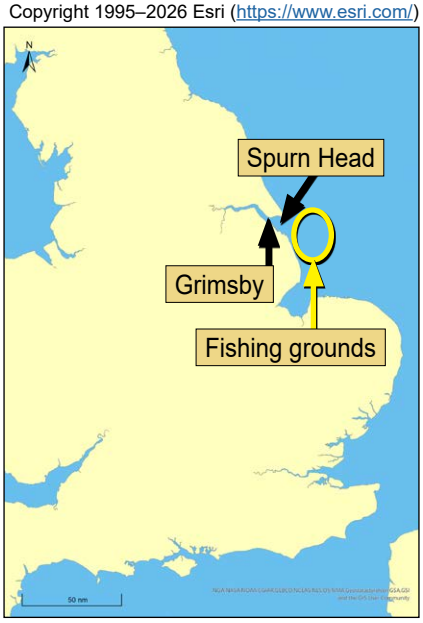


**Figure 1:** The accident location

At about 0750, deckhand 2 recovered the first string of 40 pots from the seabed via the pot hauler. Deckhand 3 and deckhand 4 processed the pots before they were passed to deckhand 1, who restacked the pots to be re-shot. The skipper remained in the wheelhouse to navigate the vessel and oversee the fishing operation. Once the pots were reset, deckhand 1 placed the dhan buoy[1], end weight and the first three pots to be re-shot at the transom shooting door opening. Deckhand 2, deckhand 3, and deckhand 4 moved to the catch processing area **(Figure 3)**.

At about 0820, on the skipper's signal, deckhand 1 deployed the dhan buoy and attached end weight over the stern. This subsequently dragged each pot in turn behind it. Deckhand 1 then downstacked[2] each pot sequentially until the tenth, when they selected the incorrect pot in the order. This dragged the next three pots together and knocked deckhand 1 onto the deck. Deckhand 2 immediately jumped over the pound board to assist deckhand 1. The next pot struck deckhand 1, who was taken through the open shooting door into the sea **(Figure 4)**. Shortly afterwards, unwitnessed and by mechanism unknown, deckhand 2 also entered the water.

Deckhand 3 and deckhand 4 turned and saw deckhand 1 and deckhand 2 in the water and alerted the skipper, while checking that the two deckhands were not caught in the back rope attached to the pots. Once satisfied that the pair were clear, deckhand 3 and deckhand 4 cut the back rope and the skipper stopped the vessel.

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[1] A dhan (sometimes known as dan) buoy is a marked float or pole with a flag, light, or radar reflector used by fishing vessels to indicate the position of the end of a fishing line or net at sea.

[2] The orderly manual positioning of pots or creels onto the deck to prevent entanglement and damage during deployment.


**Figure 2:** *Weston Bay*'s working deck layout

For illustrative purposes only: not to scale

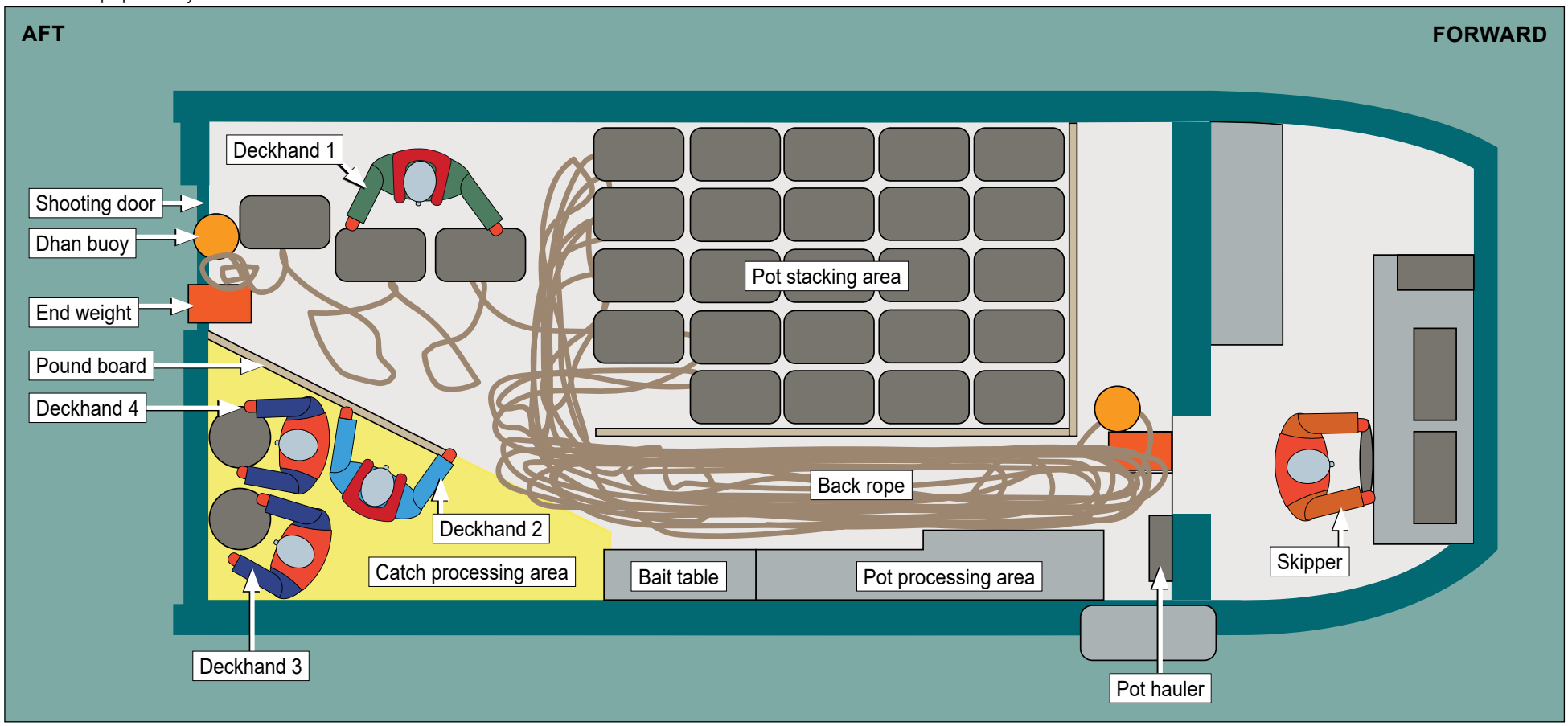


**Figure 3:** Crew positions at the shooting stations

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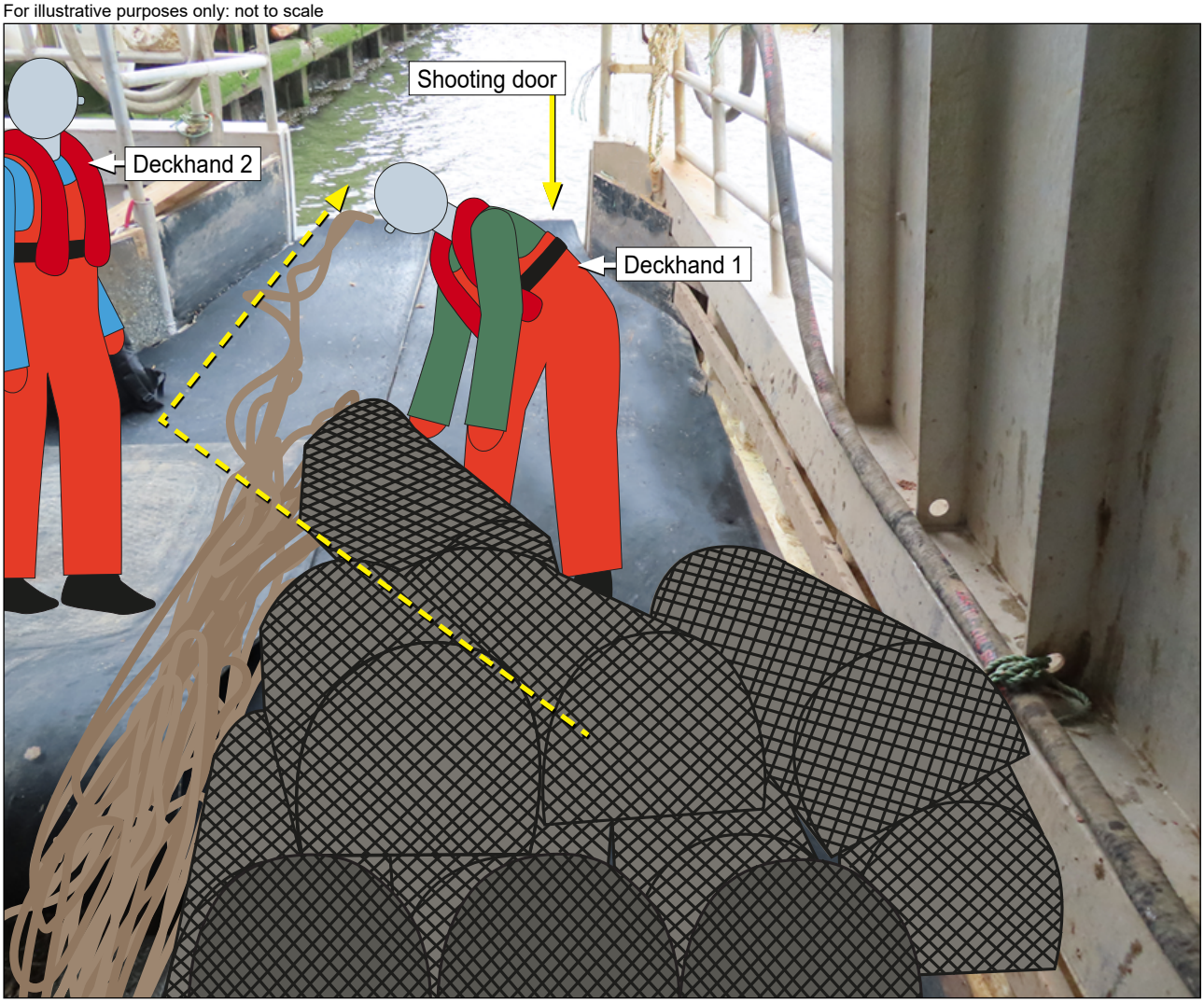


**Figure 4:** Deckhand 1 downstacking shooting pots

The skipper drove *Weston Bay* stern first towards deckhand 1 and deckhand 2 in the water, then went to the deck to rig the rescue ladder assisted by deckhand 4. A lifebuoy was thrown to deckhand 1 and deckhand 2 by deckhand 3 but this was carried away by the tidal stream. Meanwhile, deckhand 2 had become separated from his inflated PFD and was treading water.

Deckhand 3 threw a second lifebuoy with a line attached to assist deckhand 2, who looped an arm through it while directing the crew to recover deckhand 1 first. Deckhand 2 then began to struggle in the water. Deckhand 1 wrapped their legs around deckhand 2 to support him and managed to move them both to *Weston Bay*'s stern. The crew on board unsuccessfully attempted to simultaneously recover deckhand 1 and deckhand 2 by pulling them up and through the transom shooting door. The crew then deployed the emergency rescue ladder at the stern. The retaining straps snapped when deckhand 1 put their weight onto the ladder. Deckhand 4 then looped the safety ladder's top rung around their own neck and recovered deckhand 1 on board via the shooting door with assistance from the skipper and deckhand 3 **(Figure 5)**.

At 0828, the skipper issued a "Mayday" distress call via channel 16 on very high frequency radio. His Majesty's Coastguard (HMCG) Humber acknowledged the distress call and assigned rescue assets to assist, including the Humber Royal National Lifeboat Institution (RNLI) all-weather lifeboat (ALB) and rescue helicopter R192.

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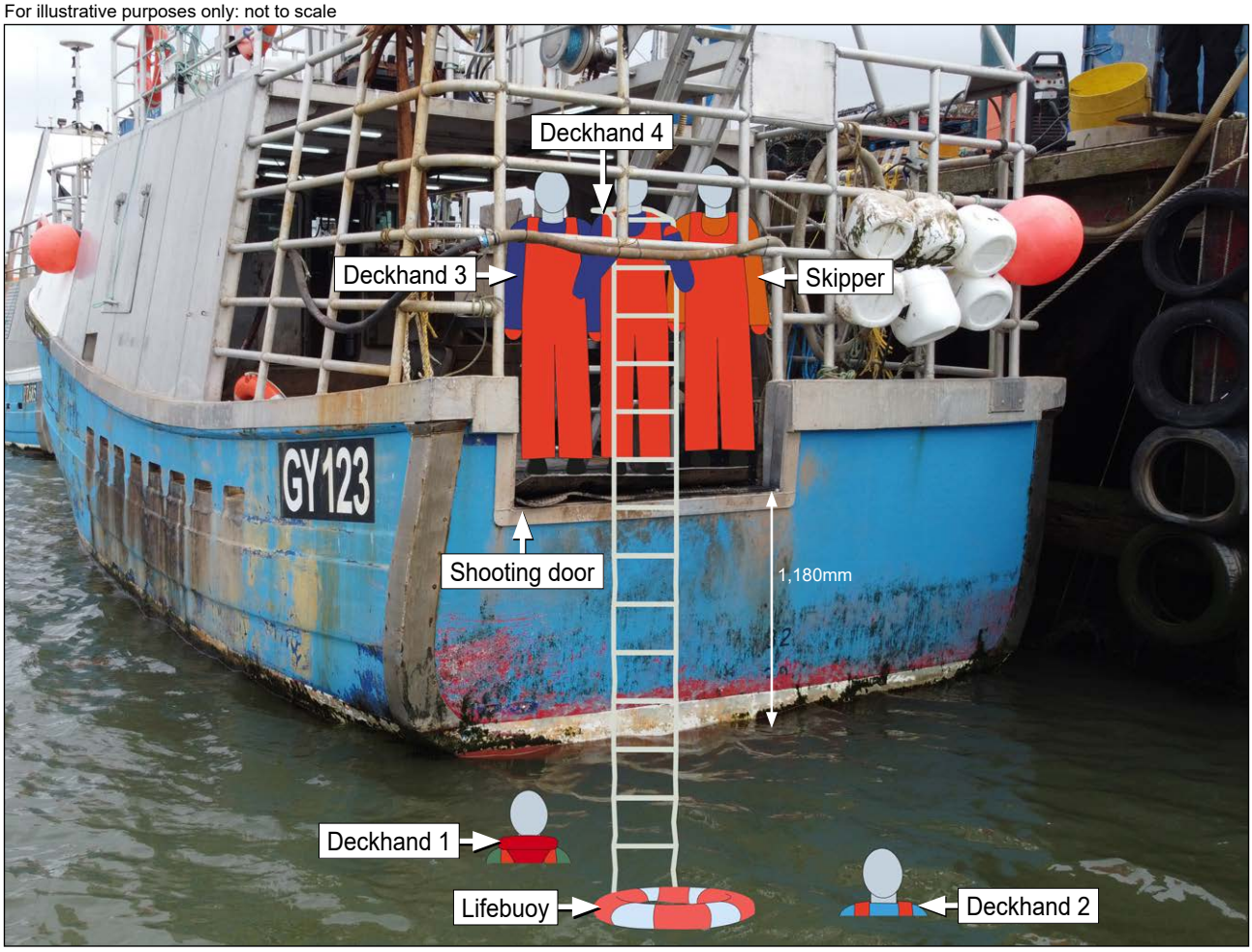


**Figure 5:** MOB recovery area (freeboard height)

Meanwhile, the crews of two nearby crew transfer vessels (CTVs) and the pilot vessel *Ouse* responded to the "Mayday" and were directed by HMCG Humber to proceed to *Weston Bay*'s position and assist.

*Weston Bay*'s crew attempted to recover deckhand 2 on board using the emergency rescue ladder. As deckhand 2 pulled on the ladder it fell apart into the sea. Deckhand 2 was treading water, but his head dropped below the water in the swells as he began to drift away from the vessel.

At about 0838, the skipper donned a PFD with a rope attached to its straps and, with deckhand 4 holding the line, jumped into the water to assist deckhand 2. The skipper was immediately overcome by the cold water and, unable to assist deckhand 2, shouted to the crew to be pulled back on board. Deckhand 4 then threw a grappling hook to pull deckhand 2 back towards *Weston Bay*, this was successful on the second attempt, but they were unable to recover deckhand 2 on board. As deckhand 2 lost consciousness, the crew looped a rope around his arm to prevent him drifting away and waited for assistance to arrive.

At 0850, the two CTVs arrived, followed shortly after by *Ouse*, which moved towards *Weston Bay*'s stern. *Ouse*'s crew deployed their man overboard (MOB) recovery system and successfully recovered deckhand 2 on board at 0904. *Ouse*'s crew immediately began cardiopulmonary resuscitation (CPR) on deckhand 2 as the vessel proceeded back to port at best speed.

At 0920, rescue helicopter R192 transferred its winchman to *Ouse* to assist the vessel's crew with ongoing CPR. At 1031, deckhand 2 was declared deceased. Shortly after, R192 recovered its winchman and returned to its base while the RNLI Humber ALB shadowed *Ouse* back to port.

At 1036, *Ouse* berthed at the Royal Dock, Grimsby and deckhand 2's body was taken ashore. Two hours later, *Weston Bay* berthed at the adjacent Fish Dock 2.

## 1.4 ENVIRONMENTAL CONDITIONS

The weather was overcast with light rain and the wind was from the north at about 12 knots (kts), accompanied by a 1m sea from the same direction. The seawater temperature was approximately 10°C.

## 1.5 *WESTON BAY*

### 1.5.1 General description

*Weston Bay* was an 11.98m UK registered fishing vessel built in 1985. The vessel was owned by Fastline Shellfish Limited (Fastline) and operated from Grimsby, fishing for brown crab, whelk and lobster. The owner of Fastline was a career fisherman who had purchased *Weston Bay* in 2020 to complement the company's two existing vessels.

*Weston Bay*'s working deck was divided by two pound boards to separate the crew from the running gear that ran between the port side pot stacking area and the starboard side catch processing area **(**see **Figure 2)**. *Weston Bay*'s freeboard was 1,180mm at the transom shooting door **(Figure 5)**. A hydraulic pot hauler was mounted on the vessel's starboard side.

### 1.5.2 Maritime and Coastguard Agency inspection

The Maritime and Coastguard Agency (MCA) had inspected *Weston Bay* out of the water at Grimsby on 16 February 2021 and in the water at Grimsby on 25 May 2021. The deficiencies recorded during these inspections included:

- *Risk assessments to be completed for the vessel*
- *All required qualifications of the crew have been sighted and are not satisfactory*
- *Means of recovering a man overboard to be developed*

The MCA's survey report form stated that it was *the Master/Skipper/Owner's responsibility to ensure that all deficiencies listed above have been rectified by the due date*. The deficiencies were assigned an action code 17 – *Master instructed to rectify deficiency before departure*. The deficiencies were subsequently closed out to the satisfaction of the MCA, and *Weston Bay* was issued with a 5-year Small Fishing Vessel Certificate subject to:

- the owner's verification that an annual self-certification inspection had been completed for the vessel; and

- the vessel's continued compliance with Merchant Shipping Notice (MSN) 1871 (F) Amendment No.2[3].

*Weston Bay*'s operator had not recorded any annual self-certification checks for the 2 years following the vessel's last MCA inspection.

### 1.5.3 Potting routine

*Weston Bay* operated from Monday to Friday, usually departing early morning and returning late afternoon. The crew worked approximately 700 pots divided into strings of 40 and would typically haul and shoot 10 to 15 strings per day. Each pot weighed approximately 30kg and the pots were spaced at 36m intervals along a 1,460m back rope, to which they were permanently attached by 1.5m leg ropes. Each end of the back rope was anchored to the seabed by a steel weight attached to a 20m line and dhan buoy.

Before shooting, the pots were stacked from forward to aft in rows of five and up to four rows high **(**see **Figure 2** and **Figure 3)**. The back rope was flaked on the deck in the area between the pot stacking area and the catch processing area **(**see **Figure 2)**. The four deckhands would rotate stations on each string, with the skipper remaining in the wheelhouse. The deckhand responsible for stacking the pots would oversee their deployment as they were familiar with the order in which the pots were stacked.

Three deckhands stood in the catch processing area between the pound boards and the starboard gunwale during the shooting operation **(**see **Figure 3)**. The deckhand who had stacked the pots would place the end weight and dhan buoy arrangement at the opening in the transom, along with the first three pots to be shot. The skipper would drive *Weston Bay* ahead at about 5kts on a steady heading and then signal to the deckhand who would manually deploy the dhan buoy and end weight into the water through the opening in the transom.

As the end weight dropped to the seabed and held, the resulting tension on the back rope as the vessel moved ahead pulled the pots through the shooting door in succession. At 5kts, *Weston Bay*'s pots deployed at a rate of one pot every 14 seconds. The pots were sequentially downstacked to prevent them fouling one another and multiple pots being dragged at once. There had been several previous incidents on *Weston Bay* of pots tangling and being shot together. On these occasions, the deckhand working the stack had taken avoiding action and jumped clear, often hanging onto the inside of the weather deck as the pots passed by.

### 1.5.4 The crew

*Weston Bay* was operated by a skipper and four deckhands, all of whom were UK nationals. The crew's certification is summarised in **Table 1**.

*Weston Bay*'s skipper was a career fisherman who had been employed by Fastline for 15 years, serving as skipper for approximately 8 years. The skipper held a Seafish[4] Under 16.5m Skipper's Certificate (Restricted)[5]. The skipper had also

[3] MSN 1871 (F) Amendment No.2 – The Code of Practice for the Safety of Small Fishing Vessels of less than 15m Length Overall.

[4] Seafish is a non-departmental public body that supports the seafood industry in the UK.

[5] A voluntary certificate comprising a number of short courses relevant to skippers of fishing vessels less than 16.5m operating within 20 nautical miles (nm) of a safe haven.

completed voluntary refresher training for the Seafish Safety Awareness and Risk Assessment course in 2019 and the Seafish Basic First Aid and Basic Fire Fighting and Prevention courses in 2020.

Deckhand 1 started working in the fishing industry in November 2023 and had joined *Weston Bay* in the week of the accident. Deckhand 1 had previously fished on a larger potting vessel that used a detachable toggle system[6] to shoot pots. Deckhand 1 weighed 70kg.

Deckhand 3 was a career fisherman of 30 years and had worked on board *Weston Bay* for 18 months.

Deckhand 4 had joined *Weston Bay* in November 2023 with no previous experience of working in the fishing industry.

| Course / Role | Basic Sea Survival | Basic First Aid | Basic Fire Fighting and Prevention | Basic Health and Safety | Safety Awareness and Risk Assessment[7] |
|---|---|---|---|---|---|
| Skipper | Yes | Yes | Yes | Yes | Yes |
| Deckhand 1 | Yes | Yes | Yes | Yes | Not applicable |
| Deckhand 2 | Yes | Yes | Yes | Yes | Yes |
| Deckhand 3 | Yes | No | Yes | Not applicable[8] | Yes |
| Deckhand 4 | Yes | No | No | No | Not applicable |

**Table 1:** *Weston Bay*'s crew training records

### 1.5.5 Deckhand 2

James (Jimmy) Haughey was 24 years old, 184cm tall and weighed 116kg. He had worked as a fisherman for 5 years and had joined *Weston Bay* in February 2024. He was in good health and was a competent swimmer.

The postmortem report recorded deckhand 2's cause of death as *immersion in water*.

[6] The toggle clip system allowed pots to be detached from the back rope for flexible storage and efficient hauling, and removed the hazard of pots being shot out of sequence.

[7] Deckhands 1 and 4 had been working in the fishing industry for less than 2 years and were not required to complete this course.

[8] Deckhand 3 was a new entrant to the fishing industry before the Basic Health and Safety course was introduced.

### 1.5.6 Safety management and risk assessment

Fastline and *Weston Bay*'s skipper had adopted the fishing vessel safety folder to document the vessel's safety policies and risk assessments. The safety folder provided fishing vessel operators with a framework to manage safety at sea and support compliance with regulations, including The Merchant Shipping and Fishing Vessels (Health and Safety at Work) Regulations 1997 and the International Labour Organization Work in Fishing Convention (No.188) (ILO 188).

Printed copies of *Weston Bay*'s documented risk assessments were kept in the safety folder on board. The vessel safety section contained risk assessments for fire, steering failure, watchkeeping, and other hazards. There were no documented risk assessments for MOB events or drills. There had been no recorded revisions to the original draft dated 10 November 2022.

The safety folder contained a section to guide operators through completing and documenting formal risk assessments and to help users identify and mitigate hazards. The safety folder provided tabbed sections for:

- health and safety policies
- crew training and certification records
- crew induction records
- hazard identification through risk assessments
- emergency checklists and drills
- lifesaving appliance (LSA) equipment records
- vessel stability.

On crew competence, *Weston Bay*'s risk assessments identified the hazard of *new crew* and the risk of *inexperience of crew leading to mistakes and injuries*, for which the documented control was *Introduction*.

The hazards of *becoming entangled in the pots and pulled into the water leading to death or serious injury* and *being struck by pots leading to death or serious injury* had been identified in the potting section of *Weston Bay*'s risk assessments. The risk outcome section was blank, with the risk level detailed as low. The documented control measure was *roller system no lifting over side*.

### 1.5.7 Safety equipment

*Weston Bay*'s safety equipment included five 150N[9] PFDs that were compliant with EN ISO[10] 12402-3:2020[11]. The PFDs were designed to automatically inflate on entering the water and could also be manually inflated. The PFDs were secured in place by the wearer with a buckled adjustable waist strap; there was no requirement in the ISO standard for a crotch strap.

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

[10] European Norm (EN) standards adopted from International Organization for Standardization (ISO) standards.

[11] Personal flotation devices Part 3: Lifejackets, performance level 150 – Safety requirements.

Posters and donning instructions displayed on board *Weston Bay* referred to the availability of foam-filled lifejackets for abandon ship purposes. There were no posters for the auto-inflate PFDs, nor any instructions for how these should be worn.

A six-person liferaft was stowed on top of *Weston Bay*'s weather deck on the port side. There were also four individual lifebuoys inboard of the upper handrails, two each on the port and starboard sides.

The most recent recorded check of *Weston Bay*'s safety equipment had been carried out by Fastline's shore engineer in May 2024. No defects or general remarks on condition were recorded for the items inspected.

### 1.5.8 Man overboard recovery equipment

*Weston Bay* was equipped with an Ocean Safety emergency ladder to assist in MOB recovery **(Figure 6)**. The ladder was made from polyester webbing and packed into a waterproof bag with adjustable metal buckles that could be attached to a handrail. The deployed length of the emergency ladder was 2.5m and its safe working load was 175kg. When new, the ladder complied with ISO 15085:2003/ Amendment 2:2017[12]. The ladder was designed as a pull-down ladder that could be reached from the water and required the person in the water to be able to assist with their recovery.

*Weston Bay*'s emergency ladder was stored on the port side of the working deck. Post-accident examination of the ladder's two fastening straps found they were broken and displayed signs of corrosion **(Figure 6)**. The rest of the ladder was unavailable for inspection as it was lost at sea during the accident.

Image courtesy of Ocean Safety

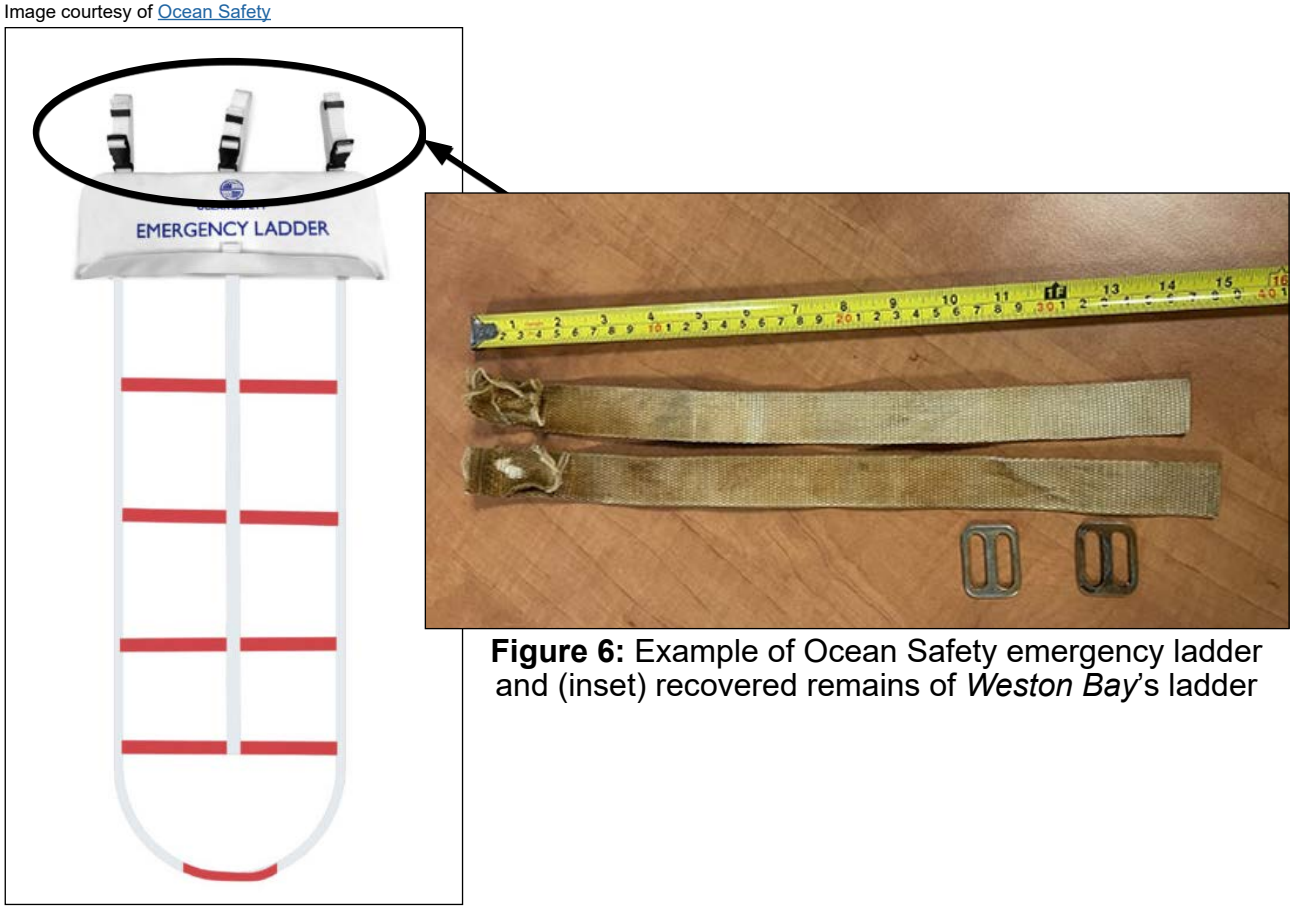


**Figure 6:** Example of Ocean Safety emergency ladder and (inset) recovered remains of *Weston Bay*'s ladder

[12] ISO 15085 Small craft — Protection from falling overboard and means of reboarding.

### 1.5.9 Manoverboard drills

*Weston Bay*'s safety folder recorded that MOB drills were completed on the 20th of each month, with the most recent recorded in November 2023. During MOB drills the skipper showed the crew the stowed locations of the vessel's LSAs, including the Emergency Position Indicating Radio Beacon, first aid kit and pyrotechnics. None of this equipment was used or demonstrated during these drills.

## 1.6 MANDATORY BASIC TRAINING

### 1.6.1 General

Fishermen serving on board UK registered fishing vessels were required to complete mandatory safety training courses as detailed in the MCA's Marine Guidance Note (MGN) 411 (M+F)[13].

Seafish delivered the majority of fishermen's training throughout the UK via its network of 19 approved training providers. Some STCW[14] basic safety training courses were also delivered by alternative MCA approved training providers. There was no STCW alternative for the Safety Awareness and Risk Assessment course and only Seafish approved training providers could deliver this course.

Four courses formed the mandatory basic training requirement. Before starting work on board a UK fishing vessel, new entrants were required to complete the 1-day Basic Sea Survival training course. Within 3 months of starting work, the 1-day Basic First Aid, 1-day Basic Fire Fighting, and 1-day Basic Health and Safety training courses were required to be completed. The MCA had agreed that fishermen could complete the STCW Personal Survival Techniques, Fire Prevention and Fire Fighting, and Elementary First Aid courses in place of the new entrant courses.

### 1.6.2 Seafish Basic Sea Survival

The 1-day Basic Sea Survival training course for new entrants to the fishing industry conformed to STCW requirements. The course specification included the requirement for both an instructor-led demonstration of PFD operation as well as the practical use of a PFD by each participant.

### 1.6.3 Seafish Basic Health and Safety

The 1-day Basic Health and Safety course was designed to conform to the requirement set out in the Fishing Vessels (Safety Training) (Amendment) Regulations 2004 that all fishermen should undergo training in basic health and safety. The course aimed to provide new entrants to the fishing industry with the knowledge and skills required to work safely on fishing vessels. The course objective was that by the end of the training participants would understand:

- *the basic terminology associated with work in the fishing industry*
- *their personal roles and responsibilities*

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

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

- *their rights and responsibilities under ILO188*
- *the dangers associated with work on a fishing vessel*
- *the skills required to work safely on board a fishing vessel*

An approved training provider delivered the course in a classroom via a PowerPoint presentation. The syllabus, detailed in **Table 2**, comprised a 15-minute introduction followed by six training sessions and a final multiple-choice theory test.

Formative assessment was required throughout the training to ensure that attendees were achieving the defined learning objectives. Summative assessment was completed at the end of each session and required active participation in group discussions and skills activities. A certificate was issued on successful completion of the course and final assessment.

| Session | Learning objectives |
|---|---|
| Know the industry<br>(1 hour and 15 minutes) | • Explain the fishing methods employed within the industry<br>• List the areas where the Law applies to fishing vessels<br>• Understand the terms hazard and risk<br>• List the dangers associated with fishing |
| Know your vessel<br>(1 hour) | • List essential vessel terminology<br>• Describe key vessel safety features<br>• Explain the operations which keep a vessel safe<br>• Put on an approved lifejacket in less than a minute |
| Roles and responsibilities<br>(30 minutes) | • List the responsibilities of common industry roles<br>• List the different ways you will be told of your responsibilities<br>• Explain how you can maximise your personal effectiveness |
| Safe working<br>(1 hour) | • List common dangers associated with working on a fishing vessel<br>• Identify the ways to minimise the risks associated with the common dangers<br>• Select appropriate PPE for use on fishing vessels |
| Safe fishing<br>(1 hour and 30 minutes) | • List the common dangers associated with different fishing methods<br>• Describe the ways to minimise the risks associated with the fishing and fishing activities<br>• Tie commonly used knots |
| Occupational health<br>(30 minutes) | • List common health issues associated with the industry<br>• Identify ways to look after their own health and mental well being |
| Final assessment<br>(1 hour) | • All learners to complete the final assessment paper |

**Table 2:** Seafish Basic Health and Safety course syllabus

### 1.6.4 Seafish Safety Awareness and Risk Assessment course

Experienced fishermen were required to complete the 1-day Safety Awareness and Risk Assessment course. MGN 411 (M+F) defined experienced fishermen as those with 2 years' experience or more. The course was designed to conform to the basic requirements of the Fishing Vessels (Safety Training) (Amendment) Regulations 2004 and aimed to *improve the safety culture on board fishing vessels through the management of safety*. The course objective was that by the end of the training participants would:

- *Understand the legal requirements that control safety in the fishing industry*
- *Understand health and safety hazards and risks*
- *Be able to complete a risk assessment for a fishing vessel*
- *Be able to develop a safety management system for a fishing vessel*

An approved training provider delivered the course in a classroom via a PowerPoint presentation. The syllabus, detailed in **Table 3**, comprised five sessions. Course completion was achieved through attendance and there was no final assessment.

| Session | Learning objectives |
|---|---|
| Legal principles<br>(1 hour) | • List the key legal requirements applicable to working on fishing vessels<br>• Identify the sections of the safety folder<br>• Use the M-Notice system to locate suitable guidance |
| Safe crew<br>(1 hour and 15 minutes) | • List the key ILO 188 legal rights for crew<br>• List ways to maintain good health and mental wellbeing while working in commercial fishing |
| Vessel safety<br>(1 hour and 15 minutes) | • Identify hazards associated with vessel safety<br>• Complete the initial risk assessment document for vessel operations<br>• Recommend ways in which risk associated with vessel operations can be reduced |
| The engine room<br>(1 hour and 15 minutes) | • Identify hazards associated with engine rooms<br>• Complete the initial risk assessment document for engine rooms<br>• Recommend ways in which risk in the engine room can be reduced |
| Fishing safety<br>(1 hour) | • Identify hazards associated with fishing activities<br>• Complete the initial risk assessment document for your own fishing activities<br>• Suggest ways in which risk can be reduced for your own fishing activities |

**Table 3:** Seafish Safety Awareness and Risk Assessment course syllabus

## 1.7 VOLUNTARY TRAINING

The voluntary Seafish Under 16.5m Skipper's Certificate (Restricted) comprised five modules:

- 2-day Bridge Watchkeeping
- 2-day Engine Room Watchkeeping
- 1-day Stability Awareness for Experienced Fishermen
- 1-day Advanced Stability Awareness
- 1-day RYA[15] GMDSS[16] Short Range (Radio Operator) Certificate

Completion of 5-day Seafish Bridge Watchkeeping and the MCA's 5-day Approved Engine Course 1 modules removed the 20nm range restriction from the certificate. Neither the Skipper's Under 16.5m (Restricted) course nor the Skipper's Under 16.5m (Unrestricted) course included risk assessment or safety management modules.

## 1.8 EFFECTS OF COLD WATER

Immersion in water temperatures of less than 15°C can result in cold water shock and/or cold incapacitation. Cold water shock typically occurs within the first 30 seconds to 2 minutes. It is characterised by a gasp reflex, hyperventilation, and a rapid increase in heart rate and blood pressure as the body encounters cold water. Panic can cause hyperventilation to continue after the initial physiological effects of cold water shock have subsided.

Cold incapacitation usually occurs within 2 to 15 minutes of entering the water. The blood vessels constrict as the body attempts to preserve heat and protect vital organs. This results in restricted blood flow to the extremities, causing cooling and subsequent deterioration in the functioning of muscles and nerve endings. Hands and feet lose useful movement, leading to the progressive incapacitation of arms and legs and impeding the ability to swim.

## 1.9 REGULATION AND GUIDANCE

### 1.9.1 Vessel inspection

Fishing vessels under 15m length overall were required to comply with MSN 1871 (F) Amendment No.2 and were subject to MCA surveys and inspections. Following successful inspection, vessels were issued with a Small Fishing Vessel Certificate (SFVC) valid for 5 years. Fishing vessel skippers were required to endorse the SFVC annually between MCA renewal inspections to confirm their vessel's ongoing conformity with MSN 1871 (F) Amendment No.2; the MCA deemed the SFVC

[15] Royal Yachting Association.

[16] Global Maritime Distress and Safety System.

to be invalid if the vessel or its operation deviated from the requirements. MSN 1871 (F) Amendment No.2 stated that the owner was responsible for ensuring the vessel was:

- *built, equipped, surveyed, inspected, certified, maintained and operated in accordance with the relevant provisions of the Code;*
- *subjected to a renewal inspection at intervals not exceeding five years;*
- *subjected to annual self-certification inspections in accordance with section 1.8;*
- *compliant with the requirements of the Code whilst registered as a Fishing Vessel;*
- *operated by appropriately qualified and certificated crew who have completed mandatory training courses.*

The MCA publication *Fishing Vessel Surveys and Inspections – How to prepare for your next MCA visit* provided advice for owners, skippers, and fishermen to ensure the successful outcome of an inspection or survey. To comply with the relevant Code requirements, the document required the fishing vessel's type and length to be checked before starting preparations and that the *most current amendment* was in use. The documents and evidence to be available for inspection were also listed. These included crew training certificates and safety awareness and risk assessment copies and noted that an MOB risk assessment *MUST be written*.

### 1.9.2 Annual self-certification

The validity of the SFVC was maintained on the basis that the owner completed the annual self-certification checks within 1 month either side of the SFVC's anniversary date. MSN 1871 (F) Amendment No.2 required four annual self-certification checks to be completed:

1. *safety equipment carried on board the vessel has been suitably maintained and serviced in accordance with the manufacturer's instructions;*
2. *the Vessel remains compliant with the requirements of this Code;*
3. *safety and other specified equipment continues to comply with the checklist appropriate to the length and construction of the vessel: and*
4. *a health and safety risk assessment has been completed and given or explained to the crew.*

By completing the annual self-certification inspection, the owner declared that the vessel remained compliant with MSN 1871 (F) Amendment No.2. The owner was required to sign the annual self-certification form and retain a copy on board for MCA inspection purposes.

### 1.9.3 Responsibility for safety

In March 2019, the MCA published MGN 587 (F) Amendment 1[17], which provided further guidance on the application of ILO 188. MGN 587 (F) Amendment 1 contained information and guidance on health and safety responsibilities and stated that:

- *A documented risk assessment is required, and safety measures put in place.*
- *All fishermen must have enough training so that they can work safely on board, including familiarization with on-board equipment and procedures.*
- *Each fisherman has a duty to look after their own health and safety and that of others working with them, and comply with the measures put in place for their safety.*

On the duties of the fishing vessel owner and skipper, the MGN stated that:

- *The fishing vessel owner … has overall responsibility to ensure that the skipper is provided with the necessary resources and facilities to comply with the Regulations. The fishing vessel owner should set the health and safety policy for the vessel so that the skipper is clear what is expected.*
- *While the fishing vessel owner always has overall responsibility, it is recognised that if they are not onboard their fishing vessel, they may have limited control of day to day activities. The Regulations provide that responsibility for health and safety also rests with any person who is in control of any particular matter. This will most likely be the skipper in respect of day to day running of the vessel.*
- *The **skipper** therefore has responsibility for the safety of fishermen on board the vessel and the safe operation of the vessel. In fulfilling their responsibility the MCA expects skippers to -*

a. *Provide supervision to ensure that fishermen work safely at all times;*

b. *Manage fishermen in a manner which respects safety and health, including prevention of fatigue;*

c. *Arrange regular on-board occupational safety and health awareness training.*

On capabilities and training, the MGN required that:

*When allocating duties on board, account shall be taken of the capabilities of crew members as regards health and safety. The risk assessment should identify those tasks which require specific training or familiarisation.*

[17] MGN 587 (F) Amendment 1 International Labour Organization Work in Fishing Convention (No.188) – Health and safety: responsibilities of fishing vessel owners, managers, skippers, and fishermen.

### 1.9.4 Personal flotation devices

It was a requirement in MSN 1871 (F) Amendment No.2 that fishermen must be provided with and wear PFDs or safety harnesses unless the risk of falling overboard was eliminated through other measures. The MSN referenced MGN 588 (F) Amendment 1[18], which included the minimum accepted performance levels for PFDs and specified that:

- *PFDs must always be worn in accordance with Manufacturers' donning instructions, which should be displayed in a prominent place.*
- *Correct adjustment/fitting to suit the wearer is essential, every time the PFD is donned (especially if the PFD is used by other crew members).*
- *Crew should be provided with training in the correct donning of their PFDs during their familiarisation training.*

### 1.9.5 Man overboard prevention

Guidance on the identification of hazards that might lead to an MOB situation was provided in MGN 571 (F)[19]. The MGN also included a risk review document designed to help fishermen assess and control the risks on board their vessels. On how to prevent crew from falling overboard, the guidance provided in Annex C included:

- *Ropes and lines should be separated from where crew stand to avoid the risk of standing in a bight or inside a line under tension.*
- *It should always be considered whether the task could be carried out in a way that removes the person from the area of risk, for example, by conducting the task by mechanical means.*

### 1.9.6 Means of recovering an unconscious person

Amendment No.2 of MSN 1871 (F) came into effect on 6 September 2021, which was 15 weeks after the MCA's most recent inspection of *Weston Bay*. The amended code required new and existing crewed vessels to have:

> *… efficient means of recovering an unconscious person from the water and enable a person in the water to get back on board the Vessel, either by a permanent boarding ladder or means deployable by the crew.*

### 1.9.7 Emergency drills and equipment

The skipper and crew were required under MSN 1871 (F) Amendment No.2 to conduct monthly emergency drills to ensure that:

> *… they are familiar in the use of all lifesaving and fire appliances and equipment with which the Vessel is provided and…that all members of the crew know where the equipment is stowed.*

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[18] MGN 588 (F) Amendment 1 – Compulsory Provision and Wearing of Personal Flotation Devices on Fishing Vessels. This was withdrawn and replaced by Amendment 2 on 30 April 2024.

[19] MGN 571 (F) – Fishing Vessels: Prevention of Man Overboard.

The MSN referred to MGN 570 (F) Amendment No.1[20], which provided specific guidance on MOB drills and stated *that drills should be conducted regularly, at least monthly, and also consider carrying out drills when 25% or more of the crew have changed*. MGN 570 (F) Amendment No.1 also advised operators to:

> *Make sure the retrieval equipment is usable with the levels of manning on board – ensure it can be operated by the crew if one of them has gone overboard.*

Emphasising that, *unless a person is rescued within 5 minutes, it is highly likely that they will be either unable to help themselves or be unconscious*, MGN 570 (F) Amendment No.1 stated that:

> *As time is vital, when deciding how to recover a person from the water, you should:*
>
> - *Have a plan for recovering a conscious person.*
> - *Have a plan for recovering an unconscious person.*
> - *Have a means to get hold of and recover an unconscious person.*
> - *Have equipment practical for the vessel.*
> - *Know how to use the equipment you have on board.*
> - *Practice using the equipment.*
> - *Conduct and record man overboard drills to familiarise your crew with the procedures.*
> - *Have written plans and procedures for recovering the casualty for the benefit of the crew.*

The MSN required lifesaving equipment and fire appliances to be inspected at least monthly.

### 1.9.8 Fishing vessel safety management

The MCA's MGN 596 (F)[21] was published to assist fishing vessels to follow the guidance in MGN 587 (F) Amendment 1 and comply with MSN 1871 (F) Amendment No.2. MGN 596 (F) encouraged the creation of a safety management system (SMS) for fishing vessels and recommended that the documentation developed and records maintained should include, among others:

- *The Safety Management Manual;*
- *Company Safety and Environment Policies;*
- *All crew certification and training records;*

[20] MGN 570 (F) Amendment No.1 – Fishing vessels: emergency drills.

[21] MGN 596 (F): Fishing Safety Management Code: Helping to Improve the Management of Safety on Fishing Vessels.

- *Vessel Operation (operating procedures and the risk assessment);*
- *Testing/Certification relating to the lifesaving appliances and fire-fighting equipment;*
- *Records of drills and safety training.*

### 1.9.9 Guidance

The MCA's Fishermen's Safety Guide offered guidance on how to identify hazards, implement control measures to mitigate risks, and enhance safety on board fishing vessels. The guide also addressed hazards such as slipping, tripping, and falling overboard and reiterated the mandate in MSN 1871 (F) Amendment No.2 on the use of PFDs and harnesses. The guide emphasised that:

> *It is now the law that you must wear a PFD or a lifeline unless you have eliminated the risk of going overboard and documented this in a written risk assessment*

The Fishermen's Safety Guide highlighted the dangers of shooting pots and advised crew to keep clear of ropes and pots, highlighting safety lessons from the *Pauline Mary* (MAIB report 8/2017[22]) and *Enterprise* (MAIB report 5/2018[23]) fatal MOB investigations involving crew members who became entangled in fishing gear and were dragged overboard.

The Fishing Industry Safety Group (FISG)[24] Home and Dry online safety campaign[25] provided guidance to the fishing industry on conducting emergency drills, PFD use, reboarding vessels from the water and the importance of risk assessments.

Published in January 2011, the Seafish FS45 Potting Safety Industry Advisory Note (Seafish advisory note)[26] highlighted hazards such as *snagged in rope when shooting* and addressed safety concerns in the potting sector of the UK fishing industry. The Seafish advisory note offered guidance on safe practices, including an example of a self-shooting system that did not require manual intervention. The Seafish advisory note further highlighted that the examples of self-shooting systems described were designed *specifically for each vessel layout and to the individual skippers' requirements*, and that any system adopted must therefore be developed as such.

The Seafish advisory note also emphasised the need for improved safety measures, including safety barriers, the use of PFDs and effective MOB recovery systems, to mitigate risks and enhance the safety of fishermen engaged in potting activities. On crew competence, the Seafish advisory note highlighted that:

> *Owing to reduced or static levels of income in the sector it may be more difficult to attract and retain experienced and competent crew. Inexperienced crew are more likely to be involved in an accident.*

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[22] MAIB report 8/2017: Pauline Mary

[23] MAIB report 5/2018: Enterprise

[24] The FISG was set up with the goal of zero preventable deaths on fishing vessels and includes the MCA, fishermen's associations, RNLI and Shipbuilders & Shiprepairers Association.

[25] Home and Dry is a safety campaign and website run by FISG to share vital fishing safety information and guidance with fishers.

[26] Seafish FS45 Potting Safety Advisory Note

The RNLI provided online safety advice[27] aimed at reducing fatalities and injuries within the UK fishing industry. The guidance highlighted critical areas such as wearing and maintaining PFDs and implementing effective MOB recovery solutions. The site provided examples of easy to deploy recovery methods, including tyre lines, weighted ladders, and haul-out systems, and featured real-life accounts from fishermen who had experienced MOB incidents.

## 1.10 SIMILAR ACCIDENTS

### 1.10.1 Man overboard incidents

The MAIB received 126 reports of MOB occurrences from UK fishing vessels between 2013 and 2023, of which 47 (37%) occurred on potting vessels. Of these 47 occurrences, 26 (55%) resulted in fatalities. A causal factor identified in 11 of the accidents was the absence of a physical separation from the gear for the crew member, resulting in entanglement when shooting. Of the 11 crew who lost their lives, nine were not wearing a PFD.

The year-end Seafish records for 2023 showed that there were 1,843 vessels engaged in potting operations across the UK, representing 47% of the total fishing fleet by number.

### 1.10.2 *Enterprise* – man overboard

On 6 November 2017, a deckhand on board the 8.95m potting vessel *Enterprise* died after becoming caught and dragged overboard by a moving back rope (MAIB report 5/2018[28]). Despite being hauled to the surface 15 minutes later, the two remaining crew members could not recover the deckhand back on board until lifeboat assistance arrived about 40 minutes later. He was transferred to hospital but could not be resuscitated.

The investigation found that the deckhand became entangled in the fishing gear after leaving a ‘safe area’ behind pound boards, which had separated him from the running lines. There was no apparent reason for the deckhand to leave the ‘safe area’. The deckhand had crossed over the moving back rope on previous occasions, indicating that he did not fully appreciate the risk of entanglement. No recommendations were made in the report.

### 1.10.3 *North Star* – man overboard

On 5 February 2018, a crew member on the 16.46m creel[29] fishing vessel *North Star* was dragged overboard after his leg became entangled in the fishing gear as the crew were shooting creels (MAIB report 19/2018[30]). The crew recovered him back on board about 10 minutes later. He was unconscious and unresponsive and, despite CPR being carried out for over an hour, the crew were unable to revive him. The investigation identified that the vessel’s documented risk controls did not reflect the operational practice on board. The crew underestimated the risks associated with becoming entangled in the back rope and dragged overboard. Shooting operations

[27] RNLI Rigged and Ready safety advice

[28] MAIB report 5/2018: Enterprise

[29] An alternative term for pot, typically used in Scotland.

[30] MAIB report 19/2018: North Star

did not follow published industry good practice. The safety drills held on board were 'discussions' rather than practical exercises that allowed the crew to practice man overboard procedures.

A recommendation was made to the MCA to improve the support and guidance it provided to commercial fishing vessel owners, and to the operator to further improve the overall safety of its crews.

### 1.10.4 *Nicola Faith* – capsize and sinking

On 27 January 2021, the 9.81m whelk potter *Nicola Faith* capsized and sank with the loss of its three crew members (MAIB report 8/2022[31]). The investigation found that the vessel was operated in an unsafe manner and without effective risk assessments in place to mitigate the hazards associated with its operation. Two of the three crew members had not completed any of the mandatory training, which possibly affected the crew's ability to assess hazards and implement their onboard risk assessments.

### 1.10.5 *Kingfisher* – man overboard

On 12 July 2024, the crew of the 18.35m fishing vessel *Kingfisher* were manually shooting a string of creels when a deckhand became entangled in a leg rope and was pulled overboard (MAIB report 12/2025[32]). Despite the deckhand's PFD automatically inflating, he was pulled underwater by the weight of the gear. *Kingfisher*'s crew retrieved the fishing gear and recovered the submerged deckhand on board within 7 minutes, but he could not be revived.

The investigation found that:

- The deckhand inadvertently threaded the creel toggle through his PFD's safety loop while connecting the toggle to the eye of the leg rope.
- The lifting strop (becket) of the deckhand's PFD created a snagging hazard.
- The vessel's onboard risk assessment had not identified the hazard posed by the becket.

The MAIB issued a safety bulletin 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.

[31] MAIB report 8/2022: Nicola Faith

[32] MAIB report 12/2025: Kingfisher

# SECTION 2 – ANALYSIS

## 2.1 AIM

The purpose of the analysis is to determine the contributory causes and circumstances of the accident as a basis for making recommendations to prevent similar accidents occurring in the future.

## 2.2 OVERVIEW

James (Jimmy) Haughey entered the water while attempting to assist deckhand 1, who had been knocked to the deck by the shooting pots. Deckhand 1 was subsequently taken overboard by the running gear where they were joined by deckhand 2 shortly after. No one witnessed deckhand 2 entering the water and the mechanism of how he came to be there is unknown. However, once in the water, and having become separated from his PFD, deckhand 2 was unable to maintain his airway clear of the sea surface and lost consciousness. Despite being recovered to another vessel, he could not be resuscitated.

The analysis will consider the factors contributing to the MOB, including the vessel's operational practices; the crew's actions; training; MOB recovery practices; and the efficacy of training available to the UK fishing industry.

## 2.3 *WESTON BAY*

### 2.3.1 The accident

Deckhand 2 probably reacted impulsively when going to assist deckhand 1, who had been knocked to the deck. With consecutive pots continuously deploying, there was little time to stop and assess the unfolding situation or separate himself and deckhand 1 from the running gear. The next pot in sequence struck deckhand 1, taking them into the sea. Once deckhand 1 and deckhand 2 had entered the water, their survival depended on maintaining their airways above the sea surface and being recovered back on board. Although both wore a PFD on deck, deckhand 2's PFD became detached from him in the water, leaving him unsupported.

Deckhand 2 had worked as a fisherman for 5 years and had completed the mandatory sea survival course. Although he was a strong swimmer and in good physical health, he quickly succumbed to the effects of the cold water once his PFD became detached. At this point, he could no longer assist in his recovery and became reliant on the crew for help. Although the benefit of a PFD was still contingent on the crew's ability to recover deckhand 2, his chances of surviving a man overboard without a PFD in a water temperature of 10°C were much reduced.

It is unknown why deckhand 2 became separated from his PFD, but it might have been because the PFD lacked crotch straps and depended on the waist strap being sufficiently tight to hold it in place. MGN 588 (F) Amendment 1 emphasised the importance of ensuring PFDs were appropriate for the task and correctly fitted. The manufacturer's instructions for the PFDs worn on board *Weston Bay* were not displayed, and the crew had not received instruction in how to wear them. This meant that there was no assurance on board that PFDs would be worn correctly and

in line with the manufacturer's instructions. This increased the risk to the crew during a man overboard event as an incorrectly worn PFD could come off or fail to function as intended.

Once deckhand 2 entered the water, and without the support of his PFD, he quickly succumbed to the effects of cold incapacitation. Unable to keep his airway clear of the water, he drowned before he could be recovered.

### 2.3.2 Method of shooting pots

*Weston Bay* operated a self-shooting system to deploy its strings of pots, which kept most of the crew separated from the gear. However, due to the number of pots per string and the height of the stack, a deckhand was required to physically downstack each pot sequentially as it deployed to reduce the risk of the pots fouling. Consequently, *Weston Bay*'s shooting method did not function as a true self-shooting system as it required manual intervention.

Both the Fishermen's Safety Guide and the Seafish advisory note provided practical recommendations to reduce the risks associated with potting operations, particularly those involving crew interaction with gear during deployment. Both publications emphasised the importance of separating the crew from the shooting gear, and the Seafish advisory note highlighted that selfshooting systems must be designed to fit the vessel's requirements and layout.

As *Weston Bay*'s pots were permanently attached to the back rope, great care needed to be taken to ensure that they were downstacked correctly without causing them to be shot out of sequence. During previous incidents of *Weston Bay*'s pots fouling and being shot in a bunch, the deckhand had been able to jump clear in time to prevent them being taken overboard. The lack of negative outcomes in these previous incidents might have contributed to the crew underestimating the risks associated with the shooting method.

The safety benefits of a self-shooting system are negated when physical interaction is required during the process, as highlighted in the cases involving *Enterprise*, *Kingfisher* and *North Star*. It remains a concern that, despite existing safety guidance and numerous previous occurrences, fishermen do not appear to appreciate fully or mitigate the risk of entanglement during shooting operations.

*Weston Bay*'s method of deploying its pots increased the risk of crew entanglement. The absence of physical separation for crew working proximate to the running gear highlighted a shortfall in deck safety and exposed the crew to an unnecessary risk of entanglement and harm.

### 2.3.3 Crew experience

Deckhand 1 had only worked in the fishing industry for 6 months before the accident and previously fished on a potting vessel with a different system of shooting pots that did not require downstacking. The accident on *Weston Bay* occurred during deckhand 1's first week on board, and only their second time operating at that station. It is unclear why deckhand 1 selected the wrong pot in sequence; however, their limited experience of downstacking combined with task unfamiliarity and the speed of the operation likely contributed to their decision-making. This led to increased risks without sufficient guidance and oversight.

The Seafish advisory note highlighted that inexperienced crew are more likely to be involved in an accident and ILO 188 emphasised that it was important to consider crew capabilities when allocating duties on board. Recognising this, the hazard of *new crew* and the risk of *inexperience of crew leading to mistakes and injuries* were identified in *Weston Bay*'s risk assessments. Despite this, the task of working the stack, arguably one of the highest risk jobs on *Weston Bay*, was allocated to one of the least experienced crew members on board.

The hazards associated with inexperienced crew were recognised and highlighted in available regulation and guidance. However, *Weston Bay*'s crew allocation on the day did not consider this. Deckhand 1 was therefore faced with working on an unfamiliar task in front of the pot stack as the pots were being deployed, which placed them at risk of injury and harm.

### 2.3.4 Man overboard recovery

*Weston Bay*'s Ocean Safety emergency ladder was in very poor condition and began to fail as soon as the crew attempted to use it. Although the crew were able to haul deckhand 1 on board using the ladder as an improvised scramble net, the ladder catastrophically failed and fell apart when deckhand 2, who was approximately 46kg heavier than deckhand 1, attempted to use it. The crew then had no available means to recover deckhand 2 on board.

*Weston Bay* was required to have a means of recovering a person from the water in line with MSN 1871 (F) Amendment No.1 at the time of the vessel's most recent MCA inspection. MSN 1871 (F) Amendment No.2, which came into force 15 weeks after that inspection, required both new and existing vessels to have a means to recover an *unconscious* person from the water. Amendment 2 had been in force for two and a half years before the accident, and *Weston Bay*'s next inspection was due in 2026. It is difficult to see how the vessel's noncompliant arrangement could have been identified before then.

The requirement in MSN 1871 (F) Amendment No.2 was for monthly inspections of lifesaving equipment, and for emergency equipment to be maintained in a condition that ensures functionality when needed. Despite the safety equipment inspection records showing no issues in May 2024, it was evident from the ladder's poor condition that it had not been properly inspected for some time. This meant that the ladder's deteriorated condition went unnoticed, with the result that it failed when most needed.

*Weston Bay*'s MOB emergency ladder required active participation from the person in the water to assist in their own recovery. The ladder did not provide a means of recovering an unconscious person, and did not meet the updated requirements of MSN 1871 (F) Amendment No.2. There is no indication that the MCA inspection highlighted the upcoming change in requirement or identified that the provided means of recovery was unsuitable for the recovery of an unconscious person.

It is evident that the emergency ladder provided on *Weston Bay* was not suitable for recovering an unconscious person from the water. This was contrary to updated requirements and placed the crew at risk in an MOB event. Additionally, *Weston Bay*'s crew had not conducted regular inspections of the vessel's MOB recovery equipment, which resulted in the ladder's significant deterioration going

unnoticed and failing catastrophically when most needed. The ladder's degraded condition hampered the crew's ability to recover deckhand 1 and its failure meant the ladder was completely ineffective to recover deckhand 2.

### 2.3.5 Emergency drills and preparedness

*Weston Bay*'s crew had not routinely conducted emergency drills, with the most recent being recorded 6 months before the accident. Although the skipper had shown the crew the stowed locations of the vessel's LSAs, the equipment was neither checked nor demonstrated. This resulted in missed opportunities for the crew to recognise the limitations of their emergency equipment and the challenges of recovering an unconscious person from the water. The lack of MOB drills could also have affected the crew's ability to assess and consider alternative MOB recovery options. Despite the efforts by *Weston Bay*'s skipper to enter the water and assist deckhand 2 and the crew's attempts to pull him up and on board, neither method was successful.

The MSN 1871 (F) requirement for monthly emergency drills provided the opportunity for crew members to familiarise themselves with the vessel's LSA and understand their emergency roles. Additionally, MGN 570 (F) Amendment No.1 outlined that realistic drills were essential for establishing effective procedures, identifying defective equipment, and preparing the crew to respond to emergencies. However, and as found in the case of *North Star*, realistic practical MOB drills were not routinely carried out on *Weston Bay* and impacted the crew's emergency preparedness. Practical MOB drills using an MOB training manikin under simulated conditions might have better prepared the crew for the urgency and challenges of a real recovery. Conducting regular drills can encourage the development of well-thought-out and workable procedures. Discussions and demonstrations of the vessels' LSA are no substitute for realistic, practical drills, especially when considering the high fatality rate associated with MOB incidents in the UK potting sector.

Despite deckhand 2 surviving his initial cold water immersion and being able to reach the stern of *Weston Bay* he was still at risk of drowning unless he was recovered quickly. Deckhand 2 was in the water for 44 minutes before the pilot vessel arrived, deployed its MOB recovery system and recovered him.

*Weston Bay*'s crew did not regularly carry out MOB drills and did not consider alternative methods of MOB recovery. This meant that they were unfamiliar with the vessel's man overboard recovery equipment and its limitations, which left them unprepared to rescue a casualty.

### 2.3.6 Responsibility for safety

Fastline was required to ensure that *Weston Bay* complied with the requirements of MSN 1871 (F) Amendment No.2 by setting the health and safety policy for vessels in its fleet. This included conducting risk assessments and completing the annual self-certification checks to verify that the vessel's risk assessments remained suitable for the fishing method and mode of operation. Additionally, the annual self-certification check provided an opportunity to verify that crew training and certification remained valid.

The guidance in MGN 587 (F) Amendment 1 recognised that the vessel's owner might have limited control of operational activities and Fastline left the day-to-day running of *Weston Bay* to the skipper. However, there were no written delegations of responsibility to the skipper and Fastline provided no formal oversight. Consequently, neither *Weston Bay*'s owner or skipper ensured that risk assessments reviews and annual self-certification checks were conducted, or that the required crew safety training was completed.

The lack of formal delegation and oversight of safety responsibilities on *Weston Bay* resulted in gaps in compliance with mandatory safety requirements and reduced the company's ability to maintain the required safety standards. This placed the crew and vessel at risk.

### 2.3.7 Risk management

*Weston Bay*'s risk assessments had not been reviewed since their completion in November 2022. Although the risk assessment for shooting pots identified the hazard of entanglement, the stated control measures of *Roller system no lifting over side* seemed to relate to hauling pots and did not address the hazards of shooting. Additionally, the outcome of the hazard was recorded as low and it therefore underestimated the high level of risk associated with this operation. The stated control measures for the identified hazards did nothing to mitigate the risks to the crew. The Seafish safety folder included guidance to support the hazard identification and risk control process; however, *Weston Bay*'s documentation lacked risk assessments for foreseeable emergencies such as MOB incidents, despite including assessments for other hazards such as fire. This absence of documentation and any consideration for the foreseeable emergency of an MOB increased the risks to crew.

Risk assessments have been mandatory on fishing vessels since 1998. To comply with MGN 587 (F) Amendment 1 and ILO 188, fishing vessels were required to have suitable and sufficient documented risk assessments for all work activities. A robust risk assessment should identify all hazards that the vessel and crew could reasonably expect to encounter during operation. When properly implemented, risk assessments contribute to risk management and improved safety by focusing attention on what actions and measures can be taken to reduce the likelihood of an incident occurring and identifying potential hazards and dangers on board a vessel. To be fully effective, risk assessments must be clearly documented, regularly reviewed, and communicated to all crew members, ensuring that the safety procedures are understood and adhered to in daily practice.

It is apparent from this and other similar accidents, such as *North Star*, that operators and crews do not always use risk assessments effectively, which diminishes their value as a tool to improve safety and safeguard lives. It is possible that some fishermen do not complete risk assessments, or do so ineffectively, because they do not fully appreciate their purpose. For example, risk assessments might be perceived as a paperwork exercise conducted for compliance purposes rather than an effective safety tool.

It is evident that *Weston Bay*'s risk management process was ineffective in protecting the safety of the vessel's crew as some of the identified hazards lacked effective mitigation control. This meant that the hazards involved in shooting pots persisted, placing the crew at risk of harm. Additionally, there were no risk

assessments for MOB recovery, and the danger resulting from going over the side had not been highlighted. This probably contributed to the crew being unprepared to resolve this type of emergency and exposed them to significant risks of injury and harm.

### 2.3.8 Crew training and certification

Deckhand 4 had not completed three out of the four mandatory basic training courses, including the Basic Health and Safety course. These courses were required to be completed within 3 months of joining the industry, yet remained incomplete after 6 months. This lack of compliance had gone unnoticed by *Weston Bay*'s owner and skipper, and the vessel's annual self-certification checks had not been completed in the 2 years before the accident. The last MCA inspection had been conducted 3 years before the accident, two and a half years before deckhand 4 entered the industry, and the next inspection was not due for another 23 months. This meant that opportunities to recognise and rectify deficiencies in deckhand 4's training were missed, and the mandatory requirement was not enforced.

Incomplete mandatory safety training has been a finding in numerous investigations, including *Nicola Faith*. Despite the accessibility of Seafish safety training throughout the UK via a network of approved training providers, some fishermen appear reluctant to complete even the compulsory courses. This might be because training has been viewed as a regulatory compliance activity rather than a valuable tool to improve crew safety.

It is evident that Fastline were not effectively verifying that its fishermen had completed all mandatory training, resulting in *Weston Bay* sailing without a fully trained and certified crew. With MCA SFVC inspections conducted every 5 years and only providing a snapshot of activities on the day, there appeared to be a lack of an enforcement mechanism to prevent vessels from operating with a crew training deficit. The 5-yearly MCA inspection cycle meant that the incomplete mandatory training courses went unenforced between inspections, resulting in a potential lack of crew safety skills. This placed the responsibility on skippers and owners to complete the necessary checks to ensure compliance, which did not happen on board *Weston Bay*.

## 2.4 TRAINING COURSES

### 2.4.1 Basic Health and Safety and Safety Awareness and Risk Assessment Training

*Weston Bay*'s skipper had completed the 1-day Basic Health and Safety and the 1-day Safety Awareness and Risk Assessment courses and had also undertaken voluntary refresher training in the latter. Deckhand 2 and deckhand 3 had both completed the Safety Awareness and Risk Assessment course and deckhand 1 had completed the Basic Health and Safety course as required. This meant that only deckhand 4 was deficient, having not completed the Basic Health and Safety course. Despite the level of completed training, and the skipper's voluntary refresher training, there were indications that risk and safety were not well-managed on board *Weston Bay* (see section 2.3.6). This indicated that the basic health and safety training was potentially ineffective at equipping fishermen with the necessary skills to operate a vessel safely.

The 1-day basic Health and Safety and 1-day Safety Awareness and Risk Assessment courses were designed to provide fishermen with the knowledge and skills to work safely in the fishing industry and to enhance the safety culture by improving safety management. Both theory-based courses were delivered in a classroom setting via PowerPoint presentations. The training was divided into subsections and covered numerous health and safety-related subjects, ranging from legal principles to occupational health, risk assessments, vessel operations and safety management. Classroom-based training that relies heavily on PowerPoint presentations might not be the most effective method for developing practical skills. Safety training, particularly in the fishing industry, benefits from hands-on experience and realistic scenarios to reinforce key safety messages. Without interactive sessions or practical demonstrations, participants could find it difficult to put theoretical knowledge into practice. An extended course with more interactive learning methods and practical application opportunities would likely enhance learning retention and safety awareness among participants.

This accident happened despite four of the five *Weston Bay* crew members having completed the appropriate safety training for their level of experience and, therefore, theoretically having the knowledge and skills required to work safely on fishing vessels. Given the broad range of subjects covered during each 1-day course, it is unlikely that the training provided participants with sufficiently embedded safety knowledge to apply in their daily routines.

The delivery of the basic Health and Safety and the Safety Awareness and Risk Assessment training courses and the wide-ranging syllabuses might have been ineffective at achieving the course aims. This meant that participants did not have a full appreciation of how to identify and effectively manage potential risks for their safety and that of others.

### 2.4.2 Seafish Under 16.5m Skipper's Certificate (Restricted)

*Weston Bay*'s skipper had completed the Seafish Under 16.5m Skipper's Certificate (Restricted) qualification. The course provided experienced fishermen with essential knowledge in navigation, stability awareness, radio operation, and engine room watchkeeping to enhance their ability to safely operate their under 16.5m vessels. However, unlike other training for experienced individuals in the fishing industry, this certificate did not include a module dedicated to safety management and risk assessment.

The absence of a standalone formal training module in safety management and risk assessment for both the restricted and unrestricted Seafish Under 16.5m Skipper's Certificate presented a significant safety gap for fishermen. This was because there was no dedicated instruction within the syllabus on how to identify hazards, conduct risk assessments and implement control measures. Without this module the course did not provide participants with the skills to approach health and safety at all levels of their operation, potentially restricting their ability to implement effective safety measures on board their vessels.

# SECTION 3 – CONCLUSIONS

## 3.1 SAFETY ISSUES DIRECTLY CONTRIBUTING TO THE ACCIDENT THAT HAVE BEEN ADDRESSED OR RESULTED IN RECOMMENDATIONS

1. Deckhand 2 died because he was unable to keep his airway clear of the water without the support of a PFD when he lost consciousness after being taken overboard. Once deckhand 2 entered the water, he quickly succumbed to the effects of cold incapacitation and drowned before he could be recovered. [2.3.1]

2. The downstacking method meant that crew were working close to the running gear with no physical separation or means to prevent them being taken overboard. This exposed deckhand 1 to a significant risk of injury and harm. [2.3.2]

3. The crew allocation had not considered the risks of inexperienced crew. This meant that deckhand 1 was faced with working on an unfamiliar task in the hazardous position in front of the pot stack as the pots were being deployed, which placed them at risk of injury and harm. [2.3.3]

4. *Weston Bay*'s crew did not regularly carry out MOB drills and did not consider alternative methods of MOB recovery. This meant that they were unfamiliar with the vessel's MOB recovery equipment and its limitations, which left them unprepared to rescue a casualty. [2.3.5]

## 3.2 SAFETY ISSUES NOT DIRECTLY CONTRIBUTING TO THE ACCIDENT THAT HAVE BEEN ADDRESSED OR RESULTED IN RECOMMENDATIONS

1. There were no donning instructions for the PFDs worn on *Weston Bay* and crew had not been instructed in their use. This increased the risk that crew did not know how to wear them correctly, potentially placing them at risk from an improperly functioning PFD on entering the water. [2.3.1]

2. The ladder provided on *Weston Bay* was unsuitable for recovering an unconscious person from the water. This was contrary to updated requirements and placed the crew at risk during an MOB event. [2.3.4]

3. *Weston Bay*'s crew had not conducted regular inspections of the vessel's MOB recovery equipment, which resulted in the ladder's significant deterioration going unnoticed and, ultimately, its catastrophic failure. The ladder's degraded condition hampered the crew's ability to recover deckhand 1 and its failure meant the ladder was completely ineffective to recover deckhand 2. [2.3.4]

4. The lack of delegation and formal oversight of safety responsibilities on *Weston Bay* resulted in gaps in compliance with mandatory safety requirements, placing the vessel and crew at risk. [2.3.6]

5. *Weston Bay*'s risk management process was ineffective in protecting the health and safety of its crews because some of the identified hazards lacked effective mitigation controls. This meant that the hazards involved in shooting persisted, placing crew at risk. [2.3.7]

6. There were no risk assessments for MOB recovery on *Weston Bay*, and the danger resulting from going over the side had not been highlighted. This probably contributed to the skipper and crew being unprepared to resolve this type of emergency. [2.3.7]

7. The 5-yearly MCA inspection cycle meant that the incomplete mandatory training courses went unenforced between inspections, resulting in a potential lack of crew safety skills. This placed the responsibility on owners and skippers to complete the necessary checks to ensure compliance, which did not happen on board *Weston Bay* [2.3.8]

8. The delivery of the Basic Health and Safety and the Safety Awareness and Risk Assessment training courses and the wide-ranging syllabuses might have been ineffective at achieving the course aims. This meant that participants did not have a full appreciation of how to identify and effectively manage potential risks for their safety and that of others. [2.4.1]

9. The Under 16.5m Skipper's Certificate (Restricted) and Under 16.5m Skipper's Certificate (Unrestricted) did not include a module on safety management and risk assessment. This meant that the course did not provide participants with the skills to approach health and safety at all levels of their operation, potentially restricting their ability to implement effective safety measures on board their vessels. [2.4.2]

# SECTION 4 – ACTION TAKEN

## 4.1 MAIB ACTIONS

The **MAIB** has issued a safety flyer to the fishing industry **(Annex A)**.

## 4.2 ACTIONS TAKEN BY OTHER ORGANISATIONS

**Fastline Shellfish Limited** has:

- Revised and adapted its MOB recovery systems so that its vessels now have means of recovering an unconscious person from the water.

- Ensured that its crew follow the guidance in MGN 588 (F) Amendment 1 and wear their working PFDs in line with the manufacturer's instructions and the vessel's risk assessments.

- Ensured that its crews conduct regular manoverboard drills with a focus on the recovery of an unconscious person.

# SECTION 5 – RECOMMENDATIONS

**Seafish** is recommended to:

**2026/131** Review its 1-day Basic Health and Safety and 1-day Safety Awareness and Risk Assessment training content and develop courses with a specific focus on prevention of shipboard accidents, emergency procedures and the application of effective risk assessments for the fishing industry.

**2026/132** Develop a course module to complement the existing modules of its Under 16.5m Skipper's Certificate (Restricted) and Under 16.5m Skipper's Certificate (Unrestricted) courses, with a specific focus on safety management systems and the application of risk assessments as effective tools in accident prevention on board fishing vessels.

**Fastline Shellfish Limited** is recommended to:

**2026/133** Develop a safety management system for the vessels it operates that follows the principles outlined in MGN 596 (F) Fishing Safety Management Code: Helping to Improve the Management of Safety on Fishing Vessels, and the guidance published in the Fishermen's Safety Guide.

**2026/134** As part of the fulfilment of 2026/133 above, ensure that crew allocation and task assignments on any vessel it operates consider the experience, familiarity, and training of newly joined crew members, particularly when assigning them to high-risk operational tasks such as deploying pots.

**2026/135** As part of the fulfilment of 2026/133 above, review its method of shooting pots to remove the need for physical interaction when deploying the pots. Further, to ensure that all crew members on vessels it operates are aware of the hazards associated with the vessel's mode of operation, paying particular attention to the risks associated with shooting pots.

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

MAIB safety flyer to the fishing industry

MAIB

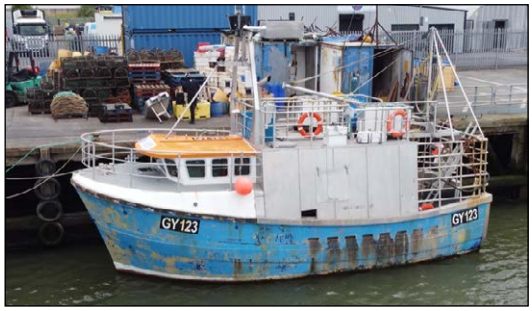
MARINE ACCIDENT INVESTIGATION BRANCH

# SAFETY FLYER TO THE FISHING INDUSTRY

## Double man overboard resulting in one fatality from the potting vessel *Weston Bay* (GY123), approximately 12 nautical miles south-east of Spurn Head, England on 22 May 2024

## Narrative

At about 0820 on 22 May 2024, two deckhands went overboard from the potting vessel *Weston Bay* in moderate sea conditions while the vessel was deploying its pots approximately 12 nautical miles south-east of Spurn Head, England. *Weston Bay*'s crew were able to recover one deckhand (deckhand 1) on board, but their efforts to recover the other deckhand (deckhand 2) were unsuccessful. About 40 minutes after entering the water, deckhand 2 was recovered by another vessel but was unresponsive and could not be resuscitated despite emergency first aid efforts.



*Weston Bay*

The accident happened when the inexperienced deckhand 1 was struck and knocked onto the deck **(**see **figure)** while downstacking a string of shooting pots and was taken overboard by the next pot in sequence. Deckhand 2 entered the water as he went to assist.

*Weston Bay*'s crew recovered deckhand 1 from the water in less than 10 minutes using the improvised emergency rescue ladder. However, this method was ineffective in assisting deckhand 2 who had succumbed to the effects of cold incapacitation and was unable to assist in his recovery. During the recovery efforts, deckhand 2's personal flotation device (PFD) had become separated from him and he consequently had no support in the water.

The investigation found that the shooting system used on *Weston Bay* did not ensure that crew were physically separated from the shooting gear in line with the guidance provided in the Maritime and Coastguard Agency's Fishermen's Safety Guide. *Weston Bay*'s crew did not conduct regular manoverboard drills and did not have an effective man overboard (MOB) recovery system to recover an unconscious person from the water.

## Safety lessons

1. Careful consideration of the self-shooting arrangements, including the number of pots and their method of stacking, can remove the need for crew interaction, which in turn reduces the crew's risk of entanglement with the running back rope. It is essential that crew remain separated from the back rope and pots at all stages of the shooting operation. This requires a safe shooting method to be established for the protection of the crew.

2. The deployment of MOB recovery equipment is one of the first actions taken during drills. However, as no recent drills had been conducted on board *Weston Bay* the crew were unfamiliar with the equipment and unaware of its limitations. The ineffective recovery equipment impeded the ability of the crew to recover deckhand 2 while he was still conscious. It is vital to practice realistic MOB scenarios to ensure an effective and prompt response in a real situation. The early deployment of effective recovery equipment in this case would likely have significantly improved the deckhand's chances of recovery and survival.

3. The wearing of a PFD in line with the manufacturer's instructions when there is any risk of entering the water increases the chances of survival as it will keep an unconscious person's airway clear of the water.

4. Potting is one of the most hazardous fishing methods, Of the 47 MOB occurrences from UK potting vessels reported to the MAIB between 2013 and 2023, 55% resulted in fatalities. By considering and implementing some or all of the invaluable suggestions in publications, such as the MCA's Fishermen's Safety Guide and the Seafish FS45 Potting Safety Industry Advisory Note, fishermen can create a safer working environment and gain a more informed approach to hazards and emergency preparedness. Further guidance is also available via the Fishing Industry Safety Group's Home and Dry safety campaign website[1].

For illustrative purposes only: not to scale

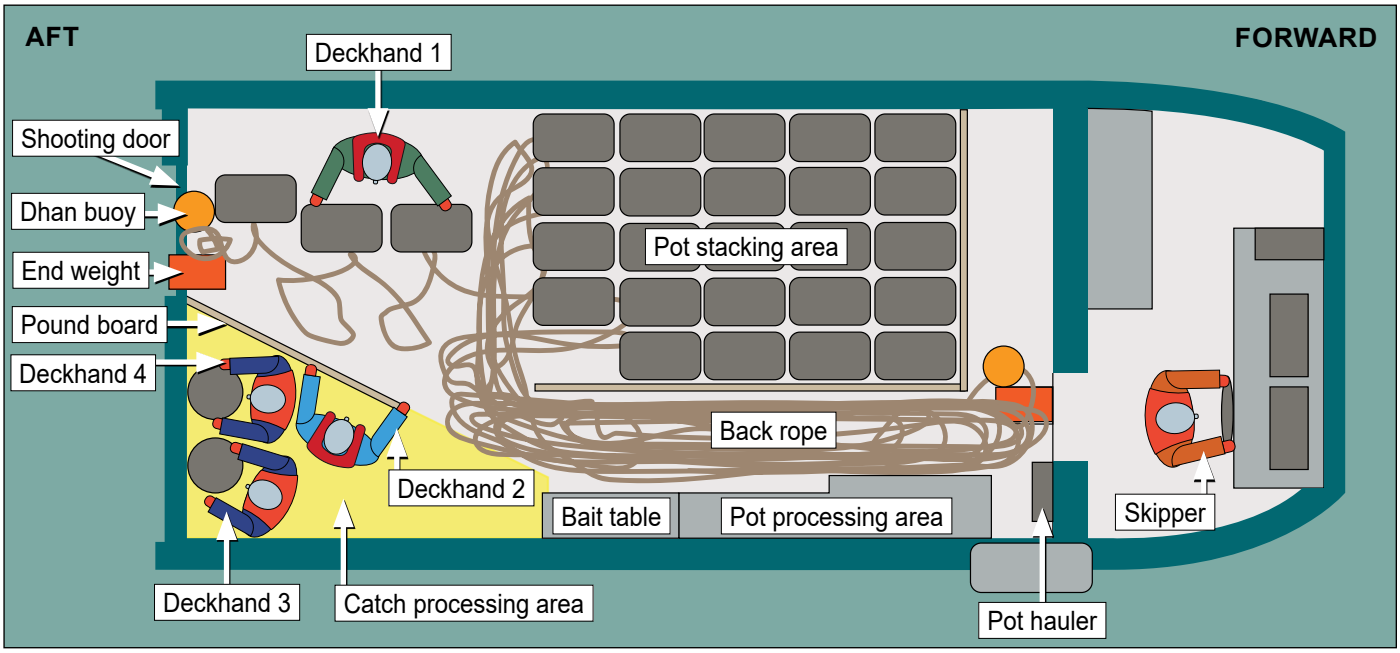



**Figure:** Crew positions at the shooting stations

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.



1 Home and Dry safety campaign

Marine Accident Report