MAIB

MARINE ACCIDENT INVESTIGATION BRANCH

FLYER TO THE FISHING INDUSTRY

MAGGIE ANN:

FATALITY DUE TO MANOVERBOARD

At about 1308 on 12 February 2009, a deckhand on board the UK registered scallop dredger *Maggie Ann* fell overboard as he was emptying a dredge bag. He had been standing on the port dredge beam, which was suspended and almost level with the gunwale, when the dredge bag lifting becket parted.

Despite the quick reactions of the skipper and crew, the deckhand sank below the sea surface before he could be rescued. Although an extensive search and rescue operation followed, his body was not recovered. Analysis of evidence based on eye witness accounts suggests that death was most likely due to cold water shock, leading to drowning or cardiac arrest.

The deckhand was a seasoned fisherman but was new to scallop dredging and had worked on board *Maggie Ann* for only 5 weeks. He had signed the Seafish Fishing Vessel Safety Folder to confirm that he had received a safety induction from the skipper, which included maintaining a secure hold of a suspension chain while attending to the dredge bags. However, he had not attended a safety awareness course and the risk assessment form neither identified any significant risk nor recorded any control measures against falling overboard. He is therefore unlikely to have had a full appreciation of the actual risks involved.

The deckhand was not wearing a personal flotation device or a safety harness when he stepped onto the elevated dredge beam, and it was not the practice for deckhands to do so. On this occasion, he let go of the suspension chain **(Figure 1)** to facilitate his emptying one of the dredge bags. As he grasped the dredge bag with both hands, the lifting becket parted, causing him to fall forward and with no protection from the bulwark, to continue to fall overboard.

The bulwark height had previously been increased to allow the scallop dredges to be taken on board in a more controlled manner. However, this meant that when the dredge bags were full, the dredge beam could not be readily lowered into a secure position before the dredge bags were emptied.

Figure 1

Safety Lessons

1. The lifting becket parted at a point of attachment to the dredge bag which was prone to wear. A robust inspection and maintenance regime for the working gear might have identified the wear and have prevented the failure. Ensure you have a regime that does so.

2. Risk assessments for the bag lifting/dredge discharge activity had failed to identify the danger, because the assessment process was not fully understood. Risk assessment is an important tool in keeping fishing safe; make sure you understand how to conduct one, or else ask for assistance.

3. The fitting of a 'tipping bar', commonly used on scallop dredgers, would have enabled all the dredge bags to be inverted at the same time and have avoided the need for deckhands to step onto the dredge beam or to lean over the gunwale. The best way to control a risk is to remove the hazard altogether.

4. The wearing of a lifejacket would have significantly improved the deckhand's survivability. Develop a habit of always wearing one when working on deck.

5. Although the crew responded rapidly to the man overboard, they were ill-prepared to mount a successful recovery. Equipment required to assist the recovery of a person from the water was not available on board and no emergency drills had been conducted which might have ensured that correct equipment was available and well rehearsed procedures were followed.

This accident was the subject of an MAIB Investigation, which can be found on MAIB's website at: www.maib.gov.uk

A copy of the report and/or the flyer will be sent, on request, free of charge.

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