

FLYER TO FISHING INDUSTRY

Our Boy Andrew: Fatal Accident to Skipper

Our Boy Andrew, a UK registered fishing vessel, departed Looe early on the 24 March 2011 and headed south-easterly to her fishing grounds north of Eddystone Rocks. The skipper was the only person on board. At 0710, he shot the port net (**Figure 1**) and then towed it east-south-easterly until 1140, at which time he decided to haul the gear. This would have required him to haul the warps and secure the trawl doors. At about 1200, he turned the vessel onto a south-westerly heading and prepared to haul the port net. It is believed that he set the net drum control lever to the 'haul' position and then stood between the net drum and stern bulwark (**Figure 2**) so that he could manually guide the net onto the drum.

Figure 1

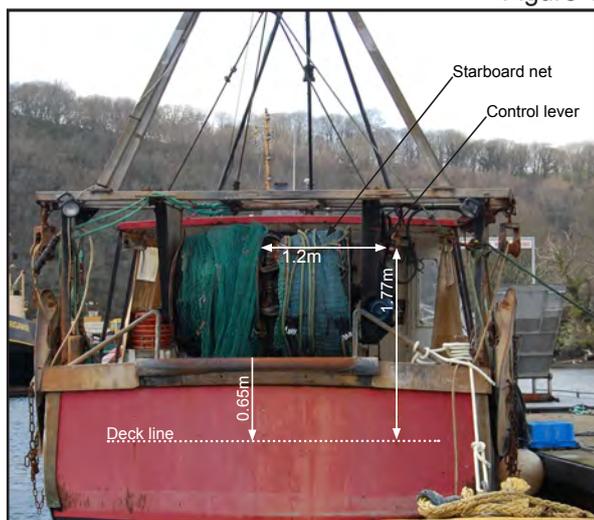


Figure 2



A drawstring toggle on the left-hand side of the stormhood on the skipper's jacket became entangled in the net (**Figure 3**) when the cod end was about 10 metres from the net drum. This would have caused the skipper to be pulled towards the rotating drum. Evidence indicates that he then reached towards the operating lever to stop the motor but was unsuccessful. The net drum stopped rotating when the cod end became wedged between the net drum and the overhead gantry. The skipper died as a result of injuries to his upper body.

Figure 3



At 2105, the coastguard was informed that *Our Boy Andrew* was overdue. Thereafter, an extensive search and rescue operation was launched which involved a lifeboat, a helicopter, merchant vessels and local fishing vessels. *Our Boy Andrew* was sighted at 2210 and a rescue helicopter arrived on scene at 2255, about 28 miles from the vessel's last known position at around midday.

Safety Lessons

1. The equipment and process used on *Our Boy Andrew* to haul in her fishing gear compromised safety for a single-handed fisherman because:
 - It was necessary to manually feed the net onto the net drum, and this exposed the fisherman to the hazard of being snagged by the net and dragged onto the drum.
 - The fisherman was required to move away from the winch controls to feed the net onto the drum.
 - There were no emergency stop controls fitted to the system.
 - There was no one available to stop the net drum if the fisherman became entangled.
2. Had the skipper conducted a sufficiently comprehensive risk assessment following his decision to operate the vessel single-handedly he may have identified and mitigated the hazard of being dragged onto the rotating net drum. Independent advice might also have helped him identify the hazards.
3. Although it would have been preferable for the skipper not to have had to work in close proximity to the moving net, the risk of an accident within the confined area adjacent to the net drum could have been lowered by ensuring that any snag hazards on the clothing he was wearing were reduced to a minimum.
4. *Our Boy Andrew* was fitted with a Class-B AIS transponder which assisted the coastguard in directing the emergency services towards the vessel. Had the vessel not been fitted with AIS, the coastguard would have undoubtedly spent additional time and resources in locating the vessel.

This flyer and the MAIB's investigation report are posted on our website:

www.maib.gov.uk

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