**LLAMA ZERO-SHOT**

The incident occurred on February 18, 2020, at Ardintoul Point, Loch Alsh, during a personnel transfer operation on board the vessel Beinn Na Caillich. There was one fatality, and the injuries were classified as very serious. [MGE]The damage or environmental impact was minimal.

There are possible causes for this incident, including the lack of maritime knowledge among the safety management team and their focus on shore-side regulations rather than safe systems of work for vessels. This oversight led to a risk assessment that did not consider the risks associated with personnel transfers on board boats. Furthermore, there is a lack of documented safety procedures in place for the boat operations. [UGE]

The accident highlights the importance of proper training, equipment, and safety management systems. The vessel's company, Marine Harvest (Scotland) Limited [NNE], has taken steps to address these issues, including introducing new equipment and training for recovery of a man overboard, engaging external auditors to review their health and safety management systems, and incorporating lessons learned into their E-Learning package.

The recommendations from the report include: 1) applying the standards set out in the Workboat Code Edition 2 to all existing workboats; 2) ensuring appropriate marine expertise is present or provided to senior management teams overseeing vessel safety and operations; and 3) fully implementing a safety management system across their fleet that complies with the principles of the International Safety Management Code.

In summary, this accident highlights the importance of prioritizing maritime knowledge, implementing effective safety procedures, and providing adequate training for personnel in high-risk industries such as fishing. By learning from this incident, companies can take necessary precautions to prevent similar accidents in the future.

**LLAMA ONE-SHOT**

On 18 February 2020 at 1510, a very serious marine casualty occurred near Ardintoul Point, Loch Alsh, involving the vessel Beinn Na Caillich. The accident resulted in one fatality and no environmental damage. The incident involved a personnel transfer operation where an assistant manager from Marine Harvest (Scotland) Limited[NNE] was crushed between the vessel and a feed barge while attempting to step onto the barge's access ladder.

The accident occurred when the bulwark gate on the barge was left open, allowing the assistant manager to proceed without proper supervision. Furthermore, it is suggested that the use of a crotch strap in conjunction with correct lifejacket fitting may have prevented the assistant manager from slipping out of their lifejacket and going into the water.

The investigation revealed that the crew on board Beinn Na Caillich was not adequately prepared to handle the emergency situation, having failed to conduct regular manoverboard recovery drills. Additionally, there was a lack of documented safe systems of work in place for personnel transfers, which contributed to the accident[UGE].

In response to the accident, Mowi (Scotland) Limited has taken steps to review and revise policies and risk assessment method statements for vessel embarking and disembarking procedures, lifejacket use, and manoverboard emergency procedures. They have also introduced new equipment and training for recovery of a man overboard and incorporated lessons learned from this incident into their E-Learning package.

In light of the accident and its causes, I offer several recommendations for future shipping operations in the aquaculture industry. Firstly, it is essential to implement safety management systems that comply with international standards, such as the International Safety Management Code. This will ensure that vessels have adequate personnel expertise present or provided by senior management teams to oversee vessel safety. Secondly, regular drills and training exercises should be conducted to prepare crew members for emergency situations, including manoverboard recoveries. Finally, it is crucial to establish documented safe systems of work for all operations on board, including personnel transfers, to prevent similar accidents in the future.

Overall, this accident highlights the importance of prioritizing vessel safety and implementing effective safety management systems that are grounded in industry best practices[UGE].

**QWEN ZERO-SHOT**

The Beinn Na Caillich, a MCA Category 2 workboat managed by Marine Harvest (Scotland) Limited[NNE], experienced a serious marine casualty on February 18, 2020, at Ardintoul Point, Loch Alsh. Although the exact cause of the accident is not detailed in the provided context[MGE], it highlights significant gaps in safety management practices within Mowi (Scotland) Ltd., including the absence of documented safe systems of work and comprehensive risk assessments for boat operations.

The existing generic risk assessment focused primarily on personnel working on fish farm installations but did not adequately address risks to those on board the boats. This oversight reflects a lack of maritime expertise among senior management, who were not fully aware of marine risks or published guidance

The accident resulted in one fatality during personnel transfer operations but fortunately caused no environmental damage due to calm sea conditions and good visibility. The company has since taken several steps to address these issues, including incorporating lessons learned into its E-Learning package for employees and engaging external auditors to review health and safety management systems

To prevent similar accidents in future shipping operations, key recommendations include developing and documenting comprehensive safe systems of work for all activities. This should involve thorough risk assessments that consider all potential hazards on board vessels. Additionally, regular training and updates in safety procedures, particularly regarding man-overboard emergency responses, are crucial.

Mowi (Scotland) Ltd. is also advised to adopt the standards set out in the Workboat Code Edition 2 and ensure that senior management has appropriate maritime expertise to oversee vessel safety effectively [2021/110]. By prioritizing these measures, companies can enhance overall safety and prevent accidents like this one from occurring again.

These actions will foster a safer working environment for all personnel involved in marine operations and help ensure the effective implementation of robust health and safety management systems.

**QWEN ONE-SHOT**

The incident occurred on March 15, 2020[DTE] at the Seafield Fish Farm[MGE]. The Beinn Na Caillich, a workboat, was involved in the personnel transfer operation to and from fish farm feed barges. A crew of fish farm technicians were scheduled for these transfers.

Despite the usual practice of using rigid boarding bridges (RBBs) for such operations, this particular incident required the use of larger vessels due to specific weather conditions or operational needs [MGE]. However, there is no documented evidence that a risk assessment was conducted prior to the transfer as per the guidance from the Workboat Association's Crew Transfer Vessels: Good Practice Guide and Marine Guidance Note (MGN) 71 by the MCA.

Furthermore, there were no records of a briefing or toolbox talk being carried out before the personnel transfer. This omission highlights a failure in adhering to standard operating procedures. Onboard Safety guidelines from 2018 required that vessel stability must be verified by crew members prior to any personnel transfer, but this was not followed during the incident.

The root cause analysis identified several issues: the lack of documented risk assessments and briefings contributed significantly to potential safety lapses. Specifically, the absence of a thorough pre-transfer risk assessment could have mitigated certain risks associated with the operation [UGE].

To prevent similar incidents in the future, recommendations include establishing strengthened internal procedures that mandate mandatory risk assessments and ensure all records are maintained. Additionally, regular crew briefings and toolbox talks must be completed before any transfer operation takes place to enhance communication and preparedness. Verifying vessel stability through comprehensive pre-transfer inspections and verifications should also become a standard practice[UGE].

**CHAT GPT ZERO-SHOT**

The report details a fatal marine accident on 18 February 2020 at Ardintoul fish farm in Loch Alsh, Scotland, involving the workboat Beinn Na Caillich. The accident occurred during a personnel transfer when the assistant manager stepped onto the barge ladder while the vessel was still moving. This led to him being crushed between the workboat’s bulwark gate and the barge ladder structure. Although he initially held onto the ladder, he slipped out of his lifejacket, fell 2.7m into the water, and drowned due to his injuries. The postmortem examination identified drowning and a severe pelvic crush injury as the causes of death.

The report identified several key causes of the accident. The transfer was not adequately planned, risk-assessed, or supervised. The bulwark gate was routinely left open, allowing the assistant manager to step off the vessel unsupervised. Additionally, the assistant manager’s lifejacket crotch straps were not fastened, which contributed to it slipping off during the fall. The crew had not conducted emergency drills and were unfamiliar with the vessel’s man-overboard recovery equipment, delaying the rescue operation. Mowi (Scotland) Ltd lacked a marine safety management system (SMS) and staff with maritime expertise to oversee vessel operations, contributing to inadequate safety practices [UGE].

This accident highlights critical lessons for improving marine safety. Personnel transfers must be risk-assessed, properly planned, and supervised, and vessels should be stationary during transfers. Lifejacket crotch straps must always be fastened to prevent loss in emergencies. Regular emergency drills can ensure readiness for man-overboard situations. Companies operating workboats should implement a robust SMS in compliance with the Workboat Code Edition 2 and employ maritime safety experts to oversee operations. By addressing these safety gaps, future incidents can be prevented, reducing risks to personnel during marine operations.

**CHAT GPT ONE-SHOT**

On 18 February 2020, the UK-flagged workboat Beinn Na Caillich was involved in a fatal marine accident at the Mowi Ardintoul fish farm site on Loch Alsh, Scotland. The accident occurred during a routine personnel transfer operation from the workboat to a fish farm feed barge at approximately 1510. The assistant manager of the fish farm, who was being transferred, was crushed between the workboat’s bulwark gate post and the barge’s ladder structure. Despite immediate rescue efforts, he fell into the water, and subsequent attempts to save him were unsuccessful. The assistant manager was pronounced deceased at the hospital, with the cause of death determined as drowning following a severe crush injury to his pelvis.

The accident unfolded when the assistant manager stepped through Beinn Na Caillich’s open bulwark gate onto the barge access ladder while the vessel was still moving slowly ahead. This movement caused the bulwark gate post to crush him against the ladder’s fender structure. Although the assistant manager managed to hold on to the ladder for a short time, he eventually slipped out of his lifejacket and fell into the water. Rescue actions by the crew of Beinn Na Caillich and nearby boats recovered him from the water, but despite CPR and the use of a defibrillator, he could not be revived.

The investigation highlighted several contributing factors to the accident. The personnel transfer operation lacked proper planning, risk assessment, and supervision. The assistant manager acted on his own initiative, stepping onto the ladder without instruction from the workboat’s skipper, and the open position of the bulwark gate facilitated this unsafe action. Additionally, while the assistant manager was wearing a lifejacket, the crotch straps were not fastened, allowing the lifejacket to slip off when he fell into the water. It was also noted that the Beinn Na Caillich crew were not adequately prepared for emergency scenarios, as they had not conducted man-overboard drills and were unfamiliar with the vessel’s recovery equipment [UGE].

Following the accident, Mowi (Scotland) Ltd implemented several corrective actions. Policies and risk assessments were revised for personnel transfers, lifejacket use, and man-overboard procedures. New equipment and training were introduced for man-overboard recovery, and the company updated its employee induction e-learning packages to include lessons learned from the incident. External auditors were also engaged to review Mowi’s health and safety management systems.

To prevent similar accidents in the future, it is recommended that Mowi (Scotland) Ltd implement a safety management system (SMS) across its fleet that complies with the principles of the International Safety Management (ISM) Code, as outlined in the Workboat Code Edition 2. This should include detailed risk assessments, standard operating procedures, and mandatory emergency drills to ensure crew preparedness. Additionally, it is crucial to ensure that all personnel wear properly fitted lifejackets with crotch straps fastened, in accordance with best practices and industry guidelines. Finally, Mowi should ensure that senior management includes maritime expertise to oversee the safety of its vessels and marine operations, promoting a consistent and proactive approach to risk management.

**LLAMA FEW-SHOT**

On 18 February 2020, at 1510 hours, a very serious marine casualty occurred on board Beinn Na Caillich, a MCA Category 2 workboat operated by Marine Harvest (Scotland) Limited [NNE]. The incident took place while the vessel was undertaking personnel transfer operations in Loch Alsh, specifically near Ardintoul Point. Unfortunately, one fatality was reported during the accident.

According to the report, the accident occurred when the crew of the Beinn Na Caillich embarked and disembarked vessels without proper life jacket wear [MGE]. The investigation revealed that the company had a generic risk assessment for its boat operations but no documented safe systems of work, which contributed to the oversight of marine risks and the lack of awareness among senior management about the importance of following safety guidelines. [UGE]Furthermore, the reported lack of maritime knowledge within the safety management team exacerbated this issue.

The accident did not result in any environmental damage or injuries to other crew members besides the fatality. However, it highlighted the need for improvement in maritime expertise and proper life jacket wear during personnel transfer operations.

In response to the incident, Mowi (Scotland) Ltd has taken several actions. The company introduced new equipment and training for recovery of a man overboard, as well as incorporated the lessons learned from this accident into its E-Learning package for employees during induction. Additionally, they engaged external auditors to undertake an audit of their current health and safety management systems.

In light of this incident, I offer several recommendations for future shipping operations: Mowi (Scotland) Ltd should prioritize implementing a comprehensive safety management system across its fleet that complies with the principles of the International Safety Management Code. This would ensure that all senior management team members are aware of marine risks and have the necessary expertise to oversee vessel safety and operations. Furthermore, it is essential for the company to conduct regular audits and assessments to identify potential hazards and take proactive measures to mitigate them. The implementation of documented safe systems of work and a robust risk assessment process would also help minimize the likelihood of similar accidents in the future. [MGE]

Finally, the importance of proper life jacket wear during personnel transfer operations cannot be overstated. Mowi (Scotland) Ltd should ensure that all crew members are properly trained on the use and maintenance of life jackets and that they consistently adhere to safety guidelines during such operations.[UGE]

**QWEN FEW-SHOT**

On 18 February 2020 at 1510, a serious marine casualty occurred involving the vessel 'Beinn Na Caillich' on Loch Alsh near Ardintoul Point in Scotland. The incident resulted in one fatality during personnel transfer operations from an embarking and disembarking vessel. The air temperature was recorded at 4°C with water temperatures ranging between 6-8°C, while winds were blowing from the southwest at force 4-5, and visibility was good with calm sea conditions.

The accident unfolded when a person on board attempted to embark or disembark the vessel but unfortunately slipped and fell into the water. [UGE]The immediate response involved manoverboard emergency procedures, yet the cold weather and challenging environmental conditions [MGE]likely contributed significantly to the fatality. No visible damage to the vessel was reported, and there were no apparent environmental impacts from the incident.

Analysis of the accident revealed that the challenges of operating multiple vessels without proper documentation or risk assessments exacerbated safety issues. The company had a single generic risk assessment for boat operations which did not adequately address maritime-specific risks such as those associated with personnel transfer. This oversight indicated a lack of appropriate marine expertise within the management team and highlighted the need for comprehensive safety measures.[UGE]

Following the incident, the company took several steps to improve safety standards. New equipment was introduced along with training specifically designed for man overboard recovery scenarios. Additionally, an E-Learning package was incorporated into their employee induction process, emphasizing key safety procedures and principles. To ensure compliance with maritime regulations, external auditors were engaged to evaluate existing health and safety management systems.

For the future, recommendations suggest that Mowi (Scotland) Ltd should apply the standards set out in the Workboat Code Edition 2 across all its workboats and implement a fully compliant safety management system that aligns with the International Safety Management Code principles. Furthermore, providing adequate marine expertise to senior management is crucial for overseeing vessel and marine operations safely.[MGE]

In summary, the Beinn Na Caillich incident on 18 February 2020 highlights the importance of robust risk assessments and comprehensive safety systems in maritime operations, especially when personnel transfer activities are involved in harsh weather conditions.

**CHAT GPT FEW-SHOT**

On 18 February 2020, at approximately 1510, a fatal accident occurred on board the UK-registered workboat Beinn Na Caillich during a personnel transfer operation at the Ardintoul fish farm near Loch Alsh, Scotland. The vessel’s assistant manager, who was stepping from the workboat onto a fixed ladder on a feed barge, was crushed between the vessel’s bulwark and the barge ladder structure. The assistant manager subsequently fell into the water and drowned due to his inability to stay afloat after slipping out of his lifejacket. Despite prompt rescue attempts by the crew of Beinn Na Caillich and other nearby vessels, the assistant manager could not be resuscitated and was later pronounced deceased in the hospital.

The accident occurred as Beinn Na Caillich approached the feed barge to facilitate the transfer of the assistant manager. The vessel was still moving slowly ahead when the assistant manager stepped through the open bulwark gate towards the barge ladder. The gate structure [MGE] caught him and crushed him against the barge fender. Despite holding onto the ladder initially, he slipped out of his oilskin coat and unfastened lifejacket and fell 2.7 meters into the cold water. The postmortem examination confirmed the cause of death as drowning following a severe crush injury to the pelvis. The vessel and its crew suffered no physical damage, but the incident highlighted significant gaps in operational safety measures.

The analysis revealed several contributing factors to the accident. The personnel transfer operation lacked proper planning, communication, and supervision. Neither the assistant manager nor the crew had a clear understanding of the transfer procedure, and there was no risk assessment or briefing before the operation. The bulwark gate on Beinn Na Caillich was routinely left open, which enabled the assistant manager to attempt the transfer without oversight. Additionally, the crew had not conducted regular manoverboard drills and were unfamiliar with the vessel’s recovery equipment, which hindered their emergency response. The assistant manager’s lifejacket, while worn, had unfastened crotch straps, which allowed him to slip out of it upon entering the water.[UGE]

Following the accident, Mowi (Scotland) Ltd, the operator of Beinn Na Caillich, implemented several corrective actions. The company revised its risk assessment and procedures for personnel transfers, mandated the use of properly secured lifejackets with crotch straps, and introduced new manoverboard recovery equipment and training for its crews. Lessons learned from the incident were incorporated into the company’s employee induction program, and external auditors were engaged to review the company’s health and safety management systems.

To prevent similar accidents in the future, it is recommended that Mowi (Scotland) Ltd fully implement a safety management system (SMS) across its fleet that adheres to the principles of the International Safety Management (ISM) Code. The company should also apply the standards outlined in the Workboat Code Edition 2 to all its existing vessels, regardless of their certification date, to ensure consistent safety practices. Furthermore, it is crucial for Mowi to employ personnel with appropriate maritime expertise to oversee marine operations and to provide their crews with regular training in emergency procedures, including manoverboard recovery drills. The importance of proper risk assessment, briefing, and supervision during personnel transfers cannot be overstated, as neglecting these measures has proven to have fatal consequences.