ACCIDENT REPORT

Report on the investigation of

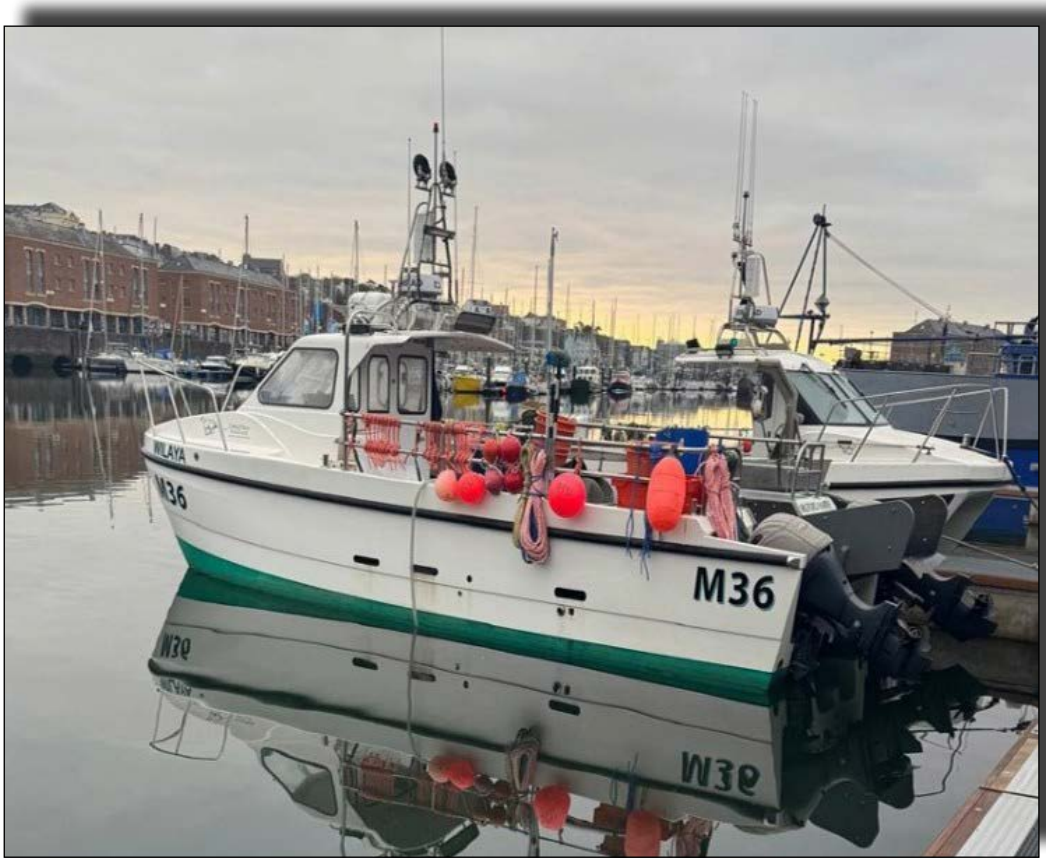
the man overboard from the potting vessel

Wilaya (M36)

resulting in one fatality

1 nautical mile north of Jack Sound, Pembrokeshire, Wales

on 1 May 2025



VERY SERIOUS MARINE CASUALTY REPORT NO 12/2026 MAY 2026

MAIB
MARINE ACCIDENT INVESTIGATION BRANCH

Extract from

The United Kingdom Merchant Shipping

(Accident Reporting and Investigation)

Regulations 2026 – Regulation 5:

The sole objective of a safety investigation into an accident under these Regulations is the prevention of future accidents through the ascertainment of its causes and circumstances. It is not the purpose of such an investigation to determine liability nor, except so far as is necessary to achieve its objective, to apportion blame.

NOTE

This report is not written with litigation in mind and, pursuant to Regulation 19(1) of The Merchant Shipping (Accident Reporting and Investigation) Regulations 2026, shall be inadmissible in any judicial proceedings concerning liability unless the Chief Inspector of Marine Accidents or a court of law determine otherwise.

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GLOSSARY OF ABBREVIATIONS AND ACRONYMS

ALB	-	all-weather lifeboat
CPR	-	cardiopulmonary resuscitation
FISG	-	Fishing Industry Safety Group
ILO	-	International Labour Organization
ILO 188	-	The International Labour Organization Work in Fishing Convention No.188
MCA	-	Maritime and Coastguard Agency
MGN	-	Marine Guidance Note
MOB	-	man overboard
MSIS	-	Marine Survey Instructions for the Guidance of Surveyors
MSN	-	Merchant Shipping Notice
PFD	-	personal flotation device
Seafish	-	Sea Fish Industry Authority
Seafish advisory	-	Seafish FS45 Potting Safety Industry Advisory Note, published January 2011
SFVC	-	Small Fishing Vessel Certificate
THC	-	delta-9-tetrahydrocannabinol
UTC	-	universal time coordinated

TIMES: all times used in this report are universal time coordinated (UTC) +1 unless otherwise stated.

Wilaya

SYNOPSIS

Image courtesy of Esri

At about 1330 on 1 May 2025, a deckhand on the UK registered potting vessel *Wilaya*, fishing off the coast of Wales, was dragged overboard by the deploying gear after his foot became caught in a bight of rope. The skipper and passenger promptly recovered the unresponsive deckhand on board but he could not be resuscitated despite emergency first aid efforts, including assistance from nearby vessels and the Royal National Lifeboat Institution.

The investigation found that the deckhand entered the water after becoming entangled in the running back rope while the pots were being deployed. Although he was wearing a personal flotation device, the deckhand was held below the surface by the weight of the attached fishing gear and subsequently drowned.

The investigation established that the method of shooting pots on *Wilaya* did not ensure separation of the crew from the running gear, and that the vessel's risk assessments were not being adhered to. The skipper, who was also *Wilaya*'s owner, had not completed all required safety training and this had gone unrecognised by the Maritime and Coastguard Agency during the vessel's inspection.

Since the accident, *Wilaya*'s skipper has completed the mandatory safety training, revised their method of shooting pots and implemented measures to achieve greater separation between crew and the running gear.

The Maritime and Coastguard Agency has instructed its technical managers to reiterate the existing guidance to their surveyors on the need to verify fishermen's training records.

Recommendations have been made to the Maritime and Coastguard Agency to review and enhance the existing guidance in the Fishermen's Safety Guide for operators to assess the risks associated with shooting pots.

The Home and Dry group has been recommended to expedite the delivery of the outcomes of its working group focusing on the operational risks associated with potting and creeling vessels, and the hazards of downstacking and self-shooting arrangements.

Wilaya's owner has been recommended to conduct a further review of the self-shooting system used on board to ensure effective separation for the crew from the deploying pots.

SECTION 1 – FACTUAL INFORMATION

1.1 PARTICULARS OF *WILAYA* AND ACCIDENT

VESSEL PARTICULARS	
Vessel's name	*Wilaya*
Flag	UK
IMO number/fishing numbers	M36
Type	Potting fishing vessel
Registered owner	Privately owned
Year of build	2023
Construction	Glass reinforced plastic
Length overall	9.34m
Registered length	8.86m
Gross tonnage	2.14
Minimum safe manning	1
Authorised cargo	Shellfish

VOYAGE PARTICULARS	
Port of departure	Milford Haven, Wales
Port of arrival	Milford Haven, Wales
Type of voyage	Commercial fishing
Cargo information	Lobster
Manning	2

MARINE CASUALTY INFORMATION	
Date and time	1 May 2025 at about 1330
Type of marine casualty or incident	Very Serious Marine Casualty
Location of incident	1nm north of Jack Sound, Pembrokeshire, Wales
Place on board	Aft deck
Injuries/fatalities	1 fatality
Damage/environmental impact	None
Vessel operation	Shooting pots
Voyage segment	Mid-water
External & internal environment	Light wind; calm seas; good visibility; estimated sea temperature 11°C
Persons on board	2 crew, 1 passenger

1.2 NARRATIVE

At 0700 on 1 May 2025, *Wilaya*'s skipper/owner (the skipper) arrived at the vessel's berth in the Port of Milford Haven, Pembrokeshire, Wales to prepare for a day's lobster fishing. The skipper was met by the deckhand and a friend who was joining the vessel as a passenger for the day.

At 0745, *Wilaya* left port and headed west to the fishing grounds. At about 0845, the crew started fishing and spent the morning hauling and shooting pots as *Wilaya* moved around the coast towards Jack Sound in St Bride's Bay. During hauling and shooting operations, the passenger and skipper were in the wheelhouse and the deckhand was out on deck.

At about 1310, *Wilaya*'s skipper hauled the thirteenth string of the day, a set of 10 pots, which the deckhand stacked in two stacks of five ready to be shot again **(Figure 1)**. *Wilaya*'s skipper then drove the vessel eastwards and signalled the deckhand to deploy the string. The deckhand placed the leading end weight at the stern ramp and manually deployed the dhan buoy[1] through the transom opening, followed by the attached end weight. The deckhand then stepped forward, between the stacked pots and the stern ramp, and downstacked[2] each pot sequentially as they deployed **(Figure 1)**. Once the last pot had deployed, the deckhand moved further forward towards the wheelhouse to reposition the tail end weight to midships. A bight formed in the running back rope as the deckhand moved the weight, snaring the deckhand's leg and dragging him overboard.

Wilaya's skipper and passenger momentarily saw the deckhand entangled in the back rope as he was dragged over the stern ramp into the water and immediately put the vessel in neutral and went to assist him. The skipper and passenger went to the stern and made the remaining dhan line fast on a cleat. They saw the deckhand, buoyed by his inflated personal flotation device (PFD), momentarily break the surface before being pulled under. The skipper turned the vessel to starboard and, assisted by the passenger, passed the remaining dhan line around the vessel's side to the pot hauler and began to recover it on board. Shortly after the line had been recovered the deckhand broke the surface alongside, with his leg still snared in the back rope and end weight. Over the next few minutes, the skipper and passenger lifted the deckhand clear of the water while simultaneously cutting away the back rope and recovered him to the vessel's deck. The deckhand was now moving but unresponsive.

At 1338, *Wilaya*'s skipper issued a "Mayday" distress call via channel 16 on the vessel's VHF radio while the passenger performed cardiopulmonary resuscitation (CPR) on the deckhand. His Majesty's Coastguard acknowledged the call and tasked emergency rescue assets to assist, including the Angle Royal National Lifeboat Institution all-weather lifeboat (ALB) and St Athan rescue helicopter R187. Two nearby local vessels also received the distress message and proceeded to assist.

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[1] A dhan (sometimes 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.

For illustrative purposes only: not to scale

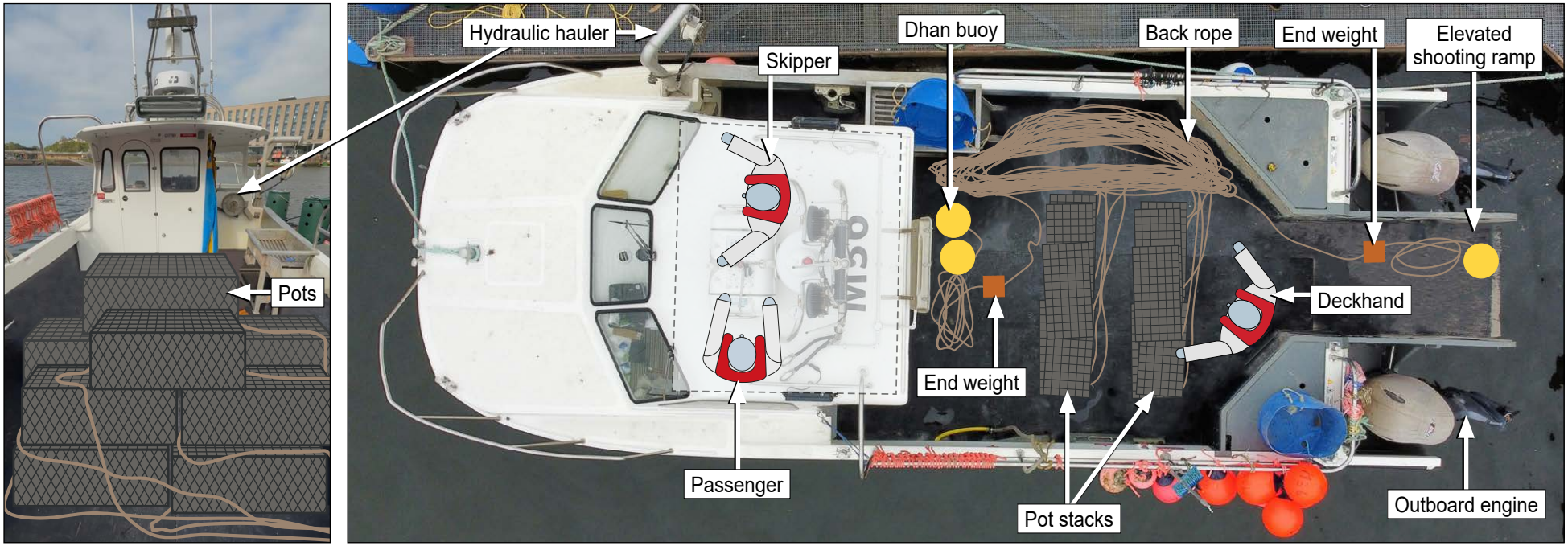

Figure 1: *Wilaya*'s working deck arrangement

At about 1343, the nearby Natural Resources Wales dive and survey vessel *Skalmey* manoeuvred alongside *Wilaya* and transferred two crew across to assist. The skipper of the passenger vessel *Dale Prince* simultaneously proceeded to Martin's Haven to collect an onshore automated external defibrillator unit, which they transferred to *Wilaya* at about 1352.

At 1353, *Wilaya*'s skipper drove the vessel towards Milford Haven as CPR efforts continued. At 1414, *Wilaya* met with the Angle ALB and transferred the casualty across. The ALB's crew continued with CPR as they returned to port.

At 1436, rescue helicopter R187 transferred a paramedic to the ALB to assist the vessel's crew with the ongoing CPR to the unresponsive casualty. By 1457, the ALB had berthed at Milford Haven. Rescue services continued to administer CPR on board the ALB. At 1540, the deckhand was declared deceased and his body was taken ashore. Shortly afterwards, *Wilaya* arrived at its berth in Milford Haven.

1.3 ENVIRONMENTAL CONDITIONS

The sea conditions were calm, with light winds and clear, sunny skies. The estimated sea temperature was 11°C.

1.4 *WILAYA*

1.4.1 General description

Wilaya was a UK registered 9.34m catamaran fishing vessel purchased new and commissioned by the skipper in 2023. The build phase was completed in March 2024. *Wilaya* was built to a standard design and fitted out to the skipper's specification with a deck layout designed for fishing with pots for lobster, crab and whelk. The vessel was powered by two outboard engines operated from inside the wheelhouse by throttle levers and a steering wheel. A hydraulic hauler was fitted on the starboard side **(Figure 1)**.

Wilaya's working deck had an elevated shooting ramp measuring 0.9m long by 1.03m wide built into the transom, with shooting guides on either side to guide the deploying pots **(Figure 1)**. The open deck area was used to process the catch and store each string of pots after they were hauled, before being shot away once more. The working deck had no pound boards to separate the crew from the running gear.

1.4.2 Potting arrangement

Wilaya operated three pot sizes, the largest of which was in use during the accident. The pots were divided into 10 per string. Each pot measured 1,220mm x 560mm x 560mm and weighed 40kg.

The system comprised a dhan buoy arrangement at each end of the string. The marker float was connected to a dhan line, which was attached to an end weight. Each of the 10 pots was evenly spaced along a back rope, to which they were permanently attached by leg ropes. The back rope was anchored to the seabed by the end weights attached to the dhan lines and marker floats **(Figure 2)**. Before shooting, the 10 pots were arranged into two stacks athwartships in a 2-2-1 formation.

For illustrative purposes only: not to scale

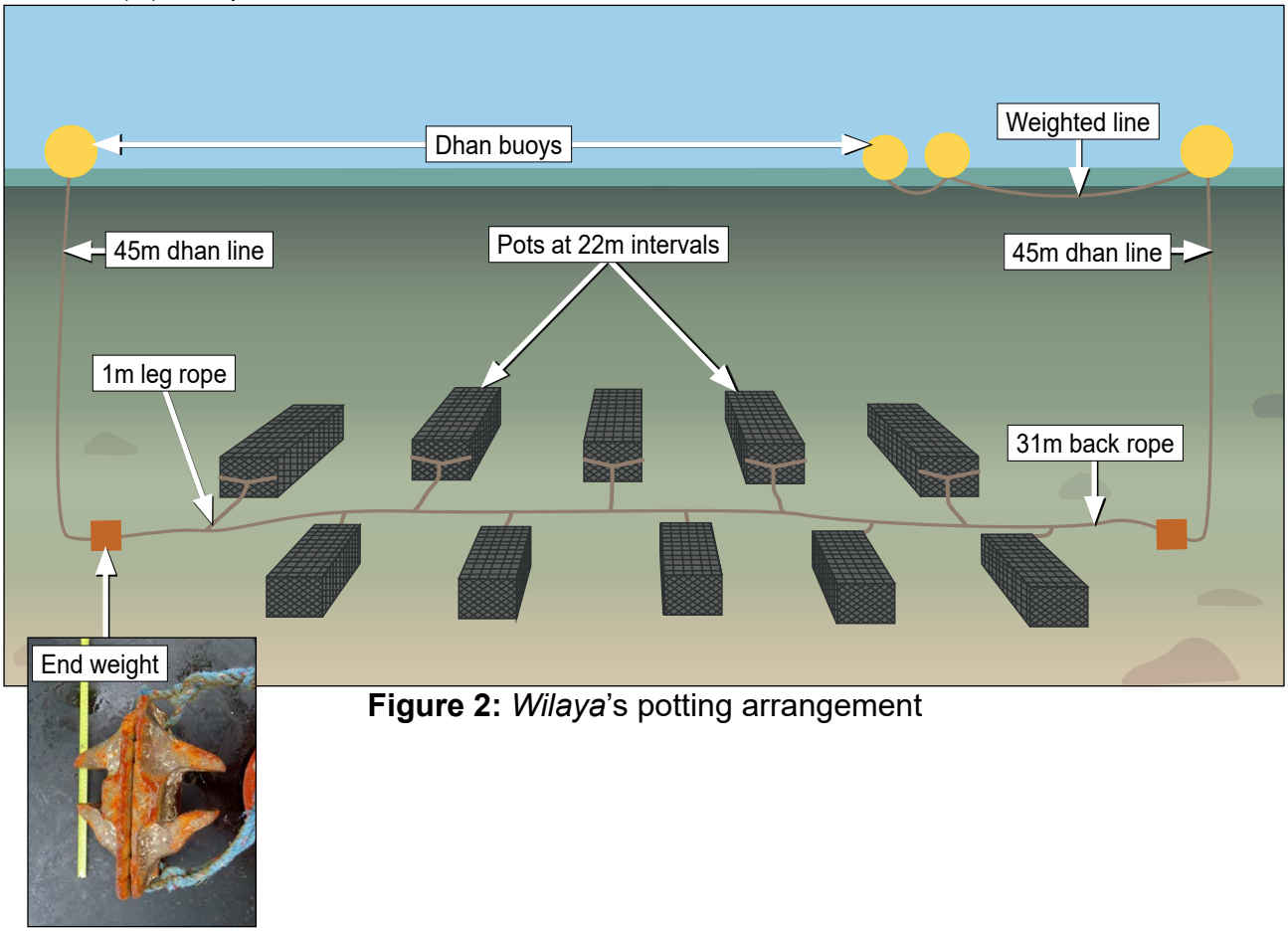

Figure 2: *Wilaya*'s potting arrangement

1.4.3 Shooting method

Wilaya's skipper oversaw the pot shooting operation from the wheelhouse while navigating the vessel. The skipper drove at a speed of about 7kts to 8kts, signalling to the deckhand to manually deploy the dhan buoy and line through the opening at the shooting ramp followed by the leading end weight. The deckhand then downstacked each pot in turn to prevent damage to the deck, aligning the pot lengthwise with the shooting ramp to prevent it from fouling, and allow the tension on the back rope to pull the pot through and into the water. Once the last pot had been shot, the deckhand walked forward and manually repositioned the attached tail end weight from behind the wheelhouse to midships to prevent damage to the deck. The tension on the back rope then dragged the end weight over the shooting ramp and into the sea, followed by the second dhan buoy.

1.4.4 The skipper

Wilaya's skipper was a career fisherman with 15 years' experience. The skipper had completed the four mandatory 1-day basic safety training courses[3]. The skipper had not completed the Sea Fish Industry Authority (Seafish)[4] 1-day Safety Awareness and Risk Assessment course for experienced fishermen (see section 1.5). The skipper had not previously experienced a man overboard (MOB) incident.

[3] Basic Sea Survival; Basic First Aid; Basic Fire Fighting and Prevention; Basic Health and Safety.

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

1.4.5 The deckhand

Wilaya's deckhand, Jack Walker, was a 35-year-old career fisherman with approximately 15 years' experience in commercial fishing. He had joined *Wilaya* about 10 months before the accident. *Wilaya*'s deckhand had completed the four mandatory 1-day basic safety training courses and the 1-day Safety Awareness and Risk Assessment course for experienced fishermen. The deckhand was reportedly competent in his role.

At the time of the accident the deckhand was wearing a 150N[5] PFD over bib and brace-style oilskins, Wellington boots and a T-shirt.

The preliminary postmortem report recorded the deckhand's cause of death as *immersion in water*. The toxicology analysis results for the deckhand reported that delta-9-tetrahydrocannabinol (THC), the main active ingredient of cannabis, and its associated metabolites were detected in the sample. The toxicology analysis also reported that cocaine (<5.0 micrograms per litre) and its associated metabolites were detected.

The toxicology report concluded that the deckhand had used cannabis and cocaine at some point before death. The report noted that it was not possible to determine when he last used these substances or whether their presence was attributable to multiple use. The report also noted that it was not possible to identify what effects, if any, the deckhand might have been experiencing because of their use in the hours leading up to his death.

1.4.6 The passenger

Wilaya's passenger was a retired workboat master. They were not involved in the vessel's fishing operations.

1.4.7 Safety management and risk assessment

Wilaya's skipper had adopted the online Safety Folder (the 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[6], which included a requirement for risk assessments, and the International Labour Organization's Work in Fishing Convention No.188 (ILO 188).

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 risks identified in *Wilaya*'s risk assessments included *Getting tangled in ropes shooting out, hit by a pot* and *falling overboard*. The documented risk control measures were *Stand in wheelhouse when gear is being shot* and *lifejacket worn*

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

[6] The regulations were made on 13 December 1997, laid before parliament on 17 December 1997, and came into force on 31 March 1998.

The risk outcomes were recorded as *personal in jury* [sic], *pulled overboard, hypothermia or death*. The risk level was recorded as *Medium Risk*. *Wilaya*'s risk assessments were identified as Version-1, drafted on 29 February 2024.

1.4.8 Man overboard prevention

As set out in Marine Guidance Note (MGN) 571 (F)[7] (see section 1.5.4), *Wilaya*'s skipper had assessed on board work activities that might lead to an MOB. The six potential hazard areas that the skipper identified and recorded are summarised in **Table 1**. There were no lanyards or body harnesses on board *Wilaya*.

Description of risk area/process	Control measures	Structural or procedural changes implemented
Skipper hauling pots over the rail	Never lean too far over the rail	Use safety lanyards when possible
Skipper and deckhand falling overboard due to slippery deck matting	Wash deck between shooting and hauling strings of pots	Wear appropriate footwear and be mindful
Deckhand tripping and falling overboard when tying vessel up in harbour	Clip safety harness into roof rail to prevent falling overboard	Wear a body harness
Deckhand or skipper falling from the back of boat while untangling rope from the propeller	Observe the person untangling the rope and wear a body harness	Wear a body harness attached to railings
Deckhand falling overboard while shooting gear	Staying clear of the gear when possible Clear communication between crew	Wear a PFD at all times Let pots self-shoot when possible
Skipper being struck and becoming entangled and going overboard if rope releases from hauler under tension	Regular winch maintenance, wear plates replacement, etc Standing clear when possible	Stand clear when possible Wear a PFD at all times

Table 1: *Wilaya*'s recorded MOB hazards and mitigation measures

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

1.4.9 Maritime and Coastguard Agency inspection

The Maritime and Coastguard Agency (MCA) inspected *Wilaya* as a new vessel on 5 March 2024. The MCA's survey report form recorded the following deficiencies:

> *Vessel Official Number to be marked on the Hull as per the Carving and Marking Note (Action code 17[8])*
>
> *Vessel-specific man overboard risk assessment to be provided in line with the guidance provided in MGN571 (Action code 17)*
>
> *Crew capacity not correctly identified on fishermans work agreement. (Rectified during inspection)* [sic]

The MCA inspection also recorded that the vessel's risk assessments *were sighted and discussed*, and that *all required qualifications of the crew have been sighted and they are satisfactory*.

The deficiencies were subsequently closed out to the MCA's satisfaction and *Wilaya* was issued a Small Fishing Vessel Certificate (SFVC), which was valid for 5 years (see section 1.5.1).

1.5 REGULATION AND GUIDANCE

1.5.1 Survey and inspection

Fishing vessels under 15m length overall were required to comply with Merchant Shipping Notice (MSN) 1871 (F) Amendment No.2[9] and were subject to MCA surveys and inspections. Following successful inspection, vessels were issued with an 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 compliance with MSN 1871 (F) Amendment No.2; the MCA deemed the SFVC to be invalid if the vessel or its operation deviated from the requirements. The owner's responsibilities listed in MSN 1871 (F) Amendment No.2 included ensuring that the vessel was *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*[10] provided advice for owners, skippers, and fishermen to ensure the successful outcome of an inspection or survey. The *Fishing Vessel Surveys and Inspections* guide specified that MSN 1871 (F) Amendment No.2 was the applicable code of practice for vessels under 15m in length overall and listed the requirements, documents and evidence to be available for inspection. This included crew training certificates and copies of risk assessments.

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[8] Action Code(s) 17 – master instructed to rectify deficiency before departure.

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

[10] Fishing Vessel surveys and Inspections guide

1.5.2 Maritime and Coastguard Agency guidance to surveyors

The MCA provided its surveyors with Marine Survey Instructions for the Guidance of Surveyors (MSIS) detailing the conduct of vessel surveys and inspections. MSIS 27 – Survey and Inspection of Fishing Vessels, chapters 1 to 17 was the applicable volume for surveyors of fishing vessels[11]. MSIS 27 included specific guidance to surveyors on fishing vessel requirements for MOB prevention and procedures, crew qualifications and training.

On survey and inspection, MSIS 27 stated that the aide-memoire for the survey and inspection of under 15m fishing vessels should be used as a prompt to ensure that the surveyor addressed all items. The document included a section outlining the checklist points for crew certificates and training records and defined the applicable requirements. The annex to the document included a flowchart, which detailed the minimum training requirements to be held by a fisherman working on an under 15m fishing vessel and the action to take if a deficiency was found.

On training and crew qualifications, MSIS 27 specified the requirements for surveyors as defined by the Fishing Vessels (Safety Training) Regulations 1989, which came into force on 1 March 1989. The 2004 Amendment to these regulations required that experienced fishermen obtain a certificate verifying that they had completed the Safety Awareness and Risk Assessment course.

On MOB, MSIS 27 included guidance that MOB risk assessments should set out whether a PFD or safety harness was to be worn if the control measures could not eliminate the risk of an MOB, and for the described risk measures to be checked.

1.5.3 Health and safety

In March 2019, the MCA published MGN 587 (F) Amendment 1[12], 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.*

[11] Revision 12.23

[12] 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.

- *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

1.5.4 Man overboard prevention

Guidance on the identification of hazards that might lead to an MOB situation was provided in MGN 571 (F). 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. Should problems occur with ropes and lines, vessels should have an agreed procedure and crew should not enter the area until it is safe to do so.*

- *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.*

Annex A of MGN 571 (F), outlined how to identify situations where man overboard risks could occur and the measures that could be taken to reduce or eliminate those risks. Annex B provided templates to describe specific risk areas and record mitigation measures.

1.5.5 Training

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

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, new entrants were required to complete the 1-day Basic First Aid, 1-day Basic Fire Fighting and Prevention, and the 1-day Basic Health and Safety courses.

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

[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.

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*

1.5.6 Guidance

The MCA's Fishermen's Safety Guide[14], offered guidance on how to identify hazards, implement control measures to mitigate risks, and enhance safety on board fishing vessels.

The Fishermen's Safety Guide highlighted the dangers of shooting pots and advised considering the number of pots on a string, how they were stacked, and ensuring the vessel's layout allowed for safe and efficient pot handling. It also emphasised that great care was needed when shooting pots and cautioned:

> ***KEEP CLEAR; SHOOTING POTS CAN BE VERY DANGEROUS; GREAT CARE IS NEEDED***
>
> *Try to separate the crew from the ropes; ideally, use a self-shooting system.*

The guide highlighted safety lessons from the *Annie T* and *Enterprise* investigations (see section 1.6).

The Fishing Industry Safety Group (FISG) was a stakeholder group[15] set up with the goal of zero preventable deaths on fishing vessels by 2027. The stated aim of the FISG was to reduce the number of serious accidents and vessel losses due to health and safety issues.

The FISG Home and Dry online safety campaign[16] provided guidance to the fishing industry on man overboard awareness, the importance of risk assessments, and potting vessel safety. In 2024, FISG was split into two: the Home and Dry group and the regulatory steering group. The Home and Dry group's remit was to look at fishing safety information and guidance.

Published in January 2011, the Seafish FS45 Potting Safety Industry Advisory Note[17] (Seafish advisory note), highlighted hazards such as *snagged in rope when shooting* and addressed safety concerns within the UK potting sector of the 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

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[14] Fishermen's Safety Guide

[15] The stakeholders included the MCA, Seafish, fishermen's associations, Royal National Lifeboat Institution and Shipbuilders & Shiprepairers Association.

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

[17] Seafish FS45 Potting Safety Industry Advisory Note

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.

1.6 EFFECTS OF CANNABIS AND COCAINE

Cannabis is a psychoactive drug containing compounds, including THC, that act on the central nervous system. Adverse effects of cannabis use can include distorted perception of space and time, slowed reactions, reduced coordination, and drowsiness.

Cocaine is a powerful central nervous system stimulant. Cocaine use can lead to aggression, dizziness, disorientation and confusion. Once the stimulant effects of cocaine have subsided, the adverse effects of its use may include paranoia, fatigue, anxiety and drowsiness.

1.7 PREVIOUS/SIMILAR ACCIDENTS

1.7.1 Potting vessel man overboard incidents

The MAIB Analysis of UK Fishing Vessel Safety 1992 to 2006 reported that 256 commercial fishermen died in UK fishing vessel accidents during that period. Of these fatalities almost a third (83) involved crew going overboard, with 18 occurring in harbour and the remaining 65 taking place while vessels were underway. Nearly a third of the 65 fatalities occurred when crew members were dragged overboard and under the surface from potting vessels, having become entangled or caught in ropes while shooting strings of pots. Potting vessels under 15m were involved in 16 of the MOB fatalities.

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 physical separation between the gear and the crew, resulting in entanglement during 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. This included 1,524 full-time employees, or 23% of the workforce.

The accident on board *Wilaya* was the sixth fatality to occur on board a UK potting vessel in the 20 months from October 2023 to May 2025.

1.7.2 *Barnacle III* – man overboard

On 13 May 2014, a deckhand on the 11.35m creel[18] vessel *Barnacle III* was dragged overboard while shooting a fleet of creels (MAIB report 1/2015[19]). The deckhand's leg likely became caught in the buoy line as he walked the end weight towards the stern. The deckhand surfaced face down a short while later and could not be resuscitated, despite being quickly recovered on board and the skipper administering CPR. The deckhand was not wearing a PFD at the time of the accident.

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

[19] MAIB Report 1/2015: Barnacle III

The investigation found that changes made to accommodate two fleets of creels on deck simultaneously removed separation between the crew and the running gear, requiring crew members to step across the back rope during shooting. The skipper had completed a risk assessment, but it was not documented and did not identify appropriate control measures for the additional risks.

The owner/skipper of *Barnacle III* was recommended to heed the contents of extant guidance on potting safety, reassess the risks when working fleets of creels on deck, and ensure appropriate control measures were implemented to minimise the risk to crew members when shooting or recovering creels.

1.7.3 *Annie T* – man overboard

On 4 October 2015, a crew member on board the 9.15m potting vessel *Annie T* was carried overboard by the shooting fishing gear when his foot became caught in the bight of a moving rope (MAIB report 21/2016[20]). By the time the skipper had recovered him on board he was unconscious, showed no signs of life and could not be resuscitated. He was not wearing a PFD at the time of the accident.

The MCA was recommended to prioritise the introduction of legislation for the compulsory wearing of constant wear PFDs on the exposed deck of all fishing vessels[21]. The MCA was also recommended to issue guidance on the recovery of a person overboard for fishing vessels under 15m length overall and to issue guidelines for MOB recovery equipment.

1.7.4 *Enterprise* – man overboard

On 6 November 2017, a deckhand on board the 8.95m potting vessel *Enterprise* died after becoming caught in and dragged overboard by a moving back rope (MAIB report 5/2018[22]). 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 the pound boards, which had separated him from the running lines. There was no apparent reason for the deckhand to leave the “safe area”, and that he 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.

[20] MAIB report 21/2016: Annie T

[21] In 2017, the MCA introduced legislation to require PFD wear unless measures were in place eliminating the risk of fishermen falling overboard.

[22] MAIB report 5/2018: Enterprise

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

The deckhand entered the water after becoming entangled in the back rope at the end of the shooting string of pots. Although he wore a PFD it was ineffective against the weight of the fishing gear, and he could not be resuscitated despite being promptly recovered on board.

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

2.3 *WILAYA*

2.3.1 The accident

Wilaya's deckhand was pulled overboard when his leg became caught in a bight of the moving back rope as he stepped over it to reposition the attached end weight. With *Wilaya* underway and the back rope paying out continuously across the deck into the sea, there would have been less than 8 seconds between the last pot shooting and the line snaring the deckhand's leg. The skipper and the vessel's passenger reacted quickly as the running line snatched the deckhand off his feet but were unable to prevent him from being dragged overboard.

The deckhand's toxicology results detected the presence of cannabis and cocaine in his blood, indicating that he had used these substances at an undetermined time before his death. However, there was no evidence that the deckhand was impaired at the time of the accident.

Although the deckhand wore a PFD, its buoyancy was insufficient to overcome the weight of the gear and he was pulled under the surface. Despite subsequent resuscitation efforts being unsuccessful, it was notable that *Wilaya*'s skipper and passenger managed to promptly recover the deckhand to the surface using the pot hauler and then lift him on board. This contrasted with the accident on the potting vessel *Enterprise*, where the crew could not recover the casualty on board until a lifeboat arrived. Without the assistance of the passenger, it is unlikely that the skipper could have recovered the deckhand.

Wilaya's deckhand became entangled in the back rope and was dragged into the sea. Despite wearing a PFD, he was pulled under the surface and drowned.

2.3.2 Method of shooting pots

Wilaya operated a self-shooting system to deploy its strings of pots, which, in principle, kept the crew clear of the deploying gear. However, the arrangement in use at the time of the accident required downstacking and the deckhand to

manually reposition the end weight during deployment. With no physical barriers on the open deck, the deckhand remained near and exposed to the running gear throughout deployment, increasing their risk of entanglement. This necessary physical interaction by the deckhand meant the system did not function as a true self-shooting system and was inherently dangerous.

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 self-shooting systems must be designed to fit the vessel's requirements and layout.

The safety benefits of a self-shooting system are negated when physical interaction is required during the process, as also highlighted in the case involving *Barnacle III*. *Wilaya*'s working deck arrangement and method of shooting pots did not support a true self-shooting system and did not separate the deckhand from the gear during the shooting process. This put the deckhand at risk of entanglement and harm.

2.3.3 Safe systems of work

Wilaya's system of work included the control measure of the crew remaining in the wheelhouse during shooting operations to mitigate the risk of entanglement. However, on the day of the accident this control was not applied, and the deckhand was both on the deck and interacting with the gear during the shooting operation.

Wilaya's skipper, as the person in command, was responsible for ensuring the safe operation of the vessel, including implementing safe systems of work and protecting the crew during fishing operations. Guidance outlined in MGN 587 (F) Amendment 1 recognised that vessel owners, skippers and crew members had a duty to identify hazards and implement protective measures to eliminate or reduce the risk of personal injuries and accidents. The guidance also outlined that each fisherman had a duty to look after their own health and safety, that of others working with them, and comply with the measures put in place for their safety.

The deckhand was regarded as a competent crew member and it is likely that, having never previously experienced an MOB incident on board, *Wilaya*'s skipper had developed a level of confidence in their working practices. The consequence of this was that control measures designed to prevent accidents were not followed, and unsafe practices had become routine.

Effective safe systems of work require consistent application of risk control measures and *Wilaya*'s adopted systems of work contradicted the vessel's risk assessments and industry guidance. *Wilaya*'s crew did not adhere to the vessel's documented control measures during shooting operations, likely believing that their experience mitigated the existing hazards. This exposed the crew to a significant risk of harm and injury.

2.3.4 Risk assessments

Wilaya's documented risk assessments had not been reviewed since their completion in February 2024. The risk assessment for shooting pots had identified the hazard of crew entanglement and included mitigation measures intended to

reduce the likelihood of such incidents. *Wilaya*'s skipper had also made use of MGN 571 (F), Annex B to identify and record six on board hazard areas and their corresponding control measures, of which two required the use of a body harness and one a safety lanyard. However, no such equipment was carried on board or available to the crew, and the documented controls were not enforced during fishing operations.

Risk assessments have been a legal requirement on UK fishing vessels since 1998. In line with MGN 587 (F) Amendment 1 and ILO 188, fishing vessels were required to maintain suitable and sufficient documentation covering all work activities. To be fully effective, risk assessments must be reviewed regularly, communicated clearly to the crew, adhered to in daily practice, and supported by the necessary equipment. When these principles are followed, risk assessments can assist crews to effectively manage the hazards associated with their vessel operation. On board *Wilaya*, the absence of review, non-existence of safety equipment and lack of implementation of documented controls indicated a disconnect between hazard recognition and operational practice.

Although *Wilaya*'s risk assessments had identified some of the hazards associated with its operations, several risk control measures were not followed while others were unachievable. This meant the risks involved in shooting were not mitigated and placed the crew at risk.

2.3.5 Crew training and certification

Wilaya's skipper had 15 years of fishing experience and therefore more than met the MCA definition of an experienced fisherman. However, the skipper had not completed the mandatory Safety Awareness and Risk Assessment training so might have lacked essential skills for managing the hazards when operating a fishing vessel.

To raise awareness of training obligations among fishermen the MCA published MGN 411 (M+F), which outlined the mandatory requirements. Further guidance was provided in the MCA's *Fishing Vessel Surveys and Inspections – How to prepare for your next MCA visit* and the *Fishermen's Safety Guide*, both of which detailed the mandatory safety training requirements for fishermen. It is unclear why *Wilaya*'s skipper was unaware of the requirement to complete the Safety Awareness and Risk Assessment course.

Although *Wilaya*'s skipper had taken several steps towards compliance with the regulations and applicable guidance, completion of the Safety Awareness and Risk Assessment course would have provided additional help and might have enhanced their safe working knowledge in this area.

Wilaya's skipper had not completed the required safety training for experienced fishermen and therefore might have lacked essential safety skills. This might have impacted their ability to implement effective risk assessment processes on the vessel, placing them and the crew at risk.

2.3.6 Maritime and Coastguard Agency vessel survey and inspection

The MCA inspected *Wilaya* in the skipper's presence on entry into service and the crew's certification was noted as sighted and satisfactory. However, this was incorrect as the skipper had not completed the Safety Awareness and Risk Assessment course and the opportunity to recognise and rectify this deficiency was missed. With the next inspection not due until March 2029, this deficiency was likely to remain undetected for several years.

The MCA's oversight of safety training during SFVC inspections relied on the surveyor's application of the guidance as outlined in MGN 411 (M+F) and MSIS 27. It also relied on the surveyor's familiarity with these requirements to interpret the documentation presented and verify that the vessel and crew were compliant. The instructions for surveyors in MSIS 27 and its annexes provided explicit guidance on the training requirements. In this context it is unclear why the missing training course was not identified during *Wilaya*'s inspection.

The MCA's inspection of *Wilaya* had not verified the skipper's mandatory safety training obligations. Without a consistent and robust inspection procedure the opportunity to verify crew certification was missed, potentially compromising vessel safety.

2.4 ACCIDENT STATISTICS

The long list of similar accidents involving fishermen who have lost their lives after becoming entangled in shooting gear highlights that potting is an inherently dangerous fishing method. The associated hazards require effective risk management to ensure safety and protect crews. Nearly half of the fatal potting vessel MOBs between 2013 and 2023 were due to a lack of physical separation between the gear and crew. Although potting-related MOBs existed during the 1992 to 2006 period, as highlighted in the MAIB's Analysis of UK Fishing Vessel Safety 1992 to 2006, more recent MAIB data from 2013 to 2023 shows a higher proportion of fatal outcomes in such incidents. It is evident that potting operations remain high risk and that crews continue to be exposed to potentially fatal entanglement hazards.

The accident on board *Wilaya* was the sixth fatality involving a UK potting vessel in a 20-month period, further emphasising the heightened risks faced by fishermen in this sector. Despite the practical safety recommendations available in publications such as the Fishermen's Safety Guide, the recurring nature of these accidents suggests inefficient communication of the safety issues and consequences of not implementing effective control measures. In particular, the criticality of physical separation between shooting gear and crew members at all stages of the process to ensure crew safety.

Although a FISG working group for single-handed fishing vessels was established, this accident indicates that further effort is needed to effectively disseminate industry guidance for the safety of all potting vessels. Despite the availability of detailed safety guidance, the recurrence of similar accidents remains a concern and suggests that valuable lessons are not being learned.

Despite the available safety guidance, some fishermen still appear to operate in a risk-tolerant manner and might not fully appreciate the consequences of doing so, placing crew and vessel safety at risk.

SECTION 3 – CONCLUSIONS

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

1. The deckhand died because he became entangled in the back rope and was dragged into the sea. Despite wearing a PFD, he was pulled under the surface and drowned. [2.3.1]

2. *Wilaya*'s working deck arrangement and method of shooting pots did not support a true self-shooting system and did not separate the deckhand from the gear during the shooting process. This put the deckhand at risk of entanglement and harm. [2.3.2]

3. *Wilaya*'s crew did not adhere to the vessel's documented control measures during shooting operations, likely believing that their experience mitigated the existing hazards. This exposed the crew to a significant risk of harm and injury. [2.3.3]

4. Although *Wilaya*'s risk assessments had identified some of the hazards associated with its operations, several risk control measures were not followed while others were unachievable. This meant the hazards involved in shooting persisted and placed the crew at risk. [2.3.4]

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

1. *Wilaya*'s skipper had not completed the required safety training for experienced fishermen and therefore might have lacked essential safety skills. This might have impacted their ability to implement effective risk assessment processes on the vessel, placing them and the crew at risk. [2.3.5]

2. The MCA's inspection of *Wilaya* had not verified the skipper's mandatory safety training obligations. Without a consistent and robust inspection procedure the opportunity to verify crew certification was missed, potentially compromising vessel safety. [2.3.6]

3. Despite the available safety guidance, some fishermen still appear to operate in a risk-tolerant manner and might not fully appreciate the consequences of doing so, placing crew and vessel safety at risk. [2.4]

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

The **Maritime and Coastguard Agency** has:

- Instructed its technical managers to reiterate to their surveyors the existing guidance on the need to verify that experienced fishermen have completed the Risk Assessment and Safety Awareness course.

- Highlighted the importance of accurate record-keeping.

***Wilaya*'s owner** has:

- Completed the Seafish 1-day Safety Awareness and Risk Assessment course.

- Reviewed and revised the effectiveness of *Wilaya*'s risk assessments to support the vessel's safe systems of work.

- Reviewed and amended the self-shooting system used on board *Wilaya* to remove the need to downstack the pots or manually handle the end weights and to keep the crew separated from the running gear during shooting operations.

SECTION 5 – RECOMMENDATIONS

The **Maritime and Coastguard Agency** is recommended to:

2026/137 Review and enhance the existing guidance in the Fishermen's Safety Guide for fishing vessel owners on formally assessing the risks associated with shooting pots. To reduce the risk of adverse outcomes, the revised guidance is to make it explicit that physical separation between the shooting gear and the crew is essential when deploying pots by any method.

The **Home and Dry group** is recommended to:

2026/138 Expedite the delivery of the outcomes of its working group on the hazards of potting/creeling vessels, with particular emphasis on the operational risks associated with downstacking and self-shooting arrangements, considering the work commissioned by the Maritime and Coastguard Agency and the Sea Fish Industry Authority.

***Wilaya*'s owner** is recommended to:

2026/139 Conduct a further review of the self-shooting method used on board *Wilaya* to ensure there is effective separation between the crew and the deploying pots at every stage of the operation.

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

Fatal man overboard from the potting vessel *Wilaya* (M36), 1 nautical mile north of Jack Sound, Pembrokeshire, Wales on 1 May 2025

Wilaya

Narrative

On the morning of 1 May 2025, the 9.34m potting vessel *Wilaya* departed the Port of Milford Haven, Pembrokeshire, Wales in fine conditions for a day's fishing. On board were the skipper, a deckhand and a passenger.

At about 1330, the deckhand was dragged overboard after his foot became caught in a bight of rope while shooting a string of pots. The deckhand was wearing a personal flotation device (PFD); however, its buoyancy was ineffective against the weight of the fishing gear and he was quickly dragged beneath the surface. *Wilaya*'s skipper and passenger reacted promptly and recovered the deckhand on board, but he was unresponsive.

The deckhand was transferred to a Royal National Lifeboat Institution all-weather lifeboat, the crew of which continued to provide emergency first aid. The lifeboat arrived at Milford Haven at about 1457 and the deckhand was pronounced deceased at 1540. His cause of death was later recorded as immersion in water.

The investigation found that *Wilaya*'s risk assessments were not being followed, and that the deckhand entered the water after becoming entangled in the running backline while repositioning the end weight attached to the pots. *Wilaya* used a self-shooting system to deploy its pots. However, due to the size, number, weight and stack height of the pots and the need to reposition the end weight, a deckhand was required to manually downstack each pot. Consequently, the system did not truly function as a self-shooting system and provide separation from the gear for the crew.

Safety lessons

1. Many fishermen use a self-shooting arrangement on potting vessels. When doing so, it is essential that the crew are separated from the fishing gear at every stage of the deployment process to prevent entanglement or being pulled overboard.

2. Working on a crowded deck with stacked pots and no pound board division to separate the crew from the running gear creates serious risk. Combined with the speed and unpredictability of the shooting gear on an unstable platform, the outcome can be deadly.

3. The risk of an accident increases if established safety measures are disregarded and shortcuts become routine. A formal, structured risk assessment process can be an effective tool for preventing accidents. The risk assessment should involve all crew members, be effectively implemented, and regularly reviewed.

4. Potting is one of the most hazardous fishing methods. The accident on board *Wilaya* was the sixth fatality on board UK potting vessels in the 20 months from October 2023 to May 2025, highlighting the vulnerability of fishermen operating in the sector. By considering and implementing some or all of the guidance provided in publications such as the Maritime and Coastguard Agency's Fishermen's Safety Guide[1] and the Seafish FS45 Potting Safety Industry Advisory Note[2], 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 Home and Dry group's online information and safety campaign[3].

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 2026 – Regulation 5:

The sole objective of a safety investigation into an accident under these Regulations is the prevention of future accidents through the ascertainment of its causes and circumstances. It is not the purpose of such an 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 19(1) of The Merchant Shipping (Accident Reporting and Investigation) Regulations 2026, shall be inadmissible in any judicial proceedings concerning liability unless the Chief Inspector of Marine Accidents or a court of law determine otherwise.

1 Fishermen's Safety Guide
2 Seafish FS45 Potting Safety Industry Advisory Note
3 Home and Dry safety campaign

Marine Accident Report