**LLAMA ZERO-SHOT**

On August 7, 2018[DTE], a fatal accident occurred on the fishing vessel Fram of Shieldaig, resulting in the drowning of its 62-year-old deckhand, Duncan Matheson. The accident occurred when the deckhand fell into the water from the tender while securing it alongside the fishing vessel. The skipper, who was on board, did not see the deckhand enter the water, but noticed him floating motionless with his airways under the water.

The investigation report found that the deckhand was not wearing a lifejacket, which significantly increased his chances of survival. The sea temperature was 12.8°C, and despite wearing warm clothing, the deckhand would have experienced a cold shock response upon immersion. The report concluded that the deckhand either lost consciousness due to a bang to his head or through the effects of cold-water immersion.

The investigation identified several factors that contributed to the accident, including the lack of regular emergency drills, the absence of a risk assessment for boarding and leaving the vessel, and the failure to wear personal flotation devices (PFDs) despite their availability on board. The report also highlighted the importance of wearing PFDs when working on deck or boarding and leaving the vessel, especially in cold water[UGE].

The accident highlights the importance of regular emergency drills, risk assessments, and the use of PFDs to prevent similar accidents in the future. The report recommends that the owner of Fram of Shieldaig implement a policy that crew must always wear PFDs while working on deck and while boarding and leaving the vessel. Additionally, the report suggests that the owner add an alcohol and drugs policy statement to the safety management folder and ensure it is adhered to.

The accident also emphasizes the need for mandatory regulations to ensure that fishermen wear PFDs and conduct regular emergency drills. The introduction and enforcement of the enhanced requirements set out in MSN 1871, following the UK's adoption of the ILO's Work in Fishing Convention (ILO 188), is expected to improve safety standards in general and the use of PFDs in particular.

**LLAMA ONE-SHOT**

On August 20th, 2018, at 14:45[DTE], a fishing vessel was involved in an incident off the coast of Scotland. The investigation found that a crew member, John Smith [NNE], had been working on the deck when he fell overboard into the sea.

The postmortem examination revealed that Mr. Smith [NNE] had suffered from severe injuries, including lacerations to his head and body. The investigation concluded that the probable cause of the incident was a combination of factors, including weather conditions, strong winds and rough seas [MGE], and inadequate vessel design, specifically the lack of handrails and safety nets on the deck [MGE].

The crew member's actions also played a significant role in the incident. He failed to secure himself while working on the deck, which ultimately led to his fall overboard. The investigation found that there were several contributing factors that contributed to the fatal accident, including inadequate training for crew members on vessel-specific safety procedures and insufficient attention to maintenance and upkeep of the vessel's equipment[UGE].

The investigation made several recommendations to prevent similar incidents in the future. Improving vessel design to include safer handrails and safety nets was one of the key recommendations. Additionally, enhancing training programs for crew members on vessel-specific safety procedures was also suggested. Regular maintenance and upkeep of the vessel's equipment were also emphasized as essential measures to prevent such incidents[MGE].

**QWEN ZERO-SHOT**

The accident involving the fishing vessel Fram of Shieldaig occurred on August 7, 2018[DTE], in Loch Torridon, Scotland. The skipper and deckhand were boarding the vessel from a tender when the deckhand fell into the water, likely due to tripping or losing balance. The deckhand was not wearing a lifejacket and drowned due to cold water immersion and potential head trauma. The skipper, unable to recover the unconscious deckhand, focused on bringing him alongside the vessel, delaying the emergency response.

The primary cause of the accident was the deckhand's failure to wear a lifejacket, which would have provided buoyancy and kept his airways clear. The skipper's delayed response to the emergency, due to prioritizing recovery, also contributed to the tragic outcome. The deckhand's high blood alcohol content (BAC) further impaired his ability to respond to the situation[UGE].

Lessons learned include the importance of wearing lifejackets, conducting regular emergency drills, and implementing safety policies. Fram of Shieldaig's owner has purchased new compact lifejackets and implemented a policy requiring their use. Additionally, the practice of lone working in the tender has been discontinued.

To prevent similar accidents in the future, shipping companies should ensure that all crew members wear lifejackets, especially when boarding and leaving vessels. Regular emergency drills, including person overboard scenarios, should be conducted to prepare crew members for quick and effective responses. Alcohol consumption should be strictly regulated, and safety policies should be enforced to maintain a safe working environment[OGE].

**QWEN ONE-SHOT**

The accident occurred on a clear day in August 2018[DTE] at Shieldaig Bay [MGE]involving the vessel Fram, which is owned by John Doe and operated by Jane Smith [MGE]. The incident took place during routine operations when a deckhand fell overboard from the port side of the boat. At the time of the fall, the freeboard on that side was only 0.78 meters high, making it difficult for the deckhand to safely board the vessel.

The deckhand, who was not wearing a lifejacket, fell into the water with a sea temperature of 12.8°C. Cold shock immediately impaired his ability to swim and survive, as he was found floating motionless in the water after the skipper initially attempted to board the raft unsuccessfully [MGE]. The skipper then returned to the beach and recruited another fisherman who was on shore. Together, they retrieved the deckhand from the water and placed him in the tender.

Despite the efforts of local paramedics and an ambulance crew who arrived at 09:14, the deckhand could not be revived. He was 36 [NNE] years old and had been working on Fram for over two decades. Despite his extensive experience, he had not worn a lifejacket during this operation, which proved to be fatal.

The environmental conditions were clear and dry with light winds and calm waters. The sea temperature of 12.8°C exacerbated the cold shock response, further compromising the deckhand's ability to survive in the water.

Vessel Fram is a GRP hulled catamaran built in 2004 by Gemini Workboats Ltd., equipped with a tender that is a 4.5-meter long Pioner 15 open boat constructed from molded polyethylene.

The safety folder on Fram did not include risk assessments for boarding and leaving the vessel, nor was the use of lifejackets included in the risk assessments for deck work. Despite the presence of high guardrails, the freeboard height on the port side boarding position made it challenging for personnel to board safely. The accident highlights the critical importance of wearing lifejackets in cold water operations.

The report concludes that if a lifejacket had been worn by the deceased, his survival would have been significantly more likely.

**CHAT GPT ZERO-SHOT**

The accident involving the fishing vessel Fram of Shieldaig on 7 August 2018[DTE] resulted in the tragic drowning of its deckhand, Duncan Matheson. The incident occurred in Loch Torridon as the deckhand operated the vessel's tender to transfer partially filled langoustine boxes. While approaching the Fram, the deckhand fell into the water, likely due to a loss of balance or tripping over the tender's deckwell or boxes. He sustained a head injury, rendering him unconscious, and subsequently drowned. The absence of a lifejacket significantly reduced his chances of survival, as it would have kept his airways clear and allowed time for rescue.

Postmortem findings revealed a blood alcohol concentration (BAC) of 276 milligrams per 100 milliliters, over five times the legal limit for seafarers, indicating alcohol impairment as a likely contributing factor. Fram's safety protocols were insufficient, with no risk assessment for boarding and leaving the vessel, no policy on alcohol consumption, and no regular person overboard drills conducted. Additionally, the skipper delayed raising a Mayday alert, focusing instead on recovery efforts, which delayed paramedics’ arrival by approximately 30 minutes. However, this delay likely did not alter the outcome[UGE].

The accident highlights several key lessons for future safety in fishing operations. Wearing personal flotation devices (PFDs) should be mandatory, particularly during high-risk activities such as boarding or using tenders. Regular emergency drills, including person overboard recovery, are essential for ensuring crews are prepared for such incidents. Alcohol consumption must be strictly prohibited, with clear policies to mitigate associated risks. Lastly, immediate communication with emergency services in such situations can expedite rescue efforts and improve survival chances.

In response, Fram's owner has implemented new safety measures, including mandatory PFD usage, ceasing lone tender operations, and introducing an alcohol and drugs policy. This case underscores the need for stricter enforcement of safety regulations and the adoption of proactive risk management to prevent similar tragedies in the future.

**CHAT GPT ONE-SHOT**

On 7 August 2018, at approximately 0800, the UK-registered fishing vessel Fram of Shieldaig experienced a fatal marine accident in Loch Torridon, off Ardheslaig, Scotland. The vessel, a 9.8m potter, was crewed by a skipper and a deckhand, Duncan Matheson, and was engaged in potting operations during daylight hours. The accident occurred during routine preparations for sea when the deckhand fell into the water from the vessel’s tender. Tragically, he drowned before being recovered.

The incident began when the crew boarded the tender and motored to Fram’s mooring. After the skipper boarded the fishing vessel with bait and empty tube boxes, the deckhand took the tender to retrieve partially filled langoustine boxes from a nearby storage raft. Upon returning to Fram, the skipper noticed the tender drifting away with its engine idling and saw the deckhand floating motionless in the water between the tender and the fishing vessel. The deckhand appeared to have a cut on the back of his head and was unresponsive. Despite the skipper's efforts to recover him using a boathook and maneuver Fram to a storage raft, he was unable to lift the deckhand out of the water alone. Assistance was sought from other fishermen, but by the time the deckhand was recovered and emergency services arrived, he had been in the water for over 75 minutes and could not be revived.

The postmortem examination confirmed drowning as the cause of death, with contributing factors including a head injury and alcohol intoxication. Toxicology results revealed that the deckhand’s blood alcohol concentration (BAC) was significantly above legal limits, impairing his coordination and judgment. It is likely he fell overboard while attempting to secure the tender alongside Fram and struck his head, rendering him unconscious. The cold-water immersion (12.8°C) would have further reduced his chances of survival without a lifejacket.

The investigation highlighted several issues contributing to the accident. Despite the availability of inflatable lifejackets on board, neither crew member was wearing one at the time of the accident. The vessel's safety folder lacked a specific risk assessment for boarding and leaving the vessel using the tender, and no procedures required the use of personal flotation devices (PFDs) during this activity. Additionally, Fram’s crew had not conducted regular emergency drills, which could have prepared them to recover an unconscious person from the water more effectively. The skipper’s failure to issue an immediate distress call delayed the arrival of emergency services, though it is unlikely this would have changed the outcome.

In response to the accident, Fram of Shieldaig’s owner has implemented several safety measures. New compact automatic-inflation lifejackets have been purchased, and a mandatory policy requiring their use during all on-deck and boarding activities has been introduced. The practice of lone working in the tender has been discontinued. The Marine Accident Investigation Branch (MAIB) also issued a Safety Flyer to the fishing industry, emphasizing the importance of wearing lifejackets and conducting regular emergency drills.

To prevent similar tragedies in the future, it is recommended that fishing vessel owners conduct comprehensive risk assessments for all activities involving boarding and leaving vessels, with a particular emphasis on the use of PFDs. Regular emergency drills, including man-overboard recovery scenarios, should be mandatory to ensure crews are prepared to respond effectively in critical situations. Furthermore, fishing vessel operators should establish and enforce strict alcohol and drug policies to mitigate the risks associated with impairment during work. Regulatory bodies should continue to promote and enforce the use of life-saving equipment, as well as provide education and training to encourage a culture of safety among fishermen[OGE].

**LLAMA FEW-SHOT**

On 7 August 2018, approximately at 0800 hours, a very serious marine casualty occurred on board the fishing vessel BRD 679, also known as Fram. The vessel was moored in Loch Torridon, off Ardheslaig, when one of the crew members fell overboard. Unfortunately, this resulted in one fatality.

The accident took place while the vessel was in calm seas with good visibility and water temperature at 12.8°C. There were only two crew members on board, which is below the minimum safe manning requirement for a fishing vessel of this size.

No damage or environmental impact was reported as a result of the accident.

The investigation into the incident revealed that regular person overboard recovery drills had not been conducted by the crew, and none of them wore Personal Flotation Devices (PFDs) even when available on board. This lack of preparation contributed to the tragic outcome of the accident.

Following this report, there was an emphasis from the Maritime and Coastguard Agency (MCA) for mandatory regulations regarding PFD use among commercial fishermen. The review of previous accidents involving person overboard incidents highlighted that only campaigns backed by regulations can effectively change entrenched behaviours in the industry.

The investigation also found that health and safety risk assessments had been completed, and the vessel's owner used the Sea Fish Industry Authority's (Seafish) online safety folder to manage its obligations. However, despite these measures, the crew's lack of PFD use and failure to conduct regular person overboard recovery drills proved fatal.

In light of this report, I offer the following recommendations for future shipping:

The fishing industry should adopt mandatory regulations requiring all commercial fishermen to wear Personal Flotation Devices (PFDs) at all times while on duty. This measure can effectively prevent similar accidents from occurring in the future. Additionally, regular person overboard recovery drills should become an essential part of any vessel's safety protocols.

Furthermore, vessels should prioritize crew training and awareness campaigns to emphasize the importance of PFD use and proper emergency procedures. By doing so, fishermen can better prepare for potential situations and reduce the risk of accidents at sea.

**LLAMA FEW-SHOT**

On 7 August 2018, approximately at 0800 hours, a very serious marine casualty occurred in Loch Torridon, off Ardheslaig, when one fatality was reported on board the fishing vessel BRD 679[NNE]. The vessel, a privately owned potter with a gross tonnage of 10.08, was moored in the location at the time of the incident. According to the marine casualty information, the accident took place when the crew overboard during a near-coastal voyage segment.

The investigation into the incident revealed that the external environment at the time was characterized by light airs, calm seas, good visibility, and sea water temperature of 12.8°C. The vessel had only two persons on board. Analysis of the circumstances suggests that the cause of the accident may be attributed to inadequate safety protocols and lack of regular person-overboard recovery drills among commercial fishermen. Furthermore, it appears that there was no use of Personal Flotation Devices (PFDs) despite their availability on board.

The MAIB's investigation report emphasizes the importance of campaigns and measures to encourage the use of PFDs among commercial fishermen. However, in this case, no such regulations were present. [MGE] The incident serves as a reminder of the significance of implementing mandatory regulations to change entrenched behaviors and prevent similar accidents from occurring in the future.

To prevent similar incidents, it is recommended that vessels operating in remote areas prioritize regular person-overboard recovery drills [MGE]and ensure the use of PFDs among crew members. Additionally, regulatory bodies should consider implementing mandatory regulations on PFD usage to promote a culture of safety among commercial fishermen. By taking proactive measures to address these issues, the maritime industry can reduce the risk of such incidents and ensure the safety of all those involved in fishing operations.In response to this incident, the harbour authority did not provide specific guidance on engine readiness or the operational status of anchoring equipment during severe weather. Recommendations moving forward should focus on enhancing communication and providing more detailed instructions for vessel operators regarding anchoring procedures in adverse conditions. [MGE] Additionally, a more robust risk assessment framework that addresses the likelihood and severity of dragging anchor incidents could be beneficial to prevent similar future occurrences. [MGE]

**QWEN FEW-SHOT**

The marine accident report for 201808.txt details an incident that occurred on August 7, 2018, around 08:00 in Loch Torridon, off Ardheslaig. The vessel involved was the fishing boat BRD 679, a GRP-built potter with a registered length of 9.40 meters and a gross tonnage of 10.08. The accident resulted in one fatality onboard.

The marine casualty information indicates that the accident occurred while the vessel was moored, suggesting the incident might have involved a crew member who fell overboard or otherwise left their position safely from the ship’s side. [MGE]Environmental conditions at the time were described as light airs with calm seas and good visibility, with sea water temperatures around 12.8°C.

Analysis of the causes suggests that safety and operational procedures may not have been strictly adhered to, particularly regarding regular emergency drills and preparedness for unforeseen events such as a person overboard scenario. The vessel was well-equipped with appropriate safety gear but had not conducted recent emergency response drills, which likely contributed to the lack of immediate and effective action following the incident.[UGE]

Following the accident, several actions were taken to address the situation and prevent future occurrences. The Maritime and Coastguard Agency (MCA) inspected the vessel as per standard procedures, ensuring that all safety and health equipment continued to comply with regulatory requirements. [MGE]The owner utilized a Seafish online safety folder, which contained various checklists, templates, and forms to document specific health and safety measures, emergency procedures, crew details, risk assessments, and records of equipment inspections.

For the future shipping industry, it is recommended that regular drills and training sessions be conducted to ensure all crew members are thoroughly prepared for emergencies. Additionally, continuous monitoring and updating of safety protocols based on incident reports could enhance overall vessel safety. The owner should also consider incorporating a more stringent and frequent drill schedule into their operational procedures, as this can significantly improve response times and outcomes in critical situations. [MGE]

**CHAT GPT FEW-SHOT**

On 7 August 2018, at approximately 0800, a fatal accident occurred involving the UK-registered fishing vessel Fram of Shieldaig in Loch Torridon, Scotland. The vessel, a 9.8m GRP-hulled catamaran used for potting operations, was crewed by a skipper and a deckhand, Duncan Matheson. The deckhand drowned after falling overboard from the vessel’s tender during routine operations. The tender, a 4.5m polyethylene open boat, was used to transport langoustine tube boxes between the vessel and a nearby storage raft. The accident took place while the deckhand was attempting to secure the tender alongside Fram. [MGE]He was found floating motionless in the water, unconscious, with a cut to the back of his head. Despite the skipper’s efforts to recover the deckhand and summon assistance, the deckhand could not be revived and was later declared deceased at the scene by paramedics.

The accident caused no physical damage to the vessel or tender, but tragically resulted in the loss of life. The postmortem examination concluded drowning as the cause of death, with toxicology revealing a blood alcohol concentration (BAC) of 276 milligrams per 100 millilitres, over five times the UK limit for seafarers. The deckhand was not wearing a lifejacket at the time of the accident. It is likely that he fell while attempting to secure the tender, possibly striking his head on the tender or Fram as he entered the water. The combination of cold shock from the 12.8°C seawater and his unconscious state rendered him unable to keep himself afloat. The absence of a lifejacket significantly reduced his chances of survival, as it would have kept his airways clear while the skipper attempted recovery.

The investigation identified several contributing factors to the accident. Fram of Shieldaig’s safety folder lacked a risk assessment for boarding and leaving the vessel via the tender, and the use of personal flotation devices (PFDs) was not included as a control measure in existing risk assessments. Although PFDs were available on board, they were never used. The crew had not conducted regular person overboard drills, which left them unprepared for emergencies such as recovering an unconscious person from the water. Additionally, alcohol consumption by the deckhand was found to have significantly impaired his coordination, risk perception, and reaction time, contributing to the accident.

In response to the accident, Fram of Shieldaig’s owner purchased new compact automatic inflation lifejackets and implemented a mandatory policy requiring their use while working on deck and boarding or leaving the vessel. The practice of working alone in the tender was also discontinued. Furthermore, the owner was recommended to add an alcohol and drugs policy to the vessel’s safety folder and ensure adherence to it.

To prevent similar tragedies in the future, the investigation underscores the importance of wearing lifejackets at all times when there is a foreseeable risk of falling overboard. Regular emergency drills, particularly for person overboard scenarios, should be conducted to ensure crews are prepared to respond effectively in emergencies. Vessel owners and operators must also enforce comprehensive risk assessments that account for all hazardous operations, including boarding and leaving the vessel. Finally, stricter adherence to alcohol policies in the fishing industry is critical to safeguarding lives and improving safety standards. The implementation and enforcement of these measures are essential to fostering a robust safety culture among fishermen and preventing further loss of life.