ACCIDENT REPORT

MAIB

MARINE ACCIDENT INVESTIGATION BRANCH

Report on the investigation of

the serious injury to a crew member on board the

scallop dredger

Jacoba (BM77)

29 nautical miles south-south-east of

Beachy Head, England

on 10 May 2025

MARINE CASUALTY REPORT NO 14/2026 JUNE 2026

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.

All MAIB publications can be found on our website: www.gov.uk/maib

For all enquiries:

Marine Accident Investigation Branch
First Floor, Spring Place
105 Commercial Road
Southampton
SO15 1GH
United Kingdom

Email: iso@maib.gov.uk
Telephone: +44 (0)23 8039 5500

Press enquiries during office hours: +44 (0)19 3244 0015
Press enquiries out of hours: +44 (0)30 0777 7878

CONTENTS

FIGURES

TABLES

ANNEXES

GLOSSARY OF ABBREVIATIONS AND ACRONYMS

CoC	-	Certificate of Competency
FSE	-	Flag State Endorsement
FVC	-	Fishing Vessel Certificate
HMCG	-	His Majesty's Coastguard
ILO	-	International Labour Organization
ILO 188	-	International Labour Organization Work in Fishing Convention No.188
JRCC	-	Joint Rescue Coordination Centre
MCA	-	Maritime and Coastguard Agency
MGN	-	Marine Guidance Note
MRCC	-	Maritime Rescue Coordination Centre
MSIS	-	Marine Survey Instructions for the Guidance of Surveyors
MSN	-	Merchant Shipping Notice
OS	-	ordinary seaman
PFD	-	personal flotation device
SMS	-	safety management system
STCW	-	International Convention on Standards of Training, Certification and Watchkeeping for Seafarers 1978, as amended
TMAS	-	Telemedical Maritime Assistance Service
UTC	-	universal time coordinated

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

SYNOPSIS

On 10 May 2025, a deckhand on the UK registered fishing vessel *Jacoba* was seriously injured while the vessel was dredging for scallops in the English Channel. The deckhand was attempting to clear a snagged dredge bag chain and was positioned in between the vessel's port side main beam and tipping bar. When *Jacoba*'s mate lowered the main beam to assist with freeing the snag the beam struck the deckhand, causing serious crush injuries. The injured deckhand was given first aid on board and evacuated by helicopter to hospital where they remained for 3 months before being repatriated to their home country. As a result of their injuries, the deckhand has been unable to return to work since the accident.

The investigation found that the vessel's risk assessments did not adequately address routine dredging tasks such as clearing snagged gear and that crew familiarisation with scallop dredging hazards was limited. Safety management on board relied largely on informal practices, with limited task-specific procedures or owner oversight. Incomplete training and certification requirements further reduced assurance that the crew had the necessary safety knowledge and skills.

Since the accident, *Jacoba*'s owner, Poseidon Trawlers Limited, has taken a number of actions including making physical changes to the vessel, introducing assessments for winch operators and starting to implement a safety management system.

Poseidon Trawlers Limited has been recommended to expedite the implementation of a safety management system that aligns with the principles outlined in Maritime and Coastguard Agency guidance. The company has also been recommended to review its risk assessments for scallop dredging and to ensure crew have undertaken the required training.

Jacoba

SECTION 1 – FACTUAL INFORMATION

1.1 PARTICULARS OF *JACOBA* AND ACCIDENT

VESSEL PARTICULARS	
Vessel's name	*Jacoba*
Flag	UK
Classification society	Not applicable
IMO number/fishing numbers	8808941/BM77
Type	Scallop dredger
Registered owner	Poseidon Trawlers Limited
Manager(s)	Poseidon Trawlers Limited
Construction	Steel
Year of build	1988
Length overall	22.18m
Registered length	19.65m
Gross tonnage	126
Minimum safe manning	4
Authorised cargo	Fish/shellfish

VOYAGE PARTICULARS	
Port of departure	Portsmouth, England
Port of arrival	Brixham, England
Type of voyage	Fishing
Cargo information	Scallops
Manning	6

MARINE CASUALTY INFORMATION	
Date and time	10 May 2025 at about 0236
Type of marine casualty or incident	Marine Casualty[1]
Location of incident	English Channel, 29nm south-south-east of Beachy Head, England
Place on board	Main deck, port side
Injuries/fatalities	1 injury
Damage/environmental impact	None
Vessel operation	Fishing
Voyage segment	Mid-water
External & internal environment	1m wave height; wind north-easterly force 4; good visibility and clear skies
Persons on board	6

[1] The *Jacoba* investigation was started under the Merchant Shipping (Accident Reporting and Investigation) Regulations 2012 (as amended) which were revoked by the Merchant Shipping (Accident Reporting and Investigation) Regulations 2026. Under the 2012 Regulations the accident on board *Jacoba* was categorised as a *Less Serious Marine Casualty*.

1.2 NARRATIVE

On 8 May 2025, *Jacoba* departed Portsmouth, England at approximately 1010 and proceeded to fishing grounds in the English Channel. At about 0045 on 9 May 2025, *Jacoba* started dredging for scallops in the eastbound lane of the traffic separation scheme and continued operating in the area **(Figure 1)** for the next 24 hours. The vessel completed 17 trawls over this period, with the crew working a 6-hour watch rotation.

At midnight on 10 May 2025, the mate took over the watch from the skipper in the wheelhouse and deckhand 1 and deckhand 2 started their watch. At 0227, the mate began hauling the second dredge of their watch. The deckhands heard the winches operating and proceeded onto the main deck. Deckhand 1 went to the port side and deckhand 2 to the starboard side **(Figure 2)**.

Figure 1: The accident location

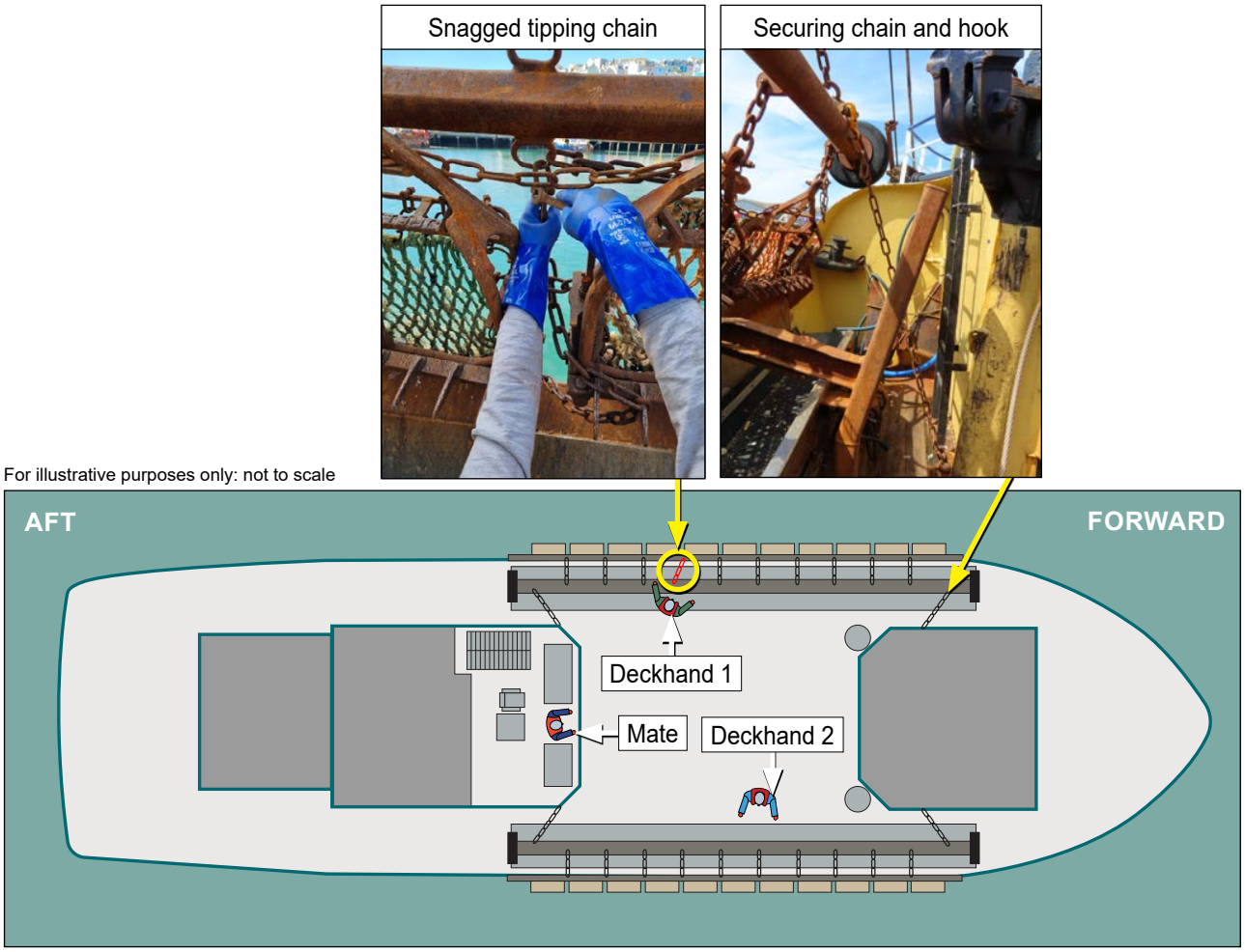

Figure 2: *Jacoba*'s working deck, showing key equipment and deckhand positions at the time of the accident

As *Jacoba*'s derricks were raised, the gear was bowsed into the side of the hull and raised up to the edge of the port and starboard bulwark and conveyor. The deckhands then attached two securing chains to each of the main beams, one at the aft end followed by one at the forward end.

As the main beam on the port side was heaved tight against the chains, the chain connecting the bottom of the chain link dredge bag to the tipping bar became caught on the teeth of one of the dredge frames. The mate adjusted the main beam by lowering and heaving it slightly while deckhand 1 reached across the conveyor to try to manually free the chain from the teeth.

While deckhand 1 was trying to free the chain on the port side the mate heaved the main beam on the starboard side and deckhand 2 started adjusting the starboard side dredges. Deckhand 1 climbed onto the port side conveyor and continued to attempt to free the caught chain.

The mate again lowered and raised the port side main beam slightly to try and dislodge the chain as deckhand 1 sat on the inner edge of the conveyor. Deckhand 1 then stepped up onto the outer edge of the conveyor to access the shackle connecting the chain to the tipping bar, intending to undo the shackle to allow the chain to be removed and freed. Deckhand 1 then stepped back to the middle of the conveyor and leaned forward between the main beam and tipping bar.

At 0236, the mate again slackened the port side main beam to help deckhand 1 undo the shackle. As the mate operated the winch control both the port and starboard main beams lowered. The port side main beam struck deckhand 1 on the back, lifting them off the conveyor and pinning them between the main beam and tipping bar **(Figure 3)**. The mate immediately raised the main beams and deckhand 1 fell onto the conveyor and rolled onto the deck, kicking and writhing in pain.

The mate exited the wheelhouse onto the deck and went with deckhand 2 to assist deckhand 1. They removed deckhand 1's personal flotation device (PFD) and gloves. The mate checked that deckhand 1 was breathing and assessed them for injuries; they did not identify any swelling or bleeding. Deckhand 1 was in a lot of pain and was kicking their legs. Because deckhand 1 could move their legs the mate decided that it was safe for deckhand 1 to be moved and alerted the skipper and off watch deckhands, who mustered to assist.

At about 0250, *Jacoba*'s skipper contacted His Majesty's Coastguard (HMCG) and was informed that *Jacoba* was operating within the French sector. HMCG passed coordination responsibility to Gris-Nez Maritime Rescue Coordination Centre (MRCC).

At 0327, the crew moved deckhand 1 down the port side of the vessel and into the mess at the rear of the accommodation. At 0404, Gris-Nez MRCC contacted *Jacoba*. During this exchange the skipper declined assistance from French authorities, including an offer of support from the Telemedical Maritime Assistance Service (TMAS). The skipper expressed a preference for UK assistance and indicated an intention to return to Portsmouth.

At 0406, coordination was transferred to the UK Joint Rescue Coordination Centre (JRCC). At 0433, the JRCC facilitated a TMAS consultation between the skipper and a doctor. Concerned about the possibility of crush injuries, the doctor determined that helicopter evacuation was medically necessary.

At 0530, a rescue helicopter arrived on scene and lowered a paramedic to *Jacoba* by winch. At 0630, deckhand 1 was transferred to the helicopter and evacuated to hospital. Deckhand 1 remained hospitalised with serious crush injuries until 11 August 2025, when they were repatriated to India.

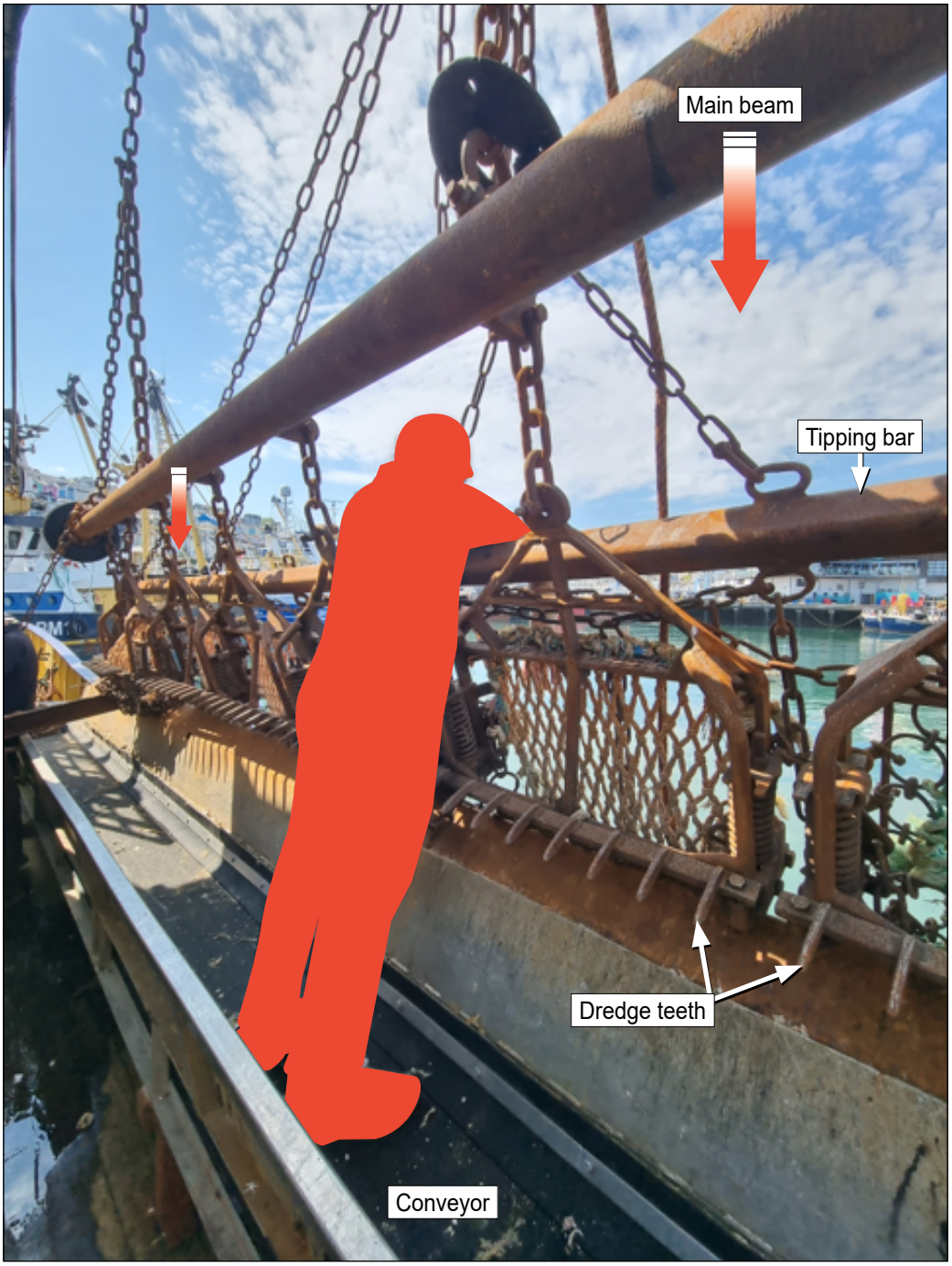

Figure 3: *Jacoba*'s port dredging equipment, showing the position of deckhand 1 at the time of the accident

1.3 ENVIRONMENTAL CONDITIONS

The wind was north-easterly at up to 14 knots, accompanied by slight seas and a low easterly swell. Visibility was good, with clear skies.

1.4 *JACOBA*

1.4.1 General description and fishing method

Jacoba was a 22.18m fishing vessel built in 1988 as a scallop dredger and later converted to a beam trawler. The vessel was purchased by the current owner in 2021 and reconverted to operate as a scallop dredger.

Jacoba carried two sets of scallop dredges, one on either side of the vessel. Each set comprised 11 dredges **(Figure 4)**. The dredges comprised triangular steel frames fitted with bars lined with metal teeth and chain link dredge bags for collecting scallops. The upper end of the dredge frame was attached to a main beam, while the dredge bags were connected by short lengths of chain to a secondary beam known as the tipping bar. During fishing operations the dredges were towed along the seabed behind the main beam. As the dredges moved across the seabed the teeth disturbed the sediment and dislodged scallops, which were collected in the chain link bags. The vessel's winches hauled in the towing warps connected to the main beams to recover the dredges. As the gear reached the surface, the derricks were raised to bowse the dredges alongside the vessel. The crew then secured each main beam with chains at the forward and aft ends to hold the gear in position.

Figure 4: *Jacoba* alongside, showing the configuration of the scallop dredges

To empty the dredges, the crew connected a wire to the tipping bar. When this wire was hauled in the tipping bar was raised above the main beam, causing the dredge bags' contents to be tipped into conveyor trays positioned along each side of the main deck. The crew sorted the catch at the conveyor trays.

There had been several previous incidents on *Jacoba* of the chains connecting the dredge bags with the tipping bar becoming caught in the teeth of the dredges, requiring the crew to free the dredge bags before their contents could be tipped. To free these snags, the crew unpinned the shackle connecting the chain to the tipping bar with the main beam suspended.

1.4.2 Crew

Jacoba had a crew of six; the skipper, mate and four deckhands. The skipper, mate and one of the deckhands were Latvian nationals and had been recruited via a Latvian crew agency. The other three deckhands, two Indian nationals and one Ghanaian national, had been recruited via a UK-based crew services agency. The crew's certification is summarised in **Table 1**.

Jacoba's skipper held a Latvian Certificate of Competency (CoC) to serve as master on fishing vessels of less than 45m operating in unlimited waters. The certificate did not hold a UK Flag State Endorsement (FSE). The skipper had sailed on *Jacoba* as mate between August 2023 and August 2024 and was promoted to master on 30 August 2024. The skipper qualified as a master on fishing vessels on 23 April 2025, having previously held a Latvian navigational watch officer CoC for fishing vessels of less than 45m operating in unlimited waters.

The mate had sailed on *Jacoba* for 25 days during 2024 with no prior fishing experience, before rejoining the vessel on 5 April 2025. The mate had previously served on tankers, as an ordinary seaman (OS) in 2023 and as an able seaman in 2024. The mate held a Latvian certificate for an ordinary seaman with a navigational watch rating.

Role \ Course	STCW[2] Personal Survival Techniques	STCW Elementary First Aid	STCW Fire Prevention and Fire Fighting	Seafish[3] Basic Health and Safety	Seafish Safety Awareness and Risk Assessment[4]
Skipper	Yes	Yes	Yes	No	Yes
Mate	Yes	Yes	Yes	No	Not applicable
Deckhand 1	Yes	Yes	Yes	No	Not applicable
Deckhand 2	Yes	Yes	Yes	No	No
Deckhand 3	Yes	Yes	Yes	No	Not applicable
Deckhand 4	Yes	Yes	Yes	No	Not applicable

Table 1: *Jacoba*'s crew training records

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

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

[4] The mate and deckhands 1, 3 and 4 had been working in the fishing industry for less than 2 years and were not required to complete this course.

1.4.3 Deckhand 1

Deckhand 1 was a 23-year-old Indian national who had joined *Jacoba* on 20 December 2024. Before joining *Jacoba*, deckhand 1 had served as an OS on bulk carriers in 2023-24 and had previously worked on a fishing vessel in Dubai.

At the time of the accident deckhand 1 was wearing bib and brace oilskin trousers, rubber boots, gloves and a PFD. Deckhand 1's injuries included a collapsed lung, liver trauma, multiple fractured ribs and spinal fractures. Deckhand 1 was unable to return to work due to their injuries and continues to receive medical care.

1.4.4 Crew induction

On board *Jacoba*, newly joined crew members completed a crew induction form that comprised three sections and was reviewed and signed by the skipper. The induction form covered:

- the location and use of safety and firefighting equipment
- routine vessel operations and general onboard procedures
- actions to be taken in the event of an emergency.

The form included a single tick box relating to fishing equipment and safety. Practical familiarisation consisted of a walk around the vessel, after which new crew members observed vessel operations for one watch before undertaking a watch under supervision.

1.4.5 Owner

Jacoba was owned and operated by Poseidon Trawlers Limited. The company operated two scallop dredgers at the time of the accident and had recently sold a third vessel, *Our Heather*, following a fire in 2024 (see section 1.6.3).

The company's two directors worked as skipper on the other vessel and owned a local chandlery that produced scallop dredging gear, respectively.

1.4.6 Safety management and risk assessment

Jacoba's owners maintained a fishing vessel safety folder on board the vessel. The folder contained documented safety policies and risk assessments and referenced 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).

Jacoba's risk assessments included a section titled *Beam trawling/dredging* that included two risk assessments relating to the vessel's beams **(Figure 5)**. A plan of the vessel's deck was displayed in the galley and included hand-drawn markings identifying *safe zones while hauling and shooting the gear* **(Figure 6)**.

Image copied from on board document

SAFETY FOLDER. Jacoba BM77
www.safetyfolder.co.uk

Beam trawling/dredging

Last edited / reviewed on: 06/02/2025

Risk id	Hazard Area/Activity	Risk	Controls in place	Risk Outcomes	Risk Level
Version - 3 06/02/2025	Beam.	Being struck by beam leading to death or serious injury Being crushed by dredge leading to death or serious injury.	Wear the correct PPE including PFD, oilskins, safety boots and hard hats, stand in safe zones clear of lifted gear, stand clear of any moving gear to reduce the risk of crushing.	Broken bones, crushings, head injuries and life threatening bleeds.	Low Risk
Version - 3 06/02/2025	Beam retrieval.	Being banged by gear on retrieval leading to major injuries Gear snagging vessel propulsion system leading to vessel loss, death or serious injury Poor communication leading to lack of awareness of work being undertaken leading to possible injuries Poor lifting and anual handling leading to possible.	Wear the correct PPE including PFD, safety boots, gloves and oilskins, stand in safe working zones clear of moving equipment, communication is essential, work as a team.	Broken bones, head injuries and lifethreatening bleeds. MOB leading to cold water shock, hypothermia or death by drowning.	Low Risk

Figure 5: Safety folder beam risk assessments

Image copied from on board document

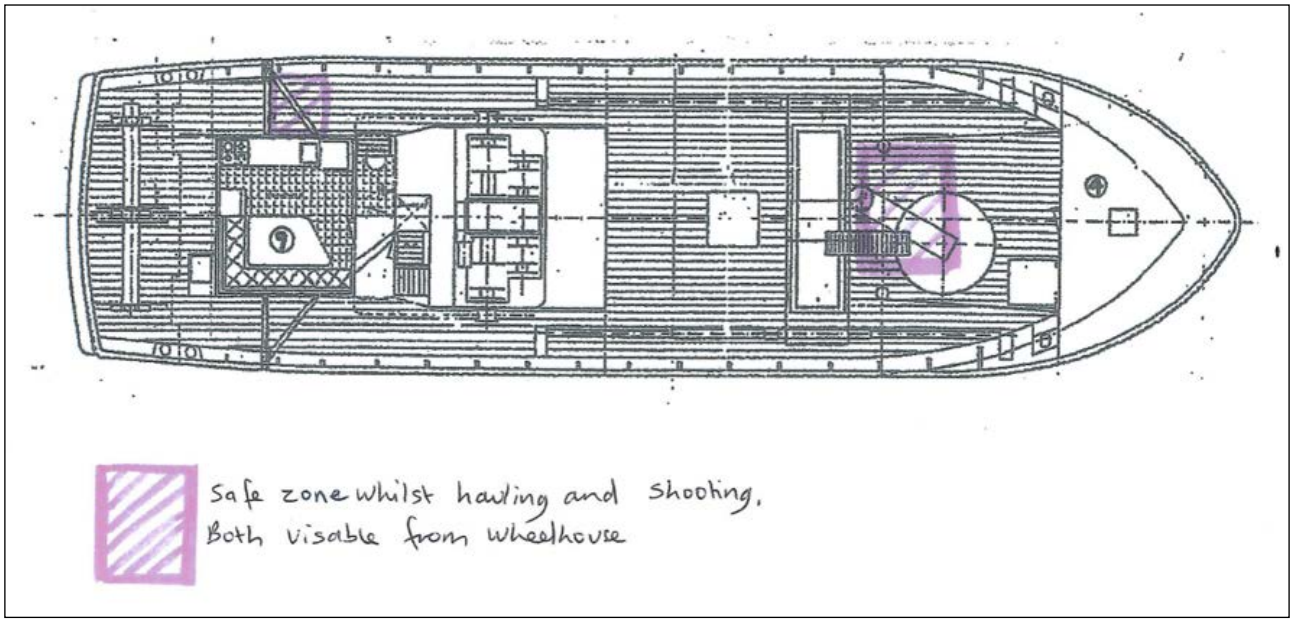

Figure 6: *Jacoba*'s deck plan, showing identified safe zones

1.4.7 Maritime and Coastguard Agency inspections

On 2 August 2023, the Maritime and Coastguard Agency (MCA) issued *Jacoba* with a Fishing Vessel Certificate valid for 5 years following an inspection on 24 July 2023.

On 7 August 2024, the MCA inspected *Jacoba* as part of a focused inspection campaign targeting lifting equipment. The inspection identified several deficiencies including that the documented lifting plan did not detail inspection and maintenance regimes, the responsibilities or competence of the nominated competent person or defect reporting arrangements. The inspection also identified that there was no risk assessment covering lifting operations.

On 12 September 2024, an inspection as part of a grant approval recorded that the deficiencies identified in *Jacoba*'s August 2024 inspection remained outstanding.

On 8 October 2024, *Jacoba* underwent a targeted general inspection by the MCA. All previously identified deficiencies were recorded as rectified. Eleven new deficiencies were identified, mainly for machinery and fittings. One deficiency related to crew training and certification, noting that one crew member was *Missing Basic Safety Awareness* and another was *Missing Experienced Fisherman's course*. The MCA required the courses to be *completed at the earliest opportunity and certificates evidence submitted to MCA within 3 months*. This deficiency was assigned an Action Code 99 – *Master instructed to* and an Action Code 98 – *Master to notify MCA Marine Office when rectified*.

At the time of the accident, 10 of the deficiencies identified during the inspection on 8 October 2024 remained open, including the deficiency relating to crew training. Only deckhand 3 had also been on board *Jacoba* during the October 2024 inspection.

1.5 REGULATION AND GUIDANCE

1.5.1 Training

Crew members serving on board UK registered fishing vessels were required to complete the mandatory safety training specified in Marine Guidance Note (MGN) 411 (M+F)[5]. Before starting work, all new crew members were required to complete a 1-day basic sea survival course. Within 3 months of starting work, new crew members were also required to complete the following mandatory courses:

- *1 day Basic Fire Fighting and Prevention*
- *1 day Basic First Aid; and*
- *1 day Basic Health and Safety*

Additionally, experienced fishermen were required to complete the Seafish[6] 1-day Safety Awareness and Risk Assessment course. MGN 411 (M+F) defined experienced fishermen as those with 2 years' experience or more.

The MCA accepted STCW certificates as equivalent training for the sea survival, first aid, and firefighting and prevention courses. There was no STCW alternative for the 1-day Basic Health and Safety and 1-day Safety Awareness and Risk Assessment courses and only Seafish approved training providers could deliver these courses. There were no Seafish approved training providers outside the UK.

1.5.2 Survey and inspection

Fishing vessels over 15m and less than 24m in length were required to comply with Merchant Shipping Notice (MSN) 1872 (F) Amendment 1[7]. Vessels operating under the Code contained in this MSN were subject to MCA surveys and inspections to verify compliance with the applicable construction, stability, machinery, safety equipment, and operational standards.

---

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

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

[7] MSN 1872 (F) Amendment 1 – The Code of Safe Working Practice for the Construction and Use of Fishing Vessels of 15m Length Overall to less than 24m Registered Length.

Following successful inspection, vessels were issued with a UK Fishing Vessel Certificate (FVC) valid for 5 years. Fishing vessel skippers were required to endorse the certificate annually between MCA renewal inspections to confirm their vessel's ongoing compliance with MSN 1872 (F) Amendment 1; the MCA deemed the FVC to be invalid if the vessel or its operation deviated from the requirements.

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 a successful outcome following an inspection or survey. The listed requirements, documents and evidence to be available for inspection included crew training certificates and copies of risk assessments.

1.5.3 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[8].

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 certifying that they had completed the Safety Awareness and Risk Assessment course.

1.5.4 Health and safety

In March 2019, the MCA published MGN 587 (F) Amendment 1[9], 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.*
- *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 –*

[8] Revision 12.23

[9] 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.

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

1.5.5 Fishing vessel safety management

The MCA's MGN 596 (F)[10] was published to assist fishing vessels to follow the guidance in MGN 587 (F) Amendment 1 and comply with MSN 1872 (F) Amendment 1. 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;*
- *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.*

1.6 PREVIOUS/SIMILAR ACCIDENTS

1.6.1 *Olivia Jean* – fatal injury

On 28 June 2019, a crew member was fatally injured on board the scallop dredger *Olivia Jean* when he was struck on the head by a scallop dredge towing bar[11] (MAIB report 5/2021[12]). The accident occurred during deck operations to replace worn dredges on the starboard towing bar. While the skipper was using the winch and derrick to lift and realign the dredge gear, one of the towing bar's securing chains had not been released and the gear became snagged.

As the skipper attempted to free the snagged gear, the towing bar suddenly released and swung inboard, striking the crew member on the head. The crew member sustained serious head injuries and was evacuated to hospital but died 12 days later. At the time of the accident, the skipper was operating the winches from the wheelhouse while deck operations were being carried out on the working deck.

The MAIB investigation identified that deck operations were not being effectively supervised or controlled and that the risk controls identified in the vessel's risk assessments were not being applied during the lifting operation.

---

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

[11] An alternative term used by the vessel to refer to the main beam.

[12] MAIB report 5/2021: Olivia Jean

1.6.2 *Cornishman* – fatal injury

On 6 February 2021, a deckhand was fatally injured on board the beam trawler *Cornishman* when he was struck by the port trawl beam (MAIB report 8/2025[13]). The accident occurred while the crew were carrying out repairs to the port trawl gear with the trawl beam hoisted and suspended above the deck. During the repair a chain forming part of the quick-release gear supporting the beam failed without warning, causing the beam to fall and strike the deckhand.

The investigation found that the chain failure was the result of material and design factors, including the use of a chain that was unsuitable for the marine environment and installation geometry that introduced additional stresses. The investigation also identified that risk assessments had not been effectively applied and that crew members were exposed to the hazards of working beneath suspended loads.

The report made several recommendations, including to *Cornishman*'s owners to review and update its risk assessments.

1.6.3 Previous accidents in the Poseidon Trawlers Limited fleet

On 10 July 2024, a crew member on board the scallop dredger *Our Heather* sustained a head injury and lacerations while attempting to clear stones from the dredging gear. The injured crew member was evacuated by helicopter to hospital.

On 22 September 2024, a crew member on board *Our Heather* suffered serious burn injuries during an engine room fire. The fire occurred following the use of an unapproved fuel system that the owner had installed on board the vessel.

On 6 April 2025, a crew member on board *Jacoba* sustained leg injuries when their leg became trapped between the chain securing one of the main beams and a vertical bar on the deck while the dredging gear was being operated. The crew member was taken to hospital for treatment.

[13] MAIB report 8/2025: Cornishman

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

Jacoba's deckhand was seriously injured after being crushed between the vessel's port side main beam and tipping bar. The deckhand was trying to free a snagged chain at the time and was working underneath the main beam. When the mate lowered the main beam to assist with freeing the snag it struck the deckhand, causing serious crush injuries.

The analysis will consider the factors contributing to deckhand 1's serious injury, including the crew's actions, training, safe systems of work and the owner's responsibilities.

2.3 *JACOBA*

2.3.1 The accident

Deckhand 1 was working to clear a snagged dredge bag chain, which was a necessary task because the snag was preventing the catch from being recovered on board. Deckhand 1 had placed themselves underneath the suspended port side main beam to access the dredge bags and free the snagged chain. While deckhand 1 was underneath the main beam, the mate lowered it. The main beam struck deckhand 1 and crushed them against the port side tipping beam.

The mate adjusted the port side main beam in the belief that this would assist deckhand 1 to free the snagged chain. However, this action involved moving the main beam while a crew member was positioned outside the vessel's documented safe zones and near suspended and moving gear. The vessel's risk assessments specified that crew members should remain within identified safe zones and clear of all moving gear during beam operations. The decision to operate the winch controls and lower the main beam under these circumstances therefore increased the risk to the deckhand.

The benign prevailing weather conditions at the time of the accident are not considered to have been a contributory factor. Sea conditions were slight, with a low swell, and were unlikely to have caused significant vessel motion. Any contribution to the movement of the port side main beam was therefore likely to have been minimal.

Jacoba's crew had experienced similar snags in the past during recovery of the fishing gear and had successfully freed these snags manually. Without documented guidance or any formal procedure for dealing with this situation, it is likely that deckhand 1 and the mate relied on previous successful outcomes and did not appreciate the risk involved in adjusting the main beam while the deckhand was working beneath suspended gear.

2.3.2 Safe systems of work

Jacoba's safety folder included a risk assessment for beam trawling and dredging. Although the risk of being struck by the main beam had been identified, the risk level was recorded as low and contradicted the recorded potential outcome of death or serious injury. Additionally, there was no task-specific risk assessment for recovering and tipping the scallop dredges nor a procedure for clearing snags.

The documented risk assessments did not adequately identify or address the hazards associated with working near suspended and moving dredging gear. Beam trawling and dredging risks were grouped together and categorised as low risk, and control measures were limited to general statements such as wearing personal protective equipment and staying inside designated safe zones. There was no documented guidance explaining how to apply these controls in the event of abnormal or unexpected situations.

The absence of clear, task-specific procedures meant that *Jacoba*'s crew relied on informal practices to manage routine hazards during dredge recovery. This reduced the effectiveness of the vessel's safe systems of work and increased the likelihood of crew members being exposed to hazardous situations, including working beneath or close to suspended and moving gear. The *Olivia Jean* and *Cornishman* investigations identified similar risk assessment and risk control issues. *Jacoba*'s risk assessments did not adequately address the operation of scallop dredging gear, resulting in associated hazards being ineffectively mitigated and placing the crew at risk.

2.3.3 Familiarisation

Although both deckhand 1 and the mate had previous seagoing experience, this was mainly outside the fishing industry and they had limited experience of working on scallop dredgers. On joining *Jacoba*, both had completed a crew induction form and received a short practical familiarisation that included a walk around the vessel and one watch under supervision.

The induction and familiarisation arrangements in place on *Jacoba* did not adequately address the specific hazards associated with scallop dredging operations. The crew induction form was generic, with a single tick box reference to fishing equipment and safety. There was no evidence of task-specific familiarisation covering the operation of dredging gear, the risks associated with working near suspended and moving equipment, or safe methods for dealing with routinely encountered situations such as clearing snagged gear. The limited practical familiarisation did not ensure that new crew sufficiently understood the vessel's gear, nor did it adequately prepare the mate for the operation of winches and dredging equipment under abnormal conditions.

The absence of effective, task-specific familiarisation exposed new crew members to operational hazards without a clear understanding of the associated risks or the control measures required to manage them. This increased reliance on informal practices and previous experience, which was in this case limited for scallop dredging operations. The lack of effective crew familiarisation meant that hazards were not fully understood, creating conditions for unsafe conduct during routine operations.

2.3.4 Training and certification

Jacoba's crew were recruited through two crewing agencies and none were UK nationals. At the time of the accident, the skipper did not have UK FSE and none of the crew members had completed the basic health and safety training required to work on a UK-registered fishing vessel. The basic health and safety training could not be completed outside of the UK and was required within 3 months of joining the industry. *Jacoba*'s owner was responsible for ensuring that crew members met UK training and certification requirements but had evidently not enforced this.

Mandatory safety training provides a baseline level of knowledge to support hazard awareness, safe working practices, and effective responses to routine and abnormal operations. Where such training is incomplete, crews may lack essential safety skills and rely instead on informal knowledge or previous experience gained on different vessel types. The risk is particularly relevant on scallop dredgers, where crew are routinely exposed to hazards associated with lifting operations, suspended gear and moving equipment.

Although *Jacoba* was subject to periodic MCA inspections, mandatory training deficiencies remained unresolved in the periods between them. Responsibility for addressing these shortcomings relied on the owner and skipper taking corrective action, which did not occur. The requirement to ensure crew had completed mandatory safety training went unenforced and *Jacoba* continued to operate with uncertified crew. This reduced assurance that those on board had the required safety knowledge.

2.3.5 Responsibility for safety

Jacoba's owner was responsible for ensuring that the vessel complied with the applicable statutory safety requirements and guidance in MSN 1872 (F) Amendment 1, including the implementation and maintenance of effective onboard safety management procedures such as setting the health and safety policy for vessels operated by the company and ensuring that suitable risk assessments were in place and remained appropriate for the vessels' fishing methods and modes of operation. Such arrangements also provided an opportunity to verify that crew training, certification and familiarisation requirements were being met. MGN 596 (F) provided guidance on how to develop an SMS and outlined the documentation required to achieve this and maintain records.

The accident on *Jacoba* was not an isolated occurrence within the owner's fleet. Previous serious injuries had occurred on vessels operated by the same company, including an injury on board *Jacoba* in April 2025 and two serious injuries on board *Our Heather* in 2024. These accidents indicate that opportunities to identify recurring hazards and strengthen safety management arrangements across the fleet were not fully realised, reducing the owner's ability to maintain consistent safety standards and increasing the risk to crew members.

Although one of the company's directors had operational fishing experience and regularly sailed as skipper on another vessel in the fleet, the management of *Jacoba* was left to the other director who had more limited operational experience and relied on the vessel's skipper for *Jacoba*'s day-to-day operation and safety management. The guidance in MGN 587 (F) Amendment 1 recognised that the vessel's owner

might have limited control of operational activities, though there was no evidence of structured oversight by the company as evidenced in the deficiencies identified with crew certification.

Safety management on board *Jacoba* was largely informal, reflecting limited company oversight at a time when the vessel was operating with a recently promoted skipper and a mate with little fishing experience. This meant that *Jacoba* did not have a structured safety management framework. The absence of a fishing SMS aligned with the guidance in MGN 596 (F) reduced assurance that risks were being systematically identified, controlled and reviewed.

2.3.6 Survey and inspection

The MCA had raised a crew training and certification deficiency during a targeted inspection in October 2024. The deficiency noted that one crew member had not completed basic health and safety training and another had not completed the Seafish Safety Awareness and Risk Assessment course. These courses provide crew with knowledge of on board hazards, safe working practices and the principles of risk assessment. The MCA allowed a 3-month rectification period, relying on the owner or skipper to either submit evidence of completed training or demonstrate that the uncertified crew members had left the vessel.

The training deficiency remained unresolved within the 3-month timeframe, and deckhand 3 remained on board and continued to sail on *Jacoba* despite their lack of basic health and safety training. The MCA does not appear to have taken any follow-up inspection or enforcement action when the deficiency was not closed. The vessel therefore continued to operate for several months with a known crew certification shortfall despite the MCA having identified and recorded the issue.

At the time of the accident, 7 months after the October 2024 inspection, the crew training deficiency remained open and deckhand 3 was still serving on board without the required certification. The absence of MCA follow-up or enforcement following an identified deficiency in crew training represented a missed opportunity to ensure all crew had completed essential safety training.

SECTION 3 – CONCLUSIONS

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

1. The deckhand was seriously injured when the main beam was lowered while they were working underneath it. [2.3.1]

2. Without documented procedure, it is likely that the deckhand and the mate based their actions on previous experience and had not appreciated the risk of adjusting the main beam while the deckhand was working beneath suspended gear. [2.3.1]

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

1. *Jacoba*'s risk assessments did not adequately address the operation of scallop dredging gear, resulting in associated hazards being ineffectively mitigated and placing the crew at risk. [2.3.2]

2. The lack of effective crew familiarisation meant that hazards were not fully understood, increasing reliance on informal practices and creating conditions for unsafe conduct during routine operations. [2.3.3]

3. The requirement to ensure crew had completed mandatory safety training went unenforced and *Jacoba* continued to operate with uncertified crew. This reduced assurance that those on board had the required safety knowledge. [2.3.4]

4. Limited company oversight and reliance on informal on board practices meant that *Jacoba* did not have a structured safety management framework. The absence of a fishing safety management system aligned with the guidance in MGN 596 (F) reduced assurance that risks were being systematically identified, controlled and reviewed. [2.3.5]

5. The absence of MCA follow-up or enforcement following an identified deficiency in crew training represented a missed opportunity to ensure all crew had completed essential safety training. [2.3.6]

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:

- Completed a targeted general inspection of *Jacoba* following the accident on 13 May 2025, during which 29 deficiencies were identified and the vessel was detained.
- Issued a prohibition notice to *Jacoba*'s owner in respect of ceasing fishing operations and required the owners to implement and demonstrate a safe system of work before fishing operations could be resumed.
- Issued improvement notices for all crew members who did not hold the required Seafish Basic Health and Safety and Safety Awareness and Risk Assessment course certificates.

Poseidon Trawlers Limited has:

Made the following alterations to *Jacoba*:

- fitted extended safety hooks for securing the dredge beam when shooting/ hauling or working on the gear
- marked a safety zone on the main deck
- renewed safety chains
- installed tugger winches
- marked winch clutch controls with labels
- posted new safety notices and polices on board
- fitted a working platform/step for crew to access the conveyor.

Made the following safety management changes:

- started implementing a new safety management system
- provided an updated set of risk assessments
- developed a new set of procedures
- created an assessment form to assess the competency of the crew member operating the winch
- produced a new lifting equipment inspection sheet.

SECTION 5 – RECOMMENDATIONS

Poseidon Trawlers Limited is recommended to:

2026/149 Expedite the implementation of a fleetwide safety management system that reflects the principles set out in Marine Guidance Note 596 (F) – Fishing Safety Management Code: Helping to Improve the Management of Safety on Fishing Vessels.

2026/150 Review and update vessel risk assessments to include routine tasks associated with scallop dredging operations, ensuring these are fully assessed and that appropriate control measures are clearly defined, documented, and communicated to the crew.

2026/151 Review crewing arrangements to ensure all crew members employed on vessels it operates hold required certification in line with Marine Guidance Note 411 (M+F) – Training and Certification Requirements for the Crew of Fishing Vessels and their Applicability to Small Commercial Vessels and Large Yachts.

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

Serious injury to a crew member on board the scallop dredger *Jacoba* (BM77), 29 nautical miles south-south-east of Beachy Head, England on 10 May 2025

Narrative

On 10 May 2025, a deckhand on the UK registered fishing vessel *Jacoba* was seriously injured while the vessel was dredging for scallops in the English Channel. The deckhand had been attempting to free a snagged dredge bag chain from the dredge teeth when recovering the dredges and was standing on the conveyor, positioned beneath the port side main beam. The mate then operated the winch from the wheelhouse and lowered the main beam, which struck the deckhand and crushed them against the tipping bar **(**see **figure)**. The deckhand suffered multiple serious injuries and was evacuated to hospital by helicopter.

Jacoba

The investigation found that the accident happened because the main beam was lowered while a deckhand was positioned beneath suspended gear. The absence of documented procedures for dealing with snagged dredging gear and an incomplete understanding of the vessel's risk assessment meant that the risks associated with this task were not fully appreciated. Unsafe working practices were therefore able to develop during routine operations.

Although some of *Jacoba*'s crew had previously served on commercial ships they had limited experience of fishing vessels. The absence of effective crew familiarisation combined with a lack of training specific to fishing vessels meant that the hazards of working on a scallop dredger were not fully understood. This increased reliance on informal working practices and created conditions for unsafe conduct during routine deck operations.

Safety lessons

1. Fishing vessels present a range of hazards specific to the fishing method and vessel layout. Experience gained on commercial ships or other fishing vessels with a different fishing method does not necessarily prepare crew for the unique hazards of a particular vessel. Thorough, vessel-specific familiarisation builds on the foundations set out in the required basic health and safety training[1] and ensures crew members understand and are prepared for the operational risks on their vessel, particularly those involving fishing gear and lifting equipment.

2. Owners and skippers should ensure all crew receive mandatory training and that on board familiarisation includes clear explanation of hazardous operations, safe working positions and agreed responses to regularly encountered problems such as snagged or fouled gear. Structured familiarisation and training specific to a vessel and its fishing method prevent informal practices or assumptions becoming accepted as routine practice, reducing the likelihood of unsafe actions that put crew at risk.

1 Marine Guidance Note 411 (M+F) – Training and Certification Requirements for the Crew of Fishing Vessels and their Applicability to Small Commercial Vessels and Large Yachts.

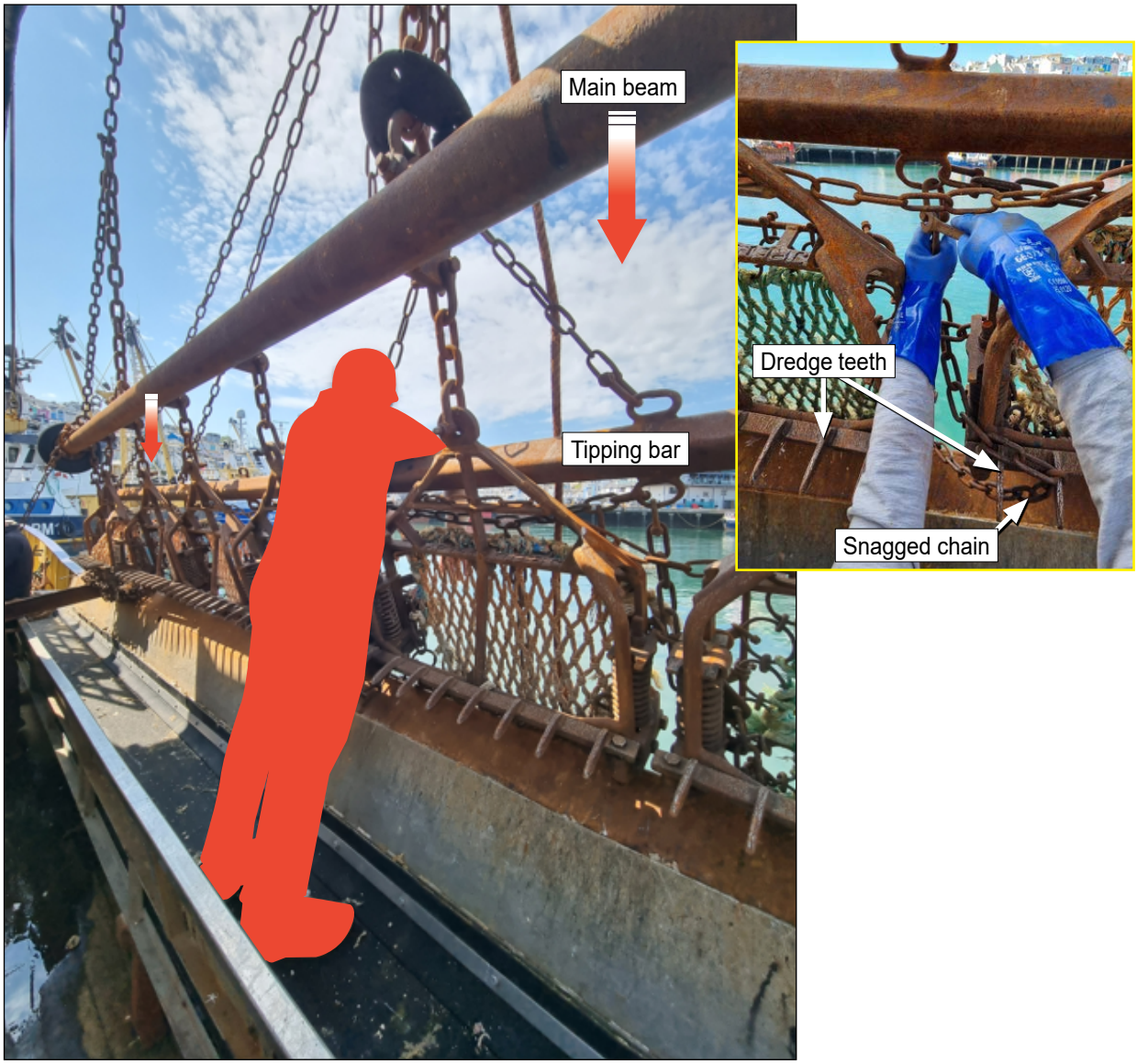

Figure: The accident

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

For all enquiries:
Marine Accident Investigation Branch
First Floor, Spring Place
105 Commercial Road
Southampton
SO15 1GH

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

Publication date: June 2026

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.

Marine Accident Report