**LLAMA ZERO-SHOT**

The Marine Accident Investigation Branch investigated an incident involving Mark's death while hauling and shooting creels [UGE]. The investigation found that Mark was not wearing a Personal Flotation Device (PFD) and was entangled in the back rope, which contributed to his death.

The possible causes of the accident were identified as Mark's concentration being adversely affected by his use of cannabis[MGE] or the familiar task of hauling and shooting creels. However, it is noted that Mark could have survived if he had been able to free himself from the back rope quickly enough after initial cold water shock.

The investigation also found some safety issues directly contributing to the accident, such as entanglement in the back rope, but others that have been addressed or resulted in recommendations for future safety measures. These include installing a physical barrier to reduce crew entanglement, equipping the vessel with PFDs, ensuring crew attend mandatory safety training, reviewing risk assessments, and introducing a drugs and alcohol policy.

The recommended lessons from this accident are primarily focused on ship operation, specifically shooting creels at mid-water, in rough conditions with wind and sea temperatures that may affect crew concentration. To avoid similar accidents in the future, shipping companies should take precautions such as providing PFDs for all crew members, ensuring they attend regular safety training, installing barriers to prevent entanglement, and having a clear drugs and alcohol policy in place[UGE].

It is also recommended to consider factors that may not be directly related to this accident but could potentially contribute to future incidents. These include the impact of weather conditions on crew concentration and the importance of adequate risk assessments. By taking these precautions and being aware of potential risks, shipping companies can help prevent similar accidents from occurring in the future.

**LLAMA ONE-SHOT**

The Marine Accident Investigation Branch (MAIB) report details an incident involving the creel fishing vessel North Star, which was flagged under the United Kingdom. The vessel, built of steel in 1996, had an overall length of 18.2 meters and a registered length of 16.46 meters. On 2018 at 1815 hours[DTE], the North Star was involved in an accident while on fishing voyage.

The incident occurred west of Scotland, although the exact location is not specified in the provided excerpts [MGE]. The report does indicate that it was an accident involving a crew member, but no further details are given about the nature of the incident or the extent of any injuries sustained by the crew member involved.

The North Star's safety record and maintenance history were likely investigated as part of the MAIB inquiry. It is possible that the investigation examined factors such as the vessel's design, its condition at the time of the incident, and the training and experience of the crew members on board. The report may have also considered any relevant regulatory requirements or industry guidelines that were in place at the time.

Despite the lack of detail provided about the specific circumstances surrounding the accident[MGE], it is clear that the MAIB investigation aimed to identify the underlying causes and contributing factors. This would typically involve analyzing various aspects such as the vessel's operations, weather conditions, equipment, and human performance. The ultimate goal of the inquiry was likely to provide recommendations for preventing similar incidents in the future.

The findings of the MAIB report may have highlighted areas where improvements can be made to improve safety standards within the fishing industry. This could include updates to regulations or guidelines, enhanced training programs for crew members, or increased scrutiny on vessel maintenance and inspections. The investigation's conclusions would likely provide valuable insights into the complexities of marine accidents and contribute to ongoing efforts to reduce risks associated with commercial fishing activities[UGE].

Overall, while the provided excerpts do not offer a comprehensive view of the incident or the MAIB investigation, it is clear that the inquiry was thorough and aimed to shed light on the circumstances surrounding the accident. The full report would likely provide more detailed information about the North Star's safety record, the crew members involved, and the factors contributing to the incident[MGE].

**QWEN ZERO-SHOT**

The r eport investigates a serious maritime incident [MGE] involving a fishing vessel named North Star that occurred 16 nautical miles north of Cape Wrath, Scotland on February 5, 2018. The primary objective of the investigation was to identify the causes and circumstances leading to the fatal accident without assigning liability or blame [MGE].

According to the report, during routine operations, an unfortunate event led to a crew member falling overboard. The exact cause of this incident remains unclear [MGE], but possible contributing factors could include equipment failure, human error, or inadequate safety measures [UGE]. The lack of specific details in the document precludes pinpointing precise causes,[MGE] yet it underscores the importance of robust safety protocols and thorough training.

The investigation highlights the critical nature of maritime safety regulations and emphasizes the need for continuous improvement to prevent similar tragedies. Key lessons learned suggest that shipping companies must prioritize employee training and equipment maintenance, as well as ensuring comprehensive emergency preparedness plans are in place. These measures can help mitigate risks and enhance overall safety standards across the industry[UGE].

By focusing on these areas, future incidents can be better prevented, thereby safeguarding crew members and preserving the integrity of maritime operations.

**QWEN ONE-SHOT**

The marine accident report #201802 details an incident that occurred on a vessel named North Star under the conditions of a south-west wind at 35 knots and rough seas with a 10.5-knot resuscitation current. Mark, one of the crew members, was involved in shooting creels when his leg became entangled in the back rope. The deckhand threw three leg ropes to help free Mark from the back rope, but the efforts were hindered by the violent movement of the vessel.

The skipper stopped the engines [MGE] and used a spotlight in the wheelhouse to search for Mark. Due to the distance, he [NNE] pressed the digital selective calling (DSC) button on the VHF radio to alert the coastguard, but was unable to hear any responses due to the distance. Consequently, he contacted a satellite phone to pass details of the accident and inform Scrabster Seafoods Limited, the owner of North Star.

By 1830, the rescue helicopter had been approved and tasked to the scene. Despite ongoing resuscitation efforts, by 1834, the skipper was informed that the helicopter would arrive at 1945. The skipper set a course to return to Scrbster[NNE] and briefed the crew on highline techniques but found it impossible to attempt a highline transfer due to the vessel's violent movement in sea and swell.

At 1955, the captain of the rescue helicopter informed the coastguard that he was returning to base. The skipper instructed the crew to cease resuscitation efforts and positioned the vessel at 2 nautical miles west of [MGE] Scrbster[NNE], Scotland. Using a CCTV display, the skipper observed that Mark had been pulled against the launching table with his left leg entangled in the back rope, ready to be launched overboard.

Deckhand 3 rushed to the shooting poles and threw three additional leg ropes to help free Mark but was unable to maintain a grip. The last creel was toggled on the table. By this time, despite continued CPR efforts, Mark was pronounced dead upon recovery aboard the vessel[MGE]. Key findings from the report highlight that the accident occurred due to entanglement in the back rope while shooting creels and noted inadequate communication between deckhands, which led to delays in freeing the victim.

**CHAT GPT ZERO-SHOT**

The report details a fatal accident aboard the United Kingdom-flagged creel fishing vessel North Star on 5 February 2018, approximately 16nm north of Cape Wrath, Scotland. During manual shooting operations, Mark Elder, a deckhand, became entangled in the back rope of a fleet of creels and was dragged overboard. Efforts to recover him were delayed due to difficulties with the creel hauler and a lack of emergency preparedness [MGE]. After being submerged for approximately 10 minutes, Mark was recovered unconscious and unresponsive. Despite CPR efforts for 90 minutes, he was pronounced deceased due to drowning upon arrival at Scrabster.

The accident did not result in damage to the vessel or environmental impact but tragically caused the loss of a life. The report identifies several contributing factors. There was no physical barrier, such as pound boards, to separate the crew from moving ropes during shooting operations. Crew members lacked knives to cut ropes in emergencies, and Mark was not wearing a personal flotation device (PFD). Additionally, Mark had not completed mandatory safety training, including Basic Sea Survival, leaving him unprepared for cold water immersion. The crew had not practiced man-overboard drills, and the vessel’s risk assessments were outdated and did not reflect operational practices. It is also noted that Mark’s concentration may have been affected by cannabis use, though its impact on the accident remains uncertain.

The investigation highlights the need for stricter safety measures, including physical barriers on working decks, training in emergency procedures, the mandatory use of PFDs, and accessible emergency tools like knives. It emphasizes the importance of updated risk assessments, regular self-certification, and adherence to industry best practices. The report also recommends proactive oversight from vessel owners and regulatory bodies, including inspections, training compliance, and clear delegation of safety responsibilities. These measures aim to prevent similar tragedies and improve overall safety in fishing operations [UGE].

**CHAT GPT ONE-SHOT**

On 5 February 2018, the 18.2m creel fishing vessel North Star was involved in a fatal accident approximately 16 nautical miles north of Cape Wrath, Scotland. During manual shooting of a fleet of creels, a deckhand, Mark Elder, became entangled in the back rope and was dragged overboard. Despite efforts by the crew to recover him quickly, Mark was submerged for approximately 10 minutes and was unresponsive when hauled back aboard. Attempts at cardiopulmonary resuscitation (CPR) were unsuccessful, and Mark was later pronounced deceased upon the vessel’s return to Scrabster. The cause of death was determined to be drowning, likely exacerbated by cold water shock in the 10°C water.

The accident occurred while Mark was manually toggling creels to the back rope at the launching table on a violently moving deck in rough seas with wind speeds of 35 knots. The vessel’s modified deck layout from August 2017 did not provide a physical barrier to separate crew from moving ropes, exposing Mark to the risk of entanglement. The skipper, despite reducing the vessel’s speed after hearing crew warnings, was unable to stop the vessel in time to prevent Mark from being dragged overboard. There were no knives available near the shooting hatch, which prevented Mark or the crew from cutting him free of the back rope. Additionally, Mark was not wearing a personal flotation device (PFD), which significantly reduced his chances of surviving the cold water immersion.

The investigation revealed several contributory factors leading to the accident. The crew’s familiarity with the task and the absence of previous fatal outcomes from similar incidents may have led to an underestimation of the risks associated with the back rope. North Star’s risk assessments had not been reviewed since 2014 and did not reflect operational practices or industry best practices. The vessel’s working deck modifications failed to address the lack of physical separation between crew and moving ropes during manual shooting operations. Furthermore, Mark had not completed the mandatory Basic Sea Survival training, leaving him ill-prepared for sudden cold water immersion. Weak safety practices onboard, such as the absence of practical emergency drills and the lack of PFDs, further compounded the severity of the accident[UGE].

In response to the accident, North Star’s owner, Scrabster Seafoods Limited, took several corrective actions. These included installing physical barriers (pound boards) on the working deck to reduce the risk of crew entanglement, equipping the vessel with PFDs, ensuring that all crew members completed mandatory safety training, and reviewing the vessel’s risk assessments. Additionally, the company introduced a drugs and alcohol policy following findings that Mark had traces of cannabis in his system, though its impact on the accident could not be conclusively determined.

To prevent similar accidents in the future, recommendations were made for both Scrabster Seafoods Limited and the Maritime and Coastguard Agency (MCA). Scrabster Seafoods Limited was advised to ensure that risk assessments are regularly reviewed, reflect industry best practices, and are aligned with the vessel’s operations. The company should also conduct practical emergency drills at least monthly and clarify skippers’ delegated responsibilities in implementing health and safety policies. The MCA was recommended to provide better support for fishing vessel owners, especially those new to the industry, by offering guidance on regulatory requirements and best practices. It was also suggested that the MCA conduct safety inspections following a change of vessel ownership and provide timely reminders for mandatory surveys and inspections.

This tragic incident underscores the importance of adhering to safety protocols, maintaining vigilant risk assessments, and fostering a culture of proactive safety management within the fishing industry. By addressing the identified shortcomings and implementing the recommendations, the likelihood of such accidents occurring in the future can be significantly reduced.

**LLAMA FEW-SHOT**

The accident involving the North Star vessel occurred on 5 February 2018 at approximately 1820 hours, approximately 16nm north of Cape Wrath, Scotland. The incident was classified as a very serious marine casualty with one fatality. According to the investigation, the accident took place when crew members were shooting creels, which resulted in one crew member becoming entangled in the back rope and subsequently lost their footing on the working deck.

The damages sustained by the vessel included none, but it is worth noting that if a physical barrier (pound board) had not been installed to reduce the risk of crew becoming entangled in the back rope, such an incident might have resulted in more severe consequences. Although there was no reported damage to the vessel itself, the accident highlights the importance of implementing safety measures to prevent similar incidents.

Analysis of the causes suggests that the accident can be attributed to a combination of factors, including inadequate safety protocols [MGE]and lack of training on crew safety procedures. The investigation also highlighted the need for better risk assessments and adherence to established safety guidelines. Furthermore, the incident underscores the importance of ensuring that vessels are equipped with Personal Flotation Devices (PFDs) and mandatory safety training courses are attended by all crew members.

In response to the accident, Scrabster Seafoods Limited, the registered owner of the North Star vessel, has taken several actions, including installing a physical barrier to reduce the risk of crew becoming entangled in the back rope, equipping the vessel with PFDs, ensuring that the crew have attended mandatory safety training courses, reviewing the vessel's risk assessments, and introducing a drugs and alcohol policy for the vessel's crew.

In light of this incident, I offer several recommendations for future shipping. Firstly, it is essential to emphasize the importance of adhering to established safety protocols and guidelines in the fishing industry. Vessels should be equipped with PFDs and mandatory safety training courses should be attended by all crew members. Additionally, regular risk assessments should be conducted to identify potential hazards and implement measures to mitigate them. The installation of physical barriers or similar safety measures can also help prevent accidents like this one. Furthermore, the importance of addressing the root causes of accidents, such as inadequate training and protocols, cannot be overstated. By prioritizing crew safety and implementing effective safety measures, the fishing industry can reduce the risk of similar incidents occurring in the future.[UGE]

**QWEN FEW-SHOT**

On 5 February 2018 at approximately 18:20, the creel fishing vessel North Star experienced a very serious marine casualty off the coast of Cape Wrath, Scotland, around 16 nautical miles north of its origin and destination port of Scrabster, Scotland. The incident occurred on the working deck while the vessel was engaged in mid-water operations, specifically shooting crabs [MGE].

The accident involved one fatality among the six crew members onboard. No damage to the ship or environmental impact was reported, which suggests that the casualty was limited to personnel and possibly equipment related to the fishing operation.

An analysis of the causes indicates a combination of human error and operational deficiencies. The report highlights that North Star lacked specific safety measures such as personal flotation devices (PFDs) and proper risk assessments for potential hazards on deck, including the risk of crew becoming entangled in ropes during creel shooting operations. Additionally, the absence of a clear drugs and alcohol policy among the crew contributed to the severity of the incident. [UGE]

Following the accident, Scrabster Seafoods Limited took several corrective actions to address identified safety concerns. These included installing physical barriers such as pound boards to mitigate risks of entanglement, equipping the vessel with PFDs for all crew members, ensuring mandatory safety training courses were attended by North Star's crew, and conducting comprehensive reviews of the risk assessments related to creel shooting operations.

Furthermore, a drugs and alcohol policy was introduced for the crew to enhance overall operational safety and prevent any form of impairment during work. These measures are aimed at improving crew safety protocols and reducing the likelihood of similar accidents in the future.

To ensure ongoing improvements in shipping safety, it is recommended that all fishing vessels implement robust safety measures such as mandatory PFDs, stringent risk assessment procedures, and comprehensive training programs for crew members. Additionally, establishing clear policies on drugs and alcohol use among seafarers can significantly contribute to safer operations at sea. The marine industry should continue engaging in consultations with regulatory bodies like ILO 188 to ensure upcoming legislation addresses identified safety issues comprehensively.

**CHAT GPT FEW-SHOT**

On 5 February 2018, at approximately 1820, the 18.2m creel fishing vessel North Star, operating 16 nautical miles north of Cape Wrath, Scotland, experienced a tragic incident during creel shooting operations. A deckhand, Mark Elder, became entangled in the back rope of a fleet of creels and was dragged overboard. Despite swift action by the crew to recover him, including immediate attempts to haul him back on board using the creel hauler, Mark was submerged for about 10 minutes before being brought to the surface. The crew performed cardiopulmonary resuscitation (CPR) for nearly 90 minutes, but Mark remained unresponsive and was later pronounced deceased after the vessel returned to port.

The accident occurred during manual creel shooting, a fishing operation that involved close proximity to moving ropes. The back rope, which was under tension, became entangled around Mark’s left leg, pulling him against the launching table and eventually overboard. The crew's efforts to recover him were hindered by delays in correctly operating the creel hauler. When Mark was finally brought back on board, he was unconscious and entangled in the gear. The environmental conditions at the time included rough seas, a south-westerly wind of 35 knots, and a water temperature of approximately 10°C, contributing to the challenges of recovery and survivability.

The investigation identified several contributing factors to the accident. The working deck layout lacked physical barriers to separate the crew from the moving back rope, a hazard that had been previously highlighted in industry safety guides and other accident investigations. The vessel’s risk assessments were outdated and did not adequately address the danger of entanglement. Furthermore, Mark had not received the mandatory Basic Sea Survival training, and neither he nor the other crew members wore personal flotation devices (PFDs) while working on deck, contrary to safety recommendations. Additionally, the crew had not conducted practical emergency drills, such as man-overboard recovery exercises, which could have better prepared them for such incidents. The absence of knives in the vicinity of the shooting hatch also prevented Mark from being freed quickly.

In response to the accident, North Star’s owner, Scrabster Seafoods Limited, implemented several safety measures to prevent similar incidents. These included installing a physical barrier (pound board) to separate the crew from the back rope, providing all crew members with PFDs, ensuring that mandatory safety training was completed, and reviewing the vessel’s risk assessments. A drugs and alcohol policy was also introduced. The Maritime and Coastguard Agency (MCA) detained the vessel following the accident and identified deficiencies in its safety management, including missed inspections and incomplete crew certifications.

To improve safety in the fishing industry, it is recommended that vessel owners and operators prioritize the implementation of effective risk assessments that reflect actual working practices. Regular reviews and updates of safety procedures should be conducted, particularly after significant modifications to the vessel. Practical emergency drills, including man-overboard recovery, should be mandated and routinely carried out. The wearing of PFDs on deck should be enforced as a standard practice, while knives or other emergency tools should be readily accessible to crew working near moving ropes. Additionally, the MCA should enhance its oversight of fishing vessels by conducting safety inspections after changes in ownership and providing clearer guidance to ensure compliance with regulatory requirements. These measures are essential to reducing the risk of similar accidents and safeguarding the lives of fishermen.[UGE]