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# Safety at sea: exploring key non-technical skills used by commercial fishermen.

Project report 1: MAIB  
incident analysis

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<https://research.abdn.ac.uk/applied-psych-hf/>

## Introduction

In September 2019, the skipper of Anna-Marie II and his son (the crewman) entered the water after their vessel capsized. The crewman managed to swim ashore, however sadly the skipper drowned (MAIB, 2020). Unfortunately, these accidents are all too common in fishing, which represents one of the riskiest occupations worldwide (Seafish, 2023). From 2013 onwards, 59 fishing professionals have died while working on a fishing vessel in the UK. The fatality rate in the industry is approximately 100 times higher than that of the general UK workforce (Seafarers, 2023). Longitudinal data shows that the mortality rates from accidents in UK commercial fishing have not significantly changed in recent years (Roberts & Carter, 2015). Furthermore, hundreds of non-fatal, albeit severe injuries happen each year in the industry.

The main proximal causes of fatalities whilst at sea are well-known and include personal injuries and drowning as well as vessel losses due to foundering, capsizing/snagged gear, collisions, grounding and fires and explosions. In recent years, with a fleet of smaller vessels with typically fewer crew on board, more deaths than in the past have arisen from personal injuries and drowning than from vessel losses (Roberts & Carter, 2015). Where fishing vessel casualties do occur, these are mostly caused by capsizing and snagged gear. Recent investigations have also shown the involvement of the stability and seaworthiness of smaller fishing vessels in fatalities (MAIB reports cited in Roberts & Carter, 2015), often linked to overloading, poor maintenance and no safety equipment. There has also been a sharp increase in deaths of lone working fishermen, typically involving falls overboard.

In the UK, there are over 400 ports and harbours and a variety of fishing vessels across which the current workforce comprising approximately 10,000 fishers operates (Government statistics, 2023; Seafish, 2023). Two thirds of the most recently surveyed fishing fleet sample were from the UK, with most non-UK workers employed as deckhands (Seafish, 2022). Most vessel owners and skippers in the sample, predominantly local, have inherited their trade and even their boats from previous generations of their family (Seafish, 2022), therefore it can be argued that fishing represents a strong part of their cultural identity (Davis, 2012).

Irrespective of provenance and role, fishermen in the UK typically learn their occupational skills on the job, although there are a series of mandatory trainings which they are required by law to attend (Seafish, 2023). For example, new entrants (trainee deckhands) must attend basic courses which cover the Maritime & Coastguard Agency (MCA) statutory safety training requirements in sea survival, first aid, firefighting and health and safety. Experienced deckhands must also attend another basic course which covers MCA statutory safety training requirements in safety awareness. Employers are responsible for providing such basic training and skills for fishers to carry out their jobs properly and safely (New

Economics Foundation, 2020). While additional, voluntary training courses exist, these can sometimes be difficult to attend presumably due to time and financial limitations (Seafarers, 2023). Nonetheless, half of surveyed fishers on vessels under 10m (typically working alone and most likely self-employed) held an additional skipper qualification which is not legally required (Seafish, 2022).

Despite knowledge of proximal causes of accidents and the implementation of safety training in fishing, there is limited research on the involvement of human factors in fishing accidents in the UK. Lazakis and colleagues (2014) explored fishing vessel accidents and near misses as well as the underlying human factors contributing to them, through an analysis of the MAIB database. They found that human factors were related to the majority of fishing vessels accidents with the principal issues referring to “non-compliance”, “equipment misuse or poorly designed”, “training” and “competence”. A similar analysis of US data found decision errors, skill-based errors, crew communication and mental readiness as contributory factors to accidents (Zohorsky, 2020). However, these studies did not explore specific skills relevant to these incidents, nor has any work been done to develop a method of training and assessing the safety critical skills required by fishers.

In other high-risk industries such as aviation, healthcare and oil and gas, there is extensive research which directly assesses the use of non-technical or safety-critical skills. Non-technical skills (NTS) are defined as the social (leadership, teamwork and communication), cognitive (decision-making, situation awareness, task management) and personal resource management skills necessary for safe and effective task performance (Flin et al., 2008). Within healthcare, for instance, a strong connection between failures in NTS such as communication and teamwork and adverse events has already been established (Catchpole et al., 2008). Similarly, failures in situation awareness have been linked to farming and forestry incidents (Tone, PhD dissertation, 2023). Finally, the strengthening of these skills through training has been shown to be an effective method for improving safety and minimising adverse events within healthcare and industry and is the basis for mandatory crew resource management (CRM) training in aviation (Flin et al., 2008).

The current report describes a brief overview of the results of a study which represents the first stage of a project funded by Trinity House aimed at developing a shared vocabulary and a coherent framework for the assessment and training of NTS in commercial fishing. The objective of the current study was to identify examples of NTS usage and lapses in the most recent 20 MAIB accident investigation reports, overseas reports and safety bulletins of commercial fishing fatalities.

## **Method**

### *Data sources*

Twenty individual data sources were retrieved from the MAIB accident investigation website. The inclusion criteria were an accident date between 2019 and 2023 to maintain relevance for current issues in commercial fishing, and the incident must involve a fishing vessel. The resulting data set comprised 17 investigation reports, 2 safety bulletins and 1 overseas report.

The resulting sample comprised a variety of ship particulars (e.g., fishing vessel types and sizes), voyage particulars (e.g., manning) and marine casualty details (e.g., injuries/fatalities). The range of ship particulars appears representative for the complexity of the UK fishing fleet overall. Furthermore, since all available data sources from the selected time period have been included, the sample is deemed representative for all very serious marine casualty accidents in the UK in recent years. A full list of the names of the sources included can be found in Appendix A. These materials are protected by Crown copyright and are hereby re-used accurately. As a disclaimer, neither the original data sources nor the current report are written to apportion liability or blame, but solely to prevent future accidents by ascertaining causes and circumstances of the accidents investigated.

The length of the shorter investigation reports ranged from 8 to 16 pages. The general structure of these reports included a summary, factual information (i.e., a narrative, information about the crew and vessel, surveying and certification, guidance and similar accidents), an analysis of the causal factors, conclusions, actions taken and recommendations. The longer investigation reports and the overseas report (Hendrika Jacoba) were significantly more detailed, albeit following a similar structure. The safety bulletins (Resurgam and Piedras) comprised short recommendations to various industry stakeholders based on safety incidents.

### *Analysis*

All data sources were analysed using a qualitative directed content analysis. Before conducting the analysis, the author, who had no prior knowledge of the commercial fishing industry, read relevant academic reports, attended meetings with industry contacts, read a glossary of fishing terms and visited a fishing port to familiarize oneself with the relevant technicalities.

In the first stage of the analysis, the author integrally read all shorter investigation reports, both safety bulletins, as well as the available overseas report and made relevant notes to familiarize oneself and engage with the data. In the second stage of the analysis, data sources were imported in NVivo, which is a qualitative analysis software. NVivo allows researchers to highlight fragments of text which are of interest and assign a relevant label or

code to the piece of data, also known as a node in NVivo. Multiple levels of sub-nodes can be created for a more granular analysis. The software allows quick, real-time visualization of how many times and in how many files a particular node appears, as well as of the entire structure of nodes at a glance.

In the current study, codes describing the general categories of non-technical skills used by lone workers and crews were created beforehand, based on prior knowledge from other similar industries such as farming or forestry thus forming a coding framework approach. It was decided by the research team to conduct separate analyses for lone and crew working based on similar approaches in other industries and on the unique challenges faced by each group within fishing.

Two investigation reports featuring lone working were randomly selected (Saint Peter and Harriett J) and were manually coded based on this structure, i.e. the researcher read the full report and assigned the appropriate skill-level code to the fragment, taking into consideration previous notes. More granular element and behavioural level codes were inductively created based on a bottom-up process, i.e., emerged from the data. A previous unpublished older analysis of fishing accidents investigation reports was also used as a guide at the element level of coding. Causal factors other than NTS elements and behaviours also emerged from the data.

A similar process was followed for crew working incidents (i.e. manual, deductive coding with inductive aspects at element and behavioural level and for other causal factors). As opposed to the first five reports, the majority of the coding in these data sources was concentrated on the analysis and conclusions sections in the case of investigation reports, which were deemed to be the most relevant for the purposes of the current analysis and report.

In the third stage, the entire coding structure for both lone and crew working was checked and refined. Code names were altered and codes were added, deleted or combined where necessary. When preparing the current report, brief definitions were also given for the skill-level categories. For the purposes of brevity, the current report only covers skill level examples with some element level highlights.

## Results

### *Lone working incidents*

*Table 1: Overview of skill categories and elements relevant to lone working incidents*

<b>Skill category</b>	<b>Skill element</b>
Task management	Managing resources Following protocol Maintaining standards Planning and preparation
Decision-making	Assessment and management of risk
Personal resource management	Management of physical limitations Training and experience
Communication	Sharing information
Situation awareness	Comprehension of situation

### *Incident types*

There were 5 incidents in lone working circumstances, all of which resulted in a fatality due to drowning (note: one fatality is solely presumed in the report). All of these incidents occurred on creel fishing vessels, four of which were single-handedly operated and one which was occasionally operated by multiple fishers but single-handedly operated at the time of the incident. In three of these incidents, falling overboard and subsequent drowning likely occurred due to entanglement in equipment (lines/ropes etc.). In one of the incidents, the owner/skipper likely fell overboard during the vessel's capsizing. In another incident, the owner likely lost their balance whilst attending to the engine and fell overboard.

### *Task management*

The most coded non-technical skill in the lone working incidents was **task management**, which can be defined as managing resources, i.e., infrastructure and equipment (including safety equipment), and organising tasks, in this context mainly the fishing task whilst working alone, to achieve goals in a safe and effective manner. Many issues identified were related to **the organisation and use of infrastructure and the maintaining standards and following protocol elements** of this skill. Fishers oftentimes did not have a PFD available or did not wear one if available on board, did not carry a suitable personal locator beacon when the accident occurred or did not have appropriate means for reboarding the vessel, which meant that their chances of survival after falling overboard were significantly reduced. In many incidents, there were also no barriers in place to separate the fisher from the gear as it was shooting, meaning that their chances of entanglement in equipment were high if entering the working deck: *Sea Mist's skipper was working alone on deck without a personal flotation device (PFD) and there were no barriers in place to separate him from his fishing gear.*

Positive examples of these elements of task management across the accidents included carrying a knife for self-rescue and in a minority of cases, wearing a PFD, ensuring separation from equipment and means to self-rescue.

Another important **element of task management** consisted of **planning and preparation** prior to the operation starting, which comprises the set of actions which fishers take prior to going out at sea or starting the fishing task. These actions indicated a general proactive attitude and awareness of several safety issues, such as purchasing, carrying on board, or occasionally wearing a PFD, purchasing and carrying a PLB albeit of the incorrect type, changing operations in response to inspections, working only in good weather, storing and preparing equipment in a safe manner, adapting operations etc. Nonetheless, all incidents also featured significant deficiencies under this element, especially surrounding the mitigation of man overboard situations. In the case of two of the incidents, the owners/skippers had not accessed safety information or trainings on offer: *May C's skipper responded positively to the man overboard deficiency in the MCA's inspection report, avoided bad weather and worked short strings of creels; all these actions demonstrated a positive attitude to safe operations. However, the skipper had not completed the annual self-certifications of May C or attended the sea survival refresher training on offer from WIFA.*

### ***Decision-making***

Another cognitive non-technical skill which was widely coded within the lone working incidents was **decision making**, which can be defined as making decisions to reach a judgement about a situation, e.g. assessing the level of risk involved, and/or to choose an action based on prior experience and/or new information. Many of the task management issues identified above can also be considered decision errors under the **assessment and management of risk element**. For instance, one fisher wore their PFD when heading out at sea, but later decided to remove it, potentially due to an incorrect assessment of the level of risk. Another fisher did not wear it despite being unable to swim. Similarly, despite working alone, the majority of the owners decided to not carry the appropriate PLB to raise the alarm in case of emergency. In some cases, the aforementioned lack of separation from fishing gear was also compounded by the decision to store equipment in a manner which created clutter. Similarly, the inability to reboard the vessel in some situations was due to not wearing a safety harness or to not ensuring safety lines were present.

Nonetheless, perhaps the most crucial decision-making error in all of the incidents is the one which we retroactively know that led to the fatal consequences of the accident. In three of the incidents, the fisher entered the working deck to deal with snagged or jammed equipment, placing oneself in a vulnerable position and at risk of entanglement. In another

incident, the skipper likely tried to clear seaweed from the engine, putting themselves in a hazardous situation. In two incidents, a dangerous routine action was performed: *The practice of kicking snagged gear to release it was reportedly common and it is likely that, when the skipper moved into the working area to release a snag, his booted right foot became entrapped in the chain loop. (Harriet J).*

Positive examples of decision making apart from the ones overlapping with examples outlined under task management include routine safe actions (not performed at the time at the accident) such as remaining in the wheelhouse while shooting gear.

### ***Personal resource management***

Another important non-technical skill identified within the lone working context comprised of **personal resource management**, encompassing the **managing of physical limitations and having the correct training and experience elements**. The majority of the owners/skippers involved in the accidents had pre-existing heart conditions and other illnesses which made swimming difficult, and which predisposed them to complications once entering cold water. In such circumstances, wearing a PFD and PLB would have been crucial for maximising chances of survival. Some positive examples of managing physical limitations did exist within the accidents, such as: *Due to his physical limitations and the constraints of his very small boat, May C's skipper had rigged his gear into strings of 12 creels*. All fishermen had ample experience and attended all mandatory trainings.

### ***Communication and situation awareness***

Despite working alone, the fishers involved in these accidents did use **interpersonal non-technical skills** to keep themselves safe at work, including the sharing of plans with friends and family who were able to raise the alarm in case of accident or working surrounded by other trusted individuals. Nonetheless, most fishers did not have means to communicate with others after falling overboard and thus of raising the alarm.

Finally, whilst it is impossible to definitely determine from the investigation reports which again do not unfortunately contain survivor perspectives, some **situation awareness** errors were also tentatively identified in the data. **Situation awareness** can be defined as the perception of the elements in a situation, the comprehension of their meaning and the projection of their status in the near future or the mental picture which fishers have about what is going on in a particular situation. It may be that some previously mentioned decision-making errors were in fact situation awareness errors, whereby the fisher did not accurately or completely understand or project the level of risk involved: *His decision not to wear a PFD or carry a PLB demonstrate that he was probably unaware of the severe hazard associated with falling overboard (May C).*

### ***Causal factors***

It is important to note that many of the above non-technical skill failures did not occur in an isolated fashion, but rather were potentially related to other causal factors at various levels. These include changes in regulation surrounding the use of PFDs and PLBs, highlighting the continuous need of raising awareness amongst vessel owners regarding these changes and existing regulation. In the case of one incident (Goodway), an inspection deficiency may have also contributed to the unsuitability of the PLB carried: *It was evident that both he and the owner were under the misapprehension that the owner had purchased an approved 406MHz PLB.* Technical issues were also involved in the accidents, mainly to do with the snagging or jamming of the fleet of creels. Health and personal issues, especially illness, disability, and injury, as well as tiredness and the inability to swim, may have also contributed to the accident indirectly. Finally, environmental conditions may have increased the chances of an accident occurring and may have decreased the chances of survival once overboard.

### ***Crew-based incidents***

*Table 2: Overview of skill categories and elements relevant to crew-based incidents*

<b>Skill category</b>	<b>Skill element</b>
Task management	Managing resources Following protocol Maintaining standards Planning and preparation
Decision-making	Assessment and management of risk
Personal resource management	Management of physical limitations and fatigue Training and experience Managing alcohol consumption, distractions, and own safety
Communication and teamwork	Coordination, i.e. establishing team roles, positions, and schedules throughout a task amongst the crew
Situation awareness	Perception of elements Comprehension of situation Projection of future status
Leadership	Modifications of the vessel Following regulations and providing clear guidance Personal responsibility and coordinating others

### ***Task management and decision-making***

Whilst **task management and decision making** were also widely identified across crew-based incidents, with the same **key elements** as for lone working, it should be noted that the specific corresponding behaviours were applicable at various levels within the team, from owners to sharp-end staff. What is more, the corresponding behaviours were not solely concentrated on the fishing task, as it was predominantly the case in lone working incidents,

but rather on navigational tasks and other aspects of the operation as well, reflective of its complexity on larger vessels.

### ***Situation awareness***

In contrast with the lone working incidents, the data sources featuring crew work allowed for many clear instances of **situation awareness** issues to be identified since some of these investigation reports were also reliant on survivor and/or witness accounts. Errors in the use of this skill occurred at all three levels described in the previous section, i.e. under the **perception of the elements in the environment element**, the **comprehension of their meaning element** and the **projection of their status in the near future element**.

In many cases, poor **perception** was due to **inaccurate or incomplete information** from the environment or from other data sources, in the context of unsuitable navigation equipment, insufficient alarms, alerts or signals etc. suggesting the importance of the technical element in building situation awareness. Nonetheless, many issues under this element were also potentially caused by **ineffective lookout and monitoring of equipment and other crew members**: *The skipper also did not see the racon from the lighthouse or returns from the low-lying reefs on the radar display, Ve Skerries ahead of the vessel on the chart plotter, or the lighthouse light as he left the wheelhouse. Such omissions reflect a combination of an absence of passage planning, ineffective lookout and position monitoring, and possibly inaccurate or incomplete electronic chart data (Coelleira).*

**Comprehension** errors typically co-occurred in incidents featuring perception errors described above and oftentimes happened when crew members were placed **in non-routine situations**. These problems were exacerbated by **overconfidence or familiarity** with normal operations: *The effectiveness of the general service pumps to remove the floodwater would have been degraded by leaving the sea suction valves partly open; a common practice on board for routine draining of bilges, but not appropriate during a flooding emergency. (Olivia Jean)*. The few positive examples of comprehension behaviours featuring effective evacuations suggest the need for continuous emergency training and drills on board of vessels.

Finally, **projection** errors in the form of **inaccurate prediction of risk** typically resulted from the lower-level errors described before: *The engineer might not have been aware that the gear had become snagged and thought it safe to approach the dredge gear when it came to rest. (Olivia Jean)*. It is also worth noting that several factors may have impacted situation awareness across all of its elements, including **excessive task focus or**

**distraction, alcohol consumption and fatigue**, highlighting the need for crew members to monitor their own state when working: *It is possible that Coelleira's skipper's attention to the vessel's navigation was diminished by his focus on the administrative tasks he was completing on the wheelhouse computer. [...] However, it is equally possible that his performance, particularly his alertness, was also influenced by fatigue and the time of day.*

### ***Leadership***

As opposed to the lone working incidents, **leadership** was naturally identified as an important skill in the context of crew-based work, at various levels within the organisational diagram. Aspects related to **modifications of the vessel and other technical issues** found in several of these incidents were mostly an indication of poor leadership on the owners' or the companies' part, as well as problems with **following regulations and providing clear guidance** on alcohol consumption, staffing levels etc. Nonetheless, the skipper also played an important role in ensuring that these regulations and guidelines were followed in practice, including **both an element of personal responsibility and of coordinating others**: *Talis did not follow the company's SMS requirements to have two officers on the bridge during periods of restricted visibility, and the C/O allowed himself to become distracted by administrative work instead of monitoring the radar.*

### ***Communication and teamwork***

Given that the majority of these incidents feature coordination between several crew members, **communication and teamwork** have also emerged from the data as important social skills. In several scenarios, **coordination, i.e. establishing team roles, positions, and schedules throughout a task amongst the crew**, was defective, which oftentimes led to poor understanding of others' roles and states and of the overall task and poor decision making: *There was no shared mental model of the repair task and the roles of those involved. (Copious)*. Once more, some positive examples did occur in isolated cases of emergency evacuations, highlighting the need for regular drills and appropriate manning of vessels.

### ***Personal resource management***

Similar to the **personal resource management skill** identified for lone working, incidents on vessels with a crew also highlighted the necessity for **having the appropriate training and experience**, as well as of **managing physical limitations and fatigue**. Novel elements identified hereby included **managing alcohol consumption, distractions, and own safety**: *While he had succeeded with this during the day, his ability to bridge the gap was most likely*

*impaired by a combination of alcohol intoxication, head trauma and the type of footwear at the time of the accident.* Whilst it is acknowledged that employers have legal responsibilities for keeping their employees safe at work, personal responsibility also appears important in practice, especially when working alongside others.

### **Conclusion and further directions**

To conclude, the current study based on an analysis of 20 MAIB accident investigation reports, overseas reports and safety bulletins from the past 5 years has tentatively identified the importance of specific safety critical skills in commercial fishing, which include situation awareness, decision making, task management, communication, teamwork and leadership (only in crew scenarios), and personal resource management skills, with their corresponding elements and behaviours. Nonetheless, as mentioned in the previous section, these data sources often do not rely on witness or survivor accounts since these are sometimes unavailable. Consequently, it is necessary to further develop and consolidate the current framework through interviews based on the critical incident technique with commercial fishers allowing access to first-hand accounts of incidents, an approach which represents the following and second stage of the project. Further discussion groups and an academic review will also be employed in the latter stages of the project in order to develop a coherent framework for the assessment and training of safety critical skills in commercial fishing.

## Appendix A

Safety warning issued about servicing and certification after a liferaft failed to inflate during an emergency (/maib-reports/safety- warning-issued-about-servicing-and-certification-after-a-liferaft-failed-to- inflate-during-an-emergency)

This bulletin urges all owners and operators of DSB liferafts serviced by Comfer Marin SL, Spain between Jan 2017 and June 2022 to contact the nearest approved Survitec liferaft service station.

Vessel type: Fishing vessel

Report type: Safety bulletin

Occurred: 1 June 2022

Person overboard from stern trawler Copious with loss of 1 life (/maib-reports/person-overboard-from-stern-trawler-copious-with-loss- of-1-life)

Location: south-east of the Shetland Islands, Scotland.

Vessel type: Fishing vessel

Report type: Investigation report Occurred: 18 February 2021

Person overboard from creel fishing vessel Harriet J with loss of 1 life (/maib-reports/person-overboard-from-creel-fishing-vessel-harriet- j-with-loss-of-1-life)

Location: west of Fast Castle Head, south-east Scotland.

Vessel type: Fishing vessel

Report type: Investigation report Occurred: 28 August 2021

Persons overboard from prawn trawler Reul A Chuain with loss of 1 life (/maib-reports/persons-overboard-from-prawn-trawler-reul-a- chuain-with-loss-of-1-life)

Location: Sound of Rùm, Scotland.

Vessel type: Fishing vessel

Report type: Investigation report Occurred: 24 June 2021

Capsize of single-handed creel fishing vessel Goodway with loss of 1 life (/maib-reports/capsize-of-single-handed-creel-fishing-vessel- goodway-with-loss-of-1-life)

Location: Near Cairnbulg, Scotland.

Vessel type: Fishing vessel

Report type: Investigation report Occurred: 16 October 2021

Person overboard from fishing vessel Hendrika Jacoba with the loss of 1 life (/maib-reports/person-overboard-from-fishing-vessel- hendrika-jacoba-with-the-loss-of-1-life)

Location: Thyborøn, Denmark.

Vessel type: Fishing vessel

Report type: Overseas report

Occurred: 29 May 2022

Capsize and sinking of whelk potter Nicola Faith with loss of 3 lives (/maib-reports/capsize-and-sinking-of-whelk-potter-nicola-faith- with-loss-of-3-lives)

Location: Colwyn Bay, North Wales.

Vessel type: Fishing vessel

Report type: Investigation report Occurred: 27 January 2021

Capsize and sinking of scallop dredger Joanna C with loss of 2 lives (/maib-reports/capsize-and-sinking-of-scallop-dredger-joanna-c- with-loss-of-2-lives)

Location: South of Newhaven, England

Vessel type: Fishing vessel

Report type: Investigation report Occurred: 21 November 2020

Person overboard from single-handed creel fishing vessel Saint Peter with loss of 1 life (/maib-reports/person-overboard-from-single- handed-creel-fishing-vessel-saint-peter-with-loss-of-1-life)

Location: East of Torness Point, near Dunbar, Scotland  
Vessel type: Fishing vessel  
Report type: Investigation report Occurred: 2 May 2021

Flooding, capsize and sinking of prawn trawler Diamond D (/maib-reports/flooding-capsize-and-sinking-of-prawn-trawler-diamond-d)  
Location: 20 nautical miles north-east of Tynemouth, England.  
Vessel type: Fishing vessel  
Report type: Investigation report Occurred: 16 August 2020

Subsea explosion resulting in damage to crab potting vessel Galwad-Y-Mor and injuries to crew (/maib-reports/subsea-explosion-resulting-in-damage-to-crab-potting-vessel-galwad-y-mor-and-injuries-to-crew)  
Location: 22 nautical miles north of Cromer, Norfolk, England.  
Vessel type: Fishing vessel  
Report type: Investigation report Occurred: 15 December 2020

Collision between prawn trawler Achieve and general cargo vessel Talis and subsequent sinking of Achieve (/maib-reports/collision-between-prawn-trawler-achieve-and-general-cargo-vessel-talis-and-subsequent-sinking-of-achieve)  
Location: Off Tynemouth, England.  
Vessel type: Merchant vessel 100 gross tons or over and 1 others  
Report type: Investigation report Occurred: 8 November 2020

Crush incident on scallop dredger Olivia Jean with loss of 1 life (/maib-reports/crush-incident-on-scallop-dredger-olivia-jean-with-loss-of-1-life)  
Location: North-east of Aberdeen, Scotland.  
Vessel type: Fishing vessel  
Report type: Investigation report Occurred: 28 June 2019

Flooding and sinking of trawler Ocean Quest (/maib-reports/flooding-and-sinking-of-trawler-ocean-quest)  
Location: 70 miles north-east of Fraserburgh, Scotland.  
Vessel type: Fishing vessel  
Report type: Investigation report Occurred: 18 August 2019

Man overboard from single-handed creel boat May C with loss of 1 life (/maib-reports/man-overboard-from-single-handed-creel-boat-may-c-with-loss-of-1-life)  
Location: Loch Carnan, Outer Hebrides, Scotland.  
Vessel type: Fishing vessel  
Report type: Investigation report Occurred: 24 July 2019

Capsize of fishing vessel Anna-Marie II with loss of 1 life (/maib-reports/capsize-of-fishing-vessel-anna-marie-ii-with-loss-of-1-life)  
Location: Brora, Scotland.  
Vessel type: Fishing vessel  
Report type: Investigation report Occurred: 23 September 2019  
Grounding and loss of fishing vessel Coelleira (/maib-reports/grounding-and-loss-of-fishing-vessel-coelleira)  
Location: Off the Shetland Islands, Scotland.  
Vessel type: Fishing vessel  
Report type: Investigation report Occurred: 4 August 2019

Safety warning after inadvertent activation of condensed aerosol fire extinguishing system leads to a fatality (/maib-reports/safety-warning-after-inadvertent-activation-of-condensed-aerosol-fire-extinguishing-system-leads-to-a-fatality)  
We have issued a safety bulletin highlighting a potentially serious hazard associated with condensed

aerosol firefighting suppressant particles after the fatal accident on fishing vessel Resurgam.

Vessel type: Fishing vessel

Report type: Safety bulletin

Occurred: 15 November 2019

Fall on board fishing vessel Artemis with loss of 1 life (/maib-reports/fall-on-board-fishing-vessel-  
artemis-with-loss-of-1-life)

Location: Kilkeel, Northern Ireland.

Vessel type: Fishing vessel

Report type: Investigation report Occurred: 29 April 2019

Man overboard from single-handed creel boat Sea Mist with loss of 1 life (/maib-reports/man-  
overboard-from-single-handed-creel-boat- sea-mist-with-loss-of-1-life)

Location: Macduff, Scotland.

Vessel type: Fishing vessel

Report type: Investigation report Occurred: 27 March 2019

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<https://www.seafish.org/safety-and-training/careers-in-the-uk-seafood-industry/seafood-industry-career-paths/careers-on-fishing-vessels/>

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