

Man overboard from the lone-operated creel fishing vessel *Sea Eagle* (AH18) resulting in one presumed fatality in fishing grounds south-east of Montrose, Scotland on the 20 December 2025

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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SUMMARY

At about 1101 on 20 December 2025, an unmanned fishing vessel, *Sea Eagle*, ran aground on Inverbervie beach, Arbroath, Scotland. The alarm was raised and His Majesty's Coastguard started an extensive search operation. The search was terminated later that day with no one being found.



Sea Eagle (AH18)

The investigation established that *Sea Eagle*'s skipper, working single-handedly, had departed Arbroath earlier that morning for fishing grounds to the south-east of Montrose. At some point after 0900, following an earlier period retrieving and reshooting creels, the skipper entered the water. The vessel continued its course unmanned and on autopilot before grounding on the beach.

The investigation was unable to determine the accident circumstances and the cause of the skipper's entry into the water or whether he was wearing a personal flotation device (PFD) at the time. However, the investigation determined the skipper had been working with two strings of creels on board, which increased the risk of gear fouling and the likelihood of needing to interact with the gear.

In view of the repetition of findings from previous Marine Accident Investigation Branch (MAIB) investigations, no recommendations have been made.

FACTUAL INFORMATION

Narrative

At 0536 on 20 December 2025, *Sea Eagle*'s skipper arrived at the vessel's berth in Arbroath, Scotland. Shortly afterwards, *Sea Eagle* sailed single-handedly for the fishing grounds south-east of Montrose (**Figure 1**).

At about 0905, *Sea Eagle*'s skipper engaged the autopilot, setting the vessel on a north-westerly course at 7 knots (kts). At some point afterwards, with the vessel on autopilot and making way, the skipper left the wheelhouse and subsequently entered the water.

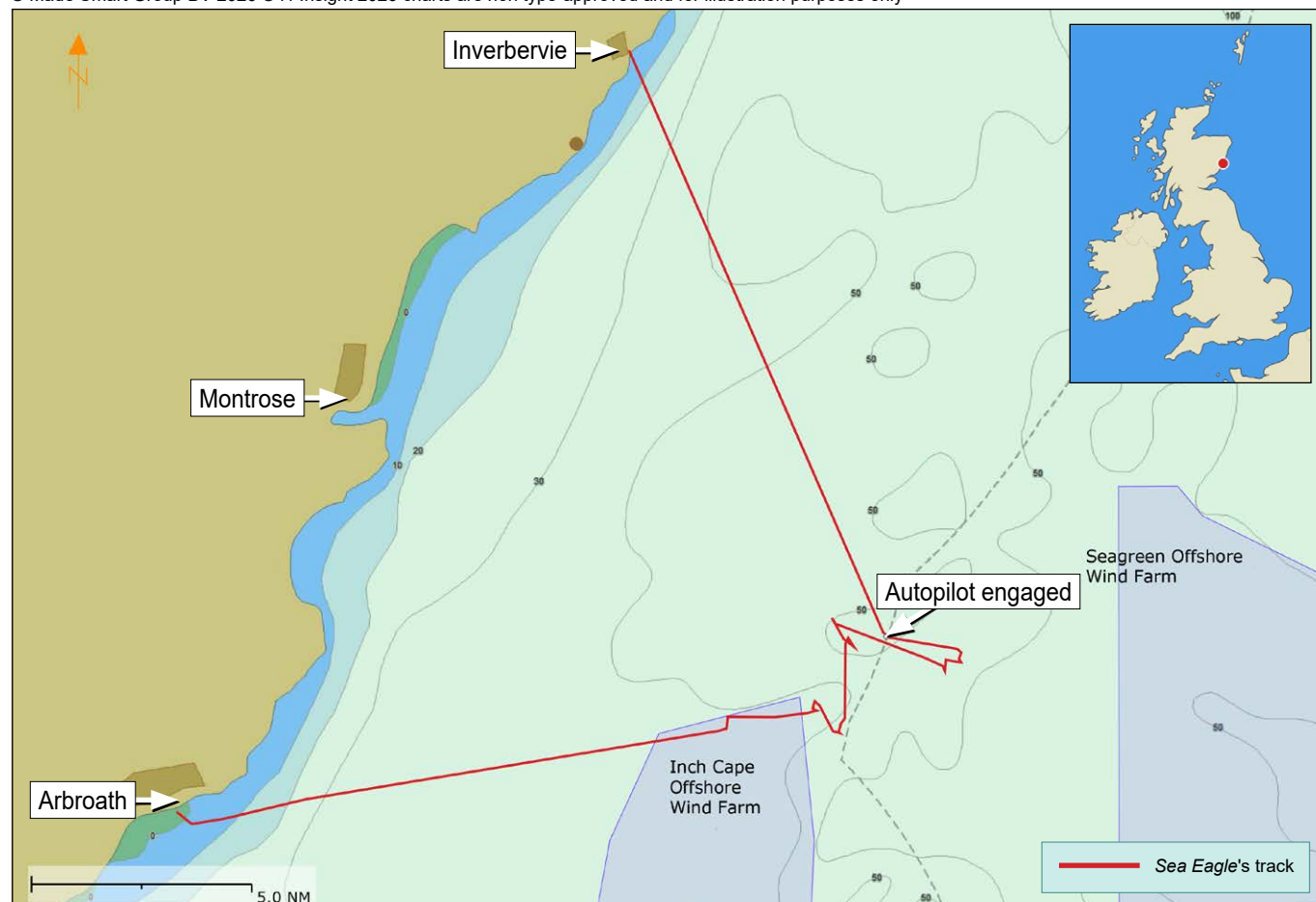


Figure 1: Sea Eagle's final track with inset of accident location south-east of Montrose

At about 1055, two people walking on Inverbervie beach noticed a fishing vessel approaching the shore continue its course until it ran ashore at 1101. The two people then approached the vessel, identified it as *Sea Eagle*, and noticed it was unmanned. They boarded the vessel, stopped its engines and, at 1112, alerted Police Scotland.

At 1115, Police Scotland notified Aberdeen Maritime Rescue Coordination Centre (MRCC), who subsequently mobilised a coastguard rescue team, four Royal National Lifeboat Institution (RNLI) all-weather lifeboats, two search and rescue (SAR) helicopters, and a SAR fixed-wing aircraft. Along with nine nearby vessels, the SAR assets conducted a search of the area to attempt to locate the missing skipper.

At about 1700, the fishing vessel *Aurora* located *Sea Eagle*'s last known string of creels and retrieved it on board to check for entanglement of the missing skipper. The string, with a dhan¹ flag missing at one end, showed no sign of the skipper. *Aurora*'s crew subsequently returned the gear to the water and restarted the search.

At 2130, Aberdeen MRCC stood down searching assets and the search for the missing skipper was terminated.

Environmental conditions

On 20 December 2025, the wind was southerly, Beaufort force 4, with good visibility and high cloud. The sea state was approximately 1m, and the sea temperature was 9°C. From 0814 until 1413, the tidal stream along the Angus coast was south/south-westerly. The depth of water was approximately 60m.

¹ A specialised, durable marker flag used by fishing vessels to indicate the position of the end of a fishing line or net in the sea. Dhan flags are typically attached to a long, weighted pole or float (a dhan buoy).

Cold water immersion

Immersion in cold water under 15°C has immediate and profound effects on the body. The body's immediate reaction to the sudden lowering of skin temperature, between 30 seconds and 2 to 3 minutes after immersion in cold water, includes a rapid rise in heart rate and blood pressure, accompanied by a gasp reflex followed by uncontrollable rapid breathing. Such effects can lead to drowning within seconds if the head goes underwater and the airway is compromised.

Cold incapacitation can set in within 2 to 15 minutes of entering the water if the cold water shock response is survived. During this response, the blood vessels are constricted as the body tries to preserve heat and protect the vital organs. This results in restricted blood flow to the extremities and loss of useful movement in hands and feet, progressively leading to the incapacitation of arms and legs. Without a correctly worn PFD, death by drowning occurs as the individual loses the ability to maintain their airway above the water.

With a water temperature of 4.5°C to 10°C, loss of dexterity can occur in under 5 minutes and exhaustion or unconsciousness between 30 minutes and an hour. The expected survival time in water of this temperature ranges from 1 hour to 3 hours.

The skipper

Sea Eagle's skipper, Ben Dowie, was a 28-year-old career fisherman who had fished from Arbroath since leaving school at 16 years old, initially with family members before purchasing his own vessel.

The skipper purchased *Sea Eagle* in November 2022, and it was the second vessel that he had owned. He had completed all the mandatory training for commercial fishermen. The skipper operated *Sea Eagle* single-handed. He had a manually activated personal locator beacon (PLB) registered to him.

Sea Eagle

Sea Eagle was a 9.98m catamaran being used as a creel² fishing vessel. It was fitted with two 150 horsepower outboard engines and a kill cord in the wheelhouse to stop the engines.

The majority of *Sea Eagle's* aft deck area was covered with an aluminium shooting table on which the creels were processed and stacked before shooting. The table's height was slightly above the vessel's side rail and there was a ramp section at the aft end to assist with the deployment of the creels over the stern. Access to the aft end of the vessel was achievable from either side of the shooting table. The creel hauler was on the starboard aft side of the wheelhouse (**Figure 2**).

Sea Eagle's wheelhouse equipment included three plotters, two fixed VHF radios and an emergency position indicating radio beacon (EPIRB). Lifesaving equipment included a four-man liferaft, two life buoys, a rescue sling and a man overboard (MOB) recovery ladder.

Sea Eagle held a fishing safety certificate issued by the Maritime and Coastguard Agency (MCA) and valid to 16 July 2027.

Fishing routine

The skipper's usual routine was to depart Arbroath at about 0530 for the local fishing grounds, a journey of around 90 minutes from *Sea Eagle's* berth. He would usually return to port between 1500 and 1600.

The skipper fished strings of 15 creels, working 800 creels in total. On a typical day, he would haul and shoot 15 to 18 strings, taking about 30 minutes per string.

² A term used in Scotland to describe a basket used to catch crab or lobster. The term pot is used in other parts of the UK. Pot and creel are interchangeable in documentation.

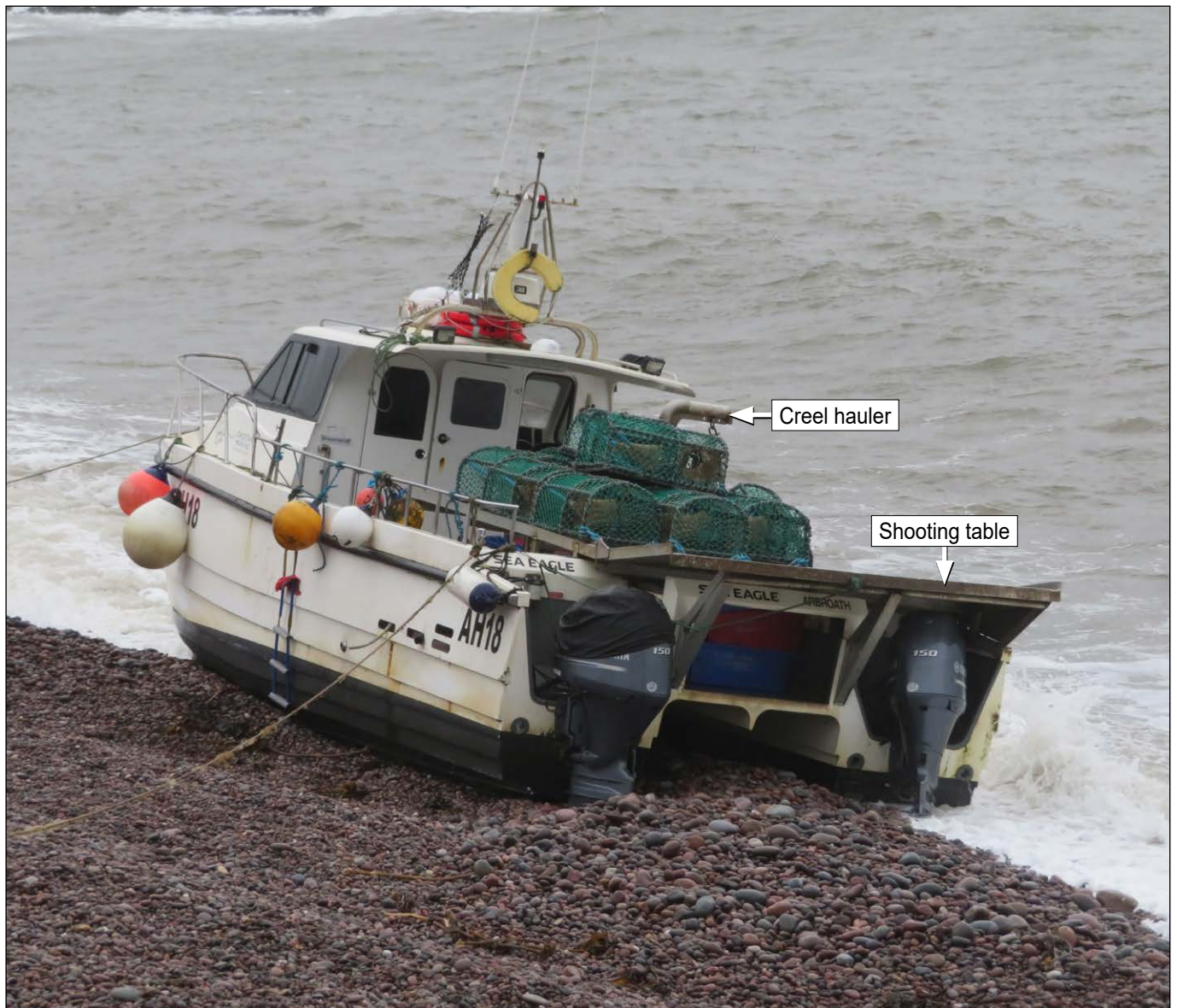


Figure 2: Sea Eagle

The creel string arrangement comprised a dhan flag float and 30kg end weight at either end of the back rope. The string had 15 creels, each weighing 20kg and permanently attached to the back rope by a leg rope. The creels were evenly spaced between the end weights.

Sea Eagle's creels were recovered on board using the vessel's hauler. The first end weight and dhan flag would be placed forward of the shooting table. The skipper would then haul and process the remaining creels in turn, restacking them on the shooting table and flaking the back rope along the vessel's starboard side, ready to be shot again. Finally, the second end weight would be placed on the shooting table, and the end dhan flag would remain outboard of the vessel and secured to a cleat near the wheelhouse, ready for deployment.

To deploy the string of creels, the skipper would drive the vessel ahead and release the dhan flag from the cleat. The resulting tension on the dhan line would pull the end weight and attached creels consecutively overboard until, lastly, the inboard dhan flag and end weight were deployed by the skipper.

The skipper usually worked one string at a time except when transiting between fishing locations when two strings of creels and associated gear were carried, including approximately 1,120m of rope. This was typically achieved by stacking the creels on top of one another up to three creels high (**Figure 3**). When deploying multiple strings it was necessary for creels to be physically downstacked.

For illustrative purposes only: not to scale

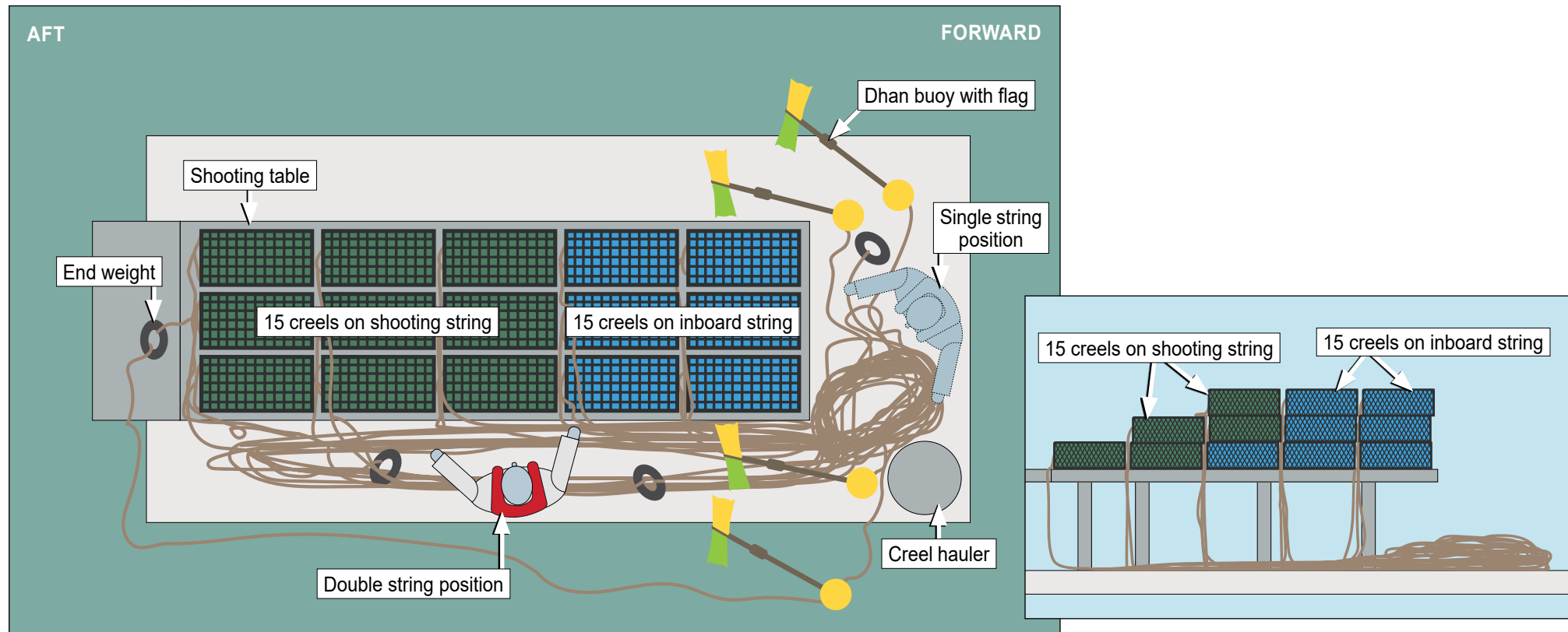


Figure 3: Illustrated aerial view of deck, showing stacking arrangement and (inset) profile view of the possible configuration at the time of the accident

Safety management

Sea Eagle's skipper had adopted the online SafetyFolder (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. This included The Merchant Shipping and Fishing Vessels (Health and Safety at Work) Regulations 1997, which contained a requirement for risk assessments, and the International Labour Organization Work in Fishing Convention, 2007 (ILO 188).

The safety folder had been accessed five times between the vessel's registered date of 14 November 2022 and the last login on 28 July 2025.

The risks identified in the safety folder risk assessments included *becoming caught in line and being pulled into the water, becoming entangled in pots and being pulled into the water and falling into the water while clearing pots*. On the stowage of creels, the risk assessment included the risk of *pots falling on crew leading to serious injury*. The documented risk control measures included *stay away from moving rope* and *don't stack pots too high*. The risk outcomes were recorded as *hypothermia and drowning* and *serious injury*. The risk levels were recorded as medium risk for *caught in line and entanglement*, and low risk for *falling pot injury*. *Sea Eagle*'s risk assessments were identified as version 2, dated 14 November 2024. The risk assessments made no reference to carriage and deployment of multiple strings, or downstacking stacked creels.

As set out in Marine Guidance Note (MGN) 571 (F)³, *Sea Eagle*'s skipper had risk assessed on board activities that might lead to an MOB. The assessment of the risk area of *moving ropes when shoot creel away* was mitigated with the control measure that *all moving rope must stay on starboard side of the boat* and that *Skipper/crew must stay well clear or in wheelhouse when shooting creels*. The assessment also noted *Creel shooting table add to keep rope clear of feet and port side* [sic]. The mitigation detailed on the assessment stated *where the risk of falling overboard has not been removed completely a PFD must be worn on this vessel*.

Post-accident vessel examination

Sea Eagle was examined at Inverbervie beach. Minor scoring damage was evident to the hull and outboard engines. The kill cord was attached to the engine controls in the wheelhouse. Equipment found on board included a four-person liferaft, two lifebuoys, a horseshoe recovery float, a set of flares, three self-inflating PFDs and an EPIRB.

The MOB recovery ladder was initially found in its stowed position (it was later deployed by initial responders). There were 15 creels on board, located at the forward end of the shooting table, with a partially filled box of crabs, another of lobster and some bait. Several creels were double stacked, including some which appeared to have toppled from the upper stack to the starboard side deck. The broken tail end of a dhan flag was on the deck forward of the shooting table.

Examination of plotters

Post-accident examination of the plotters indicated that:

- *Sea Eagle* departed Arbroath at 0536 and arrived at the fishing grounds at about 0700.
- Between 0700 and 0800, three strings of creels were hauled and reshot.
- Between 0812 and 0855, the fourth and fifth strings of creels were hauled and retained on board.
- At about 0905, the autopilot was engaged and set the vessel on a north-westerly course at 7kts. The fourth string of creels was also reshot.

³ MGN 571 (F) – Fishing Vessels: Prevention of Man Overboard.

Industry guidance

First published on 14 May 2014, the MCA's Fishermen's Safety Guide⁴ aimed to provide guidance on safe working practices and emergency procedures and to promote safety awareness. The 1 May 2020 version, which was extant at the time of the accident, stated that:

Single handed operations are not recommended due to the high level of risk involved.

The guide listed several possible risks associated with single-handed operations, including that there was no one to help raise the alarm, deal with an emergency or assist with recovering a person from the water. The guide also listed the need for a ladder to enable reboarding if the lone operator fell overboard. The guide stated that crew must wear a PFD or a safety harness if the risk of falling overboard could not be mitigated, and that a knife should be carried to enable them to cut themselves free of rope, particularly during single-handed operations.

The guidance on the layout and operation of potting vessels included:

- *Ensure that the layout of the vessel allows safe and efficient working of pots/creels. Look for possible snag points that the rope or pots may snag on when shooting*
- *To lessen the danger of crew members becoming entangled with the rope, consider if it is possible to install a barrier to contain the rope clear of the area where the crew are handling the pots*
- *Consider your safety before thinking about the number of pots that you can work.*

The MCA's Single Handed Fishing⁵ guide advised skippers to:

Remove as much risk as possible

For example: non-slip decks, separating yourself from pots/creels...

And to:

Develop your own risk assessment using the free online Safety Folder, developed by the fishing industry for industry.

The Fishing Industry Safety Group (FISG⁶) Home and Dry online safety campaign website included information on the importance of wearing a PFD and using PLBs.

No evidence was found to indicate that the skipper of *Sea Eagle* had accessed this safety guidance.

Accident statistics

The MAIB database of marine accidents between 2000 and 2023 recorded 166 fatal drowning accidents from UK registered fishing vessels. Of these, 114 were not wearing a PFD and 23 were wearing a PFD at the time of the accident. In the remaining 29 cases, it is unknown whether a PFD was worn at the time of the accident.

The MAIB received 126 reports of MOB occurrences from UK fishing vessels between 2013 and 2023, of which 47 (37%) occurred on potting/creeling 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.

⁴ [Fishermen's Safety Guide](#)

⁵ [Single Handed Fishing guide](#)

⁶ A stakeholder group that included representatives from the MCA, Seafish, The National Federation of Fishermen's Organisations (NFFO), the Scottish Fishermen's Federation (SFF), The Northern Ireland Fishermen's Federation (NIFF), the Welsh Fishermen's Association – Cymdeithas Pysgotwyr Cymru (WFA-CPC), the RNLI and the Shipbuilders and Shiprepairers Association (SSA).

The accident on *Sea Eagle* was the seventh fatality to occur on board a UK potting vessel between October 2023 and December 2025.

Previous accidents

On 13 December 2023, the skipper of the single-handed 8.18m creel fishing vessel *Nista* was pulled overboard when deploying his fishing gear (MAIB report 10/2025⁷). The investigation found that *Nista*'s skipper became trapped in the fishing gear as it was deployed. He was probably wearing a PFD, which came off when he was underwater. There was no effective means to separate him from the fishing gear while shooting, for him to reboard, or to raise the alarm from the water.

The report made no recommendation due to previous outstanding MAIB recommendations to industry organisations to promulgate safety guidance about the lone hazards.

On 28 August 2021, the owner and skipper of the lone-operated creel fishing vessel *Harriet J* went overboard while shooting the fishing gear (MAIB report 2/2023⁸).

The investigation concluded that the skipper probably became entangled in the fishing gear and FISG was recommended to:

2023/101 *Expedite the delivery of the outcomes of its working group on lone-operated fishing vessels, taking into account the work commissioned by the MCA and Seafish.*

In response, the FISG executive board established a working group focused on lone-operated fishing vessels that resulted in the identification of several proposals to improve the uptake of guidance. At the time of this report these proposals had not been implemented.

ANALYSIS

Overview

Sea Eagle's skipper entered the water at some point after setting the autopilot and leaving the wheelhouse. As the skipper was fishing alone and has not been located the accident mechanism and cause of his death are unknown. No alarm was raised and the vessel continued unmanned before running ashore 2 hours later. The skipper was not found in the ensuing SAR operation and was presumed lost.

The accident

Sea Eagle's skipper was working alone when he engaged the autopilot, left the wheelhouse and went overboard. With the vessel underway on autopilot, no crew to assist and the kill cord not attached to the skipper, there was no opportunity for the vessel to be stopped, or for the skipper to reboard or the alarm to be raised.

Cold water immersion has an immediate effect when a person enters the water, with the airway being easily compromised and the ability to swim quickly lost. Prolonged immersion can also lead to hypothermia, causing a dangerous drop in body temperature. The presence of three PFDs on the vessel and the fact that the skipper was not located despite a multi-asset search indicates that he may not have been wearing a PFD when he went over the side. If he did not have a PFD to maintain his airway or keep him afloat it is possible that the skipper succumbed to the effects of cold water and drowned.

As the kill cord was not attached to the skipper the engines continued to run when he went overboard and, with the vessel moving ahead on autopilot, there would have been little to no opportunity to reboard. The MOB recovery ladder had not been deployed, further indicating that the skipper lost contact with the vessel when he went overboard. The PLB registered to the skipper was not found on board but it is

⁷ [MAIB report 10/2025: Nista](#)

⁸ [MAIB report 2/2023: Harriet J](#)

unknown whether the skipper had it with him. In any event no alarm was raised, which might indicate that either the PLB was not carried or that the skipper was not able to manually activate it after entering the water.

Sea Eagle's skipper entered the water by mechanism unknown and has not been located. With little opportunity to reboard the vessel, vulnerable to the effects of cold water and potentially without a PFD to support his airway, it is likely that the skipper drowned.

Shooting method and working two strings of creels

It is unknown at what time and how *Sea Eagle's* skipper came to enter the water. However, the broken dhan flag found on board and the corresponding missing dhan flag at the end of the fourth string of creels indicated that the accident occurred between shooting the fourth and fifth string of creels. The fifth string had been hauled before the fourth string was re-shot, indicating that the two strings were both on board simultaneously, possibly for repositioning purposes.

Sea Eagle operated a semi-self-shooting system to deploy the creels, meaning the skipper could largely remain in the wheelhouse. However, the shooting method still required the skipper to engage with the gear to deploy the second end weight and dhan flag and, with no physical separation from the rope on deck, there remained a risk of entanglement. This risk increased when two strings were worked. This was because there was more rope on board to potentially foul the deck and the need to stack and potentially downstack the creels increased the likelihood of needing to interact with the gear during shooting.

The Fishermen's Safety Guide provided advice and recommendations to reduce the risk in creel fishing operations, including the importance of removing the crew from any interaction with the fishing gear. The MAIB accident statistics for potting vessels also highlighted the dangers of gear interaction and entanglement.

Working two strings of creels simultaneously created a greater likelihood that crew would need to interact with the gear. This increased the risk of entanglement.

Lone fishing

The risks from lone fishing were well stated in industry guidance such as the Fishermen's Safety Guide, which made clear that single-handed operations were not recommended. When he entered the water *Sea Eagle's* skipper had no one to help him get back on board, stop the vessel or raise the alarm. Although *Sea Eagle* had an EPIRB, a VHF radio and an MOB ladder, these were unavailable to the skipper once he had gone overboard. With the vessel making way at the likely time of the accident, it is probable there was little possibility for the skipper to reboard. Similarly, the *Nista* and *Harriet J* investigations both identified the challenges, and risks of working alone on small fishing vessels and the particular difficulties posed by overboard emergencies, including those of self-recovery.

The lone fishing operation put the skipper at risk and his chances of being able to self-recover once in the water were probably low.

Operational risks and safety

Sea Eagle's skipper had clearly considered some of the risks associated with creeling. The working arrangements on board required relatively little interaction with the gear when working a single string of creels and the skipper had fitted a creel table to further assist in keeping rope clear of people on the deck. The skipper had used the safety folder and had written risk assessments and identified MOB risk areas.

Despite the positive operational safety points noted, some risk areas remained. The shooting method still required interaction with the second end weight and greater interaction was necessary when more than one string of creels were worked simultaneously. The increased risk of working more than one string of creels had also not been identified in the vessel's risk assessments. The kill cord was not attached

to the skipper when he went overboard, and he was potentially not wearing a PFD. It is possible that these less positive operational points resulted from a lack of awareness of the guidance detailing safe single-handed fishing vessel operations.

The circumstances of this accident and those involving *Nista* and *Harriet J* highlight the enduring risks of lone fishing, especially while shooting. Despite the existence of extensive guidance, and the safety awareness material on these topics produced by the Home and Dry campaign, this has not yet resulted in better support to creel fishermen to improve their working deck arrangements or reduce the risks associated with singlehanded operations.

It is possible that the skipper was unaware of the industry guidance on mitigating the risks of single-handed fishing. Previous recommendations for industry initiatives to improve the promulgation of available safety guidance and information on the hazards of single-handed fishing have yet to take effect.

CONCLUSIONS

- *Sea Eagle*'s skipper entered the water by mechanism unknown and has not been found. With little opportunity to reboard the vessel, vulnerable to the effects of cold water and potentially without a PFD to support his airway, it is likely that the skipper drowned.
- Working two strings of creels simultaneously created a greater likelihood that crew would need to interact with the gear. This increased the risk of entanglement.
- The lone fishing operation put the skipper at risk and his chances of being able to self-recover once in the water were probably low.
- It is possible that the skipper was unaware of the industry guidance on mitigating the risks of single-handed fishing.
- Previous recommendations for industry initiatives to improve the promulgation of available safety guidance and information on the hazards of single-handed fishing have yet to take effect.

ACTION TAKEN

In view of the safety lessons published in previous safety flyers, including both *Nista* and *Harriet J*, no safety flyer has been produced for this report.

RECOMMENDATIONS

As a result of the recurrence of similar findings identified in previous MAIB investigations, no new recommendations have been made. The safety issues identified are considered to be well understood and existing guidance remains directly applicable.

VESSEL PARTICULARS

Vessel's name	<i>Sea Eagle</i>
Flag	UK
Classification society	Not applicable
IMO number/fishing numbers	AH18
Type	Creel fishing vessel
Registered owner	Sea Eagle AH18 Limited
Manager(s)	Sea Eagle AH18 Limited
Year of build	2020
Construction	Glass-reinforced plastic
Length overall	9.98m
Registered length	9.98m
Gross tonnage	3.48
Minimum safe manning	Not applicable
Authorised cargo	Shellfish

VOYAGE PARTICULARS

Port of departure	Arbroath, Scotland
Port of arrival	Arbroath, Scotland (intended)
Type of voyage	Fishing
Cargo information	Shellfish
Manning	1

MARINE CASUALTY INFORMATION

Date and time	20 December 2025 between 0900 and 1055
Type of marine casualty or incident	Very Serious Marine Casualty
Location of incident	Fishing grounds south-east of Montrose, Scotland
Place on board	Unknown
Injuries/fatalities	1 presumed fatality
Damage/environmental impact	Minor damage to hull and outboard engines
Vessel operation	Fishing
Voyage segment	Mid-water
External & internal environment	Good visibility; 1m wave height; wind southerly, Beaufort force 4; sea temperature approximately 9°C
Persons on board	1