**LLAMA ZER-SHOT**

The reported marine casualty occurred on August 28, 2021, when the skipper of a lone-operated creel fishing vessel, Sea Mist [NNE], went overboard and drowned. The investigation revealed that the skipper caught his boot in the backline while shooting creels and was pulled overboard. This incident is part of a pattern of similar accidents involving UK fishing vessels under 15m in length.

The accident resulted in one fatality, with no damage or environmental impact reported. However, the incident highlights concerns about the safety of lone-operated fishing vessels. The report suggests that the skipper's awareness of relevant MCA instructions and industry safety guidance would have been enhanced if he had been a member of the local fishermen's association or registered with the SafetyFolder service.

Further analysis reveals that there is still further work to be done to enhance the promulgation of relevant industry guidance on the safety of lone-operated fishing vessels. The report notes that even with potting safety reviews and specialist working groups, such as the FISG, the necessary advice may not reach all skippers without proactive effort.

In terms of possible causes, the accident could be attributed to a combination of factors, including inadequate awareness of safety guidelines and insufficient training. However, the exact cause is not explicitly stated in the report. [MGE]

The incident serves as a reminder of the importance of prioritizing safety in maritime operations. To prevent similar incidents in the future, skippers should take precautions such as registering with relevant services, staying up-to-date with industry guidance, and seeking additional training if necessary. [MGE]

**LLAMA ONE-SHOT**

The accident took place on August 28, 2021, at approximately 0736 hours, when a lone-operated fishing vessel, Harriet J, encountered a serious marine casualty [MGE]. The location of the incident was 2nm west of Fast Castle Head, south-east Scotland.

According to the report, the accident occurred when the skipper, likely entangled in the chain weight used at the end of the fourth fleet of creels worked that morning, was pulled from the vessel through the shooting door at the aft end of the working deck. The skipper's head struck the water, [MGE]and he succumbed to drowning while still in the water. A possible contributory factor to this incident was the skipper's pre-existing heart condition.

The damages suffered by Harriet J included breached fuel tanks, cracked and deformed shell plating forward, a partially detached starboard bilge keel, [MGE]and none for environmental impact. However, it is worth noting that a second fishing vessel, Sarah Grey, was nearby and received the chain fouling Kuzma Minin's port anchor.

Analysis of the causes leading to this accident highlights the importance of safety protocols for lone-operated vessels. The fact that the skipper became entangled in the chain weight suggests a lack of proper safety measures, such as adequate supervision or safe handling procedures for heavy equipment. Furthermore, the incident underscores the need for improved communication between vessel operators and nearby authorities. [MGE]

In response to this accident, an extraordinary meeting of FISG members identified several proposals, including suggestions for improved engagement and promulgation of information with industry; updating of guidance material; and consideration of vessel design. The FISG executive board established a working group focused on the safety of lone-operated fishing vessels, which was provided with a copy of the Seafish review to support their discussions.

Based on this incident, I recommend that future shipping authorities implement stricter guidelines for the safe operation of lone-operated vessels, including regular inspections and training programs for vessel operators. Additionally, the development of more robust safety equipment and communication protocols between vessels and nearby authorities is essential to preventing similar incidents in the future. By taking these steps, we can minimize the risks associated with lone-operated fishing vessels and ensure a safer maritime environment for all. [MGE]

**QWEN ZERO-SHOT**

The report details a very serious marine casualty involving a fishing vessel that occurred on August 28, 2021. The incident took place 2 nautical miles west of Fast Castle Head in southeast Scotland. The skipper was working alone when he died after going overboard; this is one among eight fatal accidents involving UK fishing vessels under 15 meters in length during the preceding five years.

The report highlights that all these incidents involved creel (or potting) fishing vessels, and only one of the fishers who died was wearing a personal floatation device (PFD), with none carrying a personal locator beacon (PLB). A specific case study mentioned is the accident on the lone-operated creel vessel Sea Mist in March 2019, where the skipper’s boot got caught in the backline while deploying fishing equipment, leading to drowning.

According to the Marine Accident Investigation Branch (MAIB) report , the key issue is that lone operators like the skipper of the vessel involved were not adequately prepared for such emergencies. The accident underscores the importance of adhering to MCA instructions and industry safety guidelines, which could be improved by being a member of local fishermen’s associations or registering with SafetyFolder services.

However, without proactive engagement, it is unlikely that a fisher would remain informed about updated advice. Furthermore, while Seafish conducted a potting safety review and established a specialist FISG working group, there remains a need for better dissemination of relevant industry guidance to ensure the safety of lone-operated fishing vessels.

From this accident, we learn the critical importance of personal protective equipment such as PFDs and PLBs. Additionally, being part of a local association or registering with SafetyFolder services can significantly enhance a fisher's awareness of safety protocols and updates. Precautions moving forward should include mandatory PFD use, regular checks for gear entanglements, and improved communication systems to ensure immediate assistance in case of emergencies. [MGE]

**QWEN ONE-SHOT**

The incidents occurred on 28 August 2021, involving two similar accidents [MGE]with lone-operated fishing vessels in Scotland's waters, both part of the FISG Home and Dry campaign reports. In each case, one fatality resulted from a skipper being pulled overboard without a properly functioning personal floatation device (PFD), highlighting critical safety issues.

On 28 August 2021, at approximately 07:36, the first incident took place about two nautical miles west of Fast Castle Head, South-East Scotland. The skipper was working on the working deck in mid-water during creel shooting when he became entangled with a rope or gear line (likely the backline). Despite wearing a PFD[MGE], he was unable to reboard due to his entanglement and the lack of easy means for distress signaling.

The second incident followed a similar pattern. [MGE]The skipper was also working on the deck during creel shooting when an entanglement with a rope or gear line occurred, resulting in him being pulled overboard without a PFD that could effectively assist in reboarding the vessel. Both incidents underscored the significant risks associated with lone-operated fishing vessels and the critical importance of proper safety measures.

Contributing factors to these accidents included fatigue and pre-existing medical conditions, particularly concerning the skipper's heart condition, which likely exacerbated his inability to survive in the water. Additionally, poor risk assessment on handling gear, especially during creel shooting, led to a lack of barriers or safety measures to contain the rope away from work areas, increasing the likelihood of entanglement. [UGE]

Key lessons learned include the necessity for comprehensive risk assessments, particularly for single-handed operations, and the identification of potential snag points with appropriate barriers. Ensuring all crew members, including solo operators, have proper PFDs is crucial, along with effective means of communication and distress signaling devices such as personal locator beacons (PLBs).

Improvements in safety guidance should include specific measures to prevent entanglements, such as revising existing safety guidance for single-handed fishing operations. Fishers are encouraged to register and utilize available resources like the Marine Accident Investigation Branch's (MAIB) Fishermen’s Safety Guide, Seafish21 website, and FISG Home and Dry campaigns.

To address these issues, recommendations include promoting better safety practices through design features that can reduce entanglement risks for single-handed operators, such as rope barriers. This comprehensive approach will help mitigate similar accidents in the future by enhancing overall safety standards and preparedness on fishing vessels. [MGE]

**CHAT GPT ZERO-SHOT**

The accident on the Harriet J, a lone-operated creel fishing vessel, occurred on 28 August 2021 when its skipper, John Wilson, was pulled overboard and drowned. The incident likely resulted from the skipper becoming entangled in the chain weight of the fishing gear while attempting to free a snag during the deployment of the fourth fleet of creels. He was dragged through the open shooting door, possibly striking his head in the process. Despite being conscious initially and freeing himself from the entrapment, he was unable to reboard the vessel, which continued moving at 5.4 knots, and succumbed to cold incapacitation in the water due to the sea temperature of around 15°C. The skipper was not wearing a personal flotation device (PFD) or carrying his personal locator beacon (PLB), both of which were stored in the wheelhouse and inaccessible during the emergency.

The vessel sustained no damage, but the accident resulted in the tragic loss of life. Contributory factors included the vessel's deck layout, which lacked effective segregation to prevent the skipper from entering hazardous areas, and the lack of a means to remotely stop the engine or aid reboarding. Additionally, while the skipper had some safety equipment onboard, it was not actively used, and industry safety guidelines for lone-operated fishing vessels were not fully implemented. [UGE]

This accident highlights critical lessons for the fishing industry. Operators of lone fishing vessels should always wear PFDs to improve buoyancy and survivability in the water and carry PLBs on their person to enable quicker emergency response. Vessels should be equipped with systems to remotely stop engines and should feature deck layouts that minimize entanglement risks and segregate crew from hazardous areas. Clear risk assessments, adherence to safety protocols, and proactive engagement with updated industry guidance are essential for mitigating risks. Enhanced dissemination of safety information, particularly for lone fishers, remains a priority to prevent similar tragedies in the future.

**CHAT GPT ONE-SHOT**

On 28 August 2021, at approximately 0736, the UK-registered creel fishing vessel Harriet J was involved in a fatal maritime accident off the southeast coast of Scotland, about 2 nautical miles west of Fast Castle Head. The vessel, operated by its lone skipper, John Wilson, encountered a tragic incident during creel fishing operations. The skipper likely became entangled in the chain weight of a creel fleet being shot overboard and was pulled through the vessel’s shooting door into the sea. Despite search and rescue efforts, the skipper was recovered unconscious from the water at 0857 [DTE]and was later declared deceased at 0955 at Edinburgh Royal Infirmary. The immediate cause of death was determined to be drowning, with ischaemic heart disease noted as a contributory factor.

The accident unfolded during routine creel fishing operations. While deploying the fourth fleet of creels that morning, the vessel’s track indicated a significant dip in speed, suggesting a snag in the gear. It is believed that the skipper accessed the working deck to release the snagged gear, which was a common practice on the vessel. In doing so, his booted foot likely became entrapped in the chain loop of the gear, causing him to be pulled overboard. A head injury sustained during the fall and the absence of a personal flotation device (PFD) further contributed to the severity of the incident. The skipper was unable to reboard the unmanned vessel, which continued moving at a speed of 5.4 knots. The skipper was not wearing a PFD at the time of the accident, and his personal locator beacon (PLB) was stowed in the wheelhouse, rendering it inaccessible.

The investigation revealed several underlying causes and contributing factors. The vessel's deck layout and stowage of equipment behind the pound board made it difficult for the skipper to access the deck safely while fishing gear was under tension. The skipper’s practice of manually intervening to release snags was a known hazard, yet it had not been effectively mitigated. The lack of a PFD diminished the skipper’s chances of survival in the water, while the absence of a remote engine stop meant the vessel continued moving, making self-recovery impossible. Additionally, the skipper’s pre-existing heart condition, combined with the physical strain of remaining afloat in cold water, likely exacerbated his incapacitation and contributed to the fatal outcome. The skipper’s awareness of safety guidance was limited, as he had not registered with available safety resources, such as the SafetyFolder service.

In response to the accident, the Maritime Accident Investigation Branch (MAIB) issued a safety flyer to the fishing industry to highlight the lessons learned. The Maritime and Coastguard Agency (MCA) has also taken steps to improve safety practices by commissioning studies with the Health and Safety Executive and the Behavioural Insights Team to promote the wearing of PFDs in the UK fishing industry. Additionally, the Fishing Industry Safety Group has enhanced its Home and Dry safety campaign and conducted man overboard awareness training events.

To prevent similar accidents in the future, several recommendations are proposed. Fishing vessel operators must ensure that working decks are designed to minimize hazards, such as entanglement risks, and provide physical barriers to separate crew members from fishing gear. The mandatory use of PFDs and the carriage of accessible PLBs should be strictly enforced, with regular drills to familiarize crew with emergency procedures. Vessel operators should also install remote engine stop mechanisms to allow lone fishers to halt their vessels in emergencies. Finally, comprehensive risk assessments and adherence to safety management guidelines must be emphasized, with greater efforts to disseminate safety information across the fishing industry. These measures would significantly enhance the safety of lone-operated fishing vessels and reduce the likelihood of future tragedies. [OGE]

**LLAMA FEW-SHOT**

On 28 August 2021, at about 0736, the skipper of Harriet J entered the water when he became entangled in the chain weight used at the end of one of the fourth fleet of creels worked that morning. He was likely pulled from the vessel through the shooting door at the aft end of the working deck, striking his head in the process. Once in the water, he was neither able to reboard the vessel nor call for assistance, succumbing to drowning while still in the water. It is likely that a pre-existing heart condition was a contributory factor to his death.

The accident took place approximately 2nm west of Fast Castle Head, south-east Scotland, and resulted in one fatality. There were no damages or environmental impact reported from this incident. The investigation into the accident has highlighted the need for improved engagement and promulgation of information with the fishing industry, as well as updating guidance material on vessel design.

The FISG executive board responded to the tragic loss by establishing a working group focused on the safety of lone-operated fishing vessels. This working group was provided with a copy of the Seafish review to support their discussions. The working group identified several proposals, including suggestions for improved engagement and promulgation of information with industry, updating guidance material, and consideration of vessel design.

In light of this incident, it is essential that the fishing industry prioritizes safety measures, particularly for lone-operated vessels. One key recommendation would be to implement mandatory Personal Locator Beacons (PLBs) on all vessels, [MGE]ensuring that fishermen can quickly call for assistance in case of an emergency. Additionally, guidelines should be updated to emphasize the importance of regular maintenance and inspection of vessel equipment, [MGE]including chain weights and shooting doors. Furthermore, there is a need for improved communication channels between the fishing industry and regulatory bodies, to ensure that safety standards are effectively disseminated to all stakeholders.

Ultimately, this incident serves as a poignant reminder of the risks faced by fishermen operating lone-operated vessels. By learning from these incidents and implementing targeted safety measures, we can reduce the incidence of accidents and minimize the loss of life in the fishing industry.

**QWEN FEW-SHOT**

On October 14, 2021[DTE], an incident occurred involving the fishing vessel "Harriet J," which is flagged in the UK with IMO number AH180. The accident took place while the vessel was operating in waters near the UK coast, specifically engaging in creel fishing activities. The skipper of the vessel, who had not registered with SafetyFolder or a local fishermen's association, was found to be alone on board when an unexpected event led him into the water.

The investigation concluded that the primary cause of the accident was the lack of awareness and preparedness for potential emergencies by the lone operator. [MGE]Although comprehensive industry safety guidelines were available, including MSN 1871 (F) – The Code of Practice for the Safety of Small Fishing Vessels, the skipper had not been fully informed about recent amendments mandating personal floatation devices (PFDs) and the requirement to carry an EPIRB or PLB from October 1, 2019. This led to a critical oversight in safety equipment that could have significantly mitigated the severity of the incident.

The damages included the skipper being in water without appropriate survival gear, which resulted in significant risk to his life. The lack of immediate rescue also compounded the situation, emphasizing the importance of having reliable emergency communication devices on board.

Following the accident, several actions were taken to address the issues highlighted. The Fishing Industry Safety Group (FISG) has made substantial investments in developing its Home and Dry safety campaign, focusing particularly on under 10m vessels. This initiative aims to enhance man overboard awareness through training events. Additionally, FISG is recommended to expedite the delivery of outcomes from its working group focused on lone-operated fishing vessels, taking into account the work commissioned by the Maritime and Coastguard Agency (MCA) and Seafish.

For future shipping, it is crucial that all operators are well-informed about current industry safety guidelines and regulations. Recommendations include encouraging skipper registration with SafetyFolder or local fishermen's associations to ensure access to up-to-date information on safety practices. Moreover, the FISG should continue to invest in comprehensive training programs for lone-operated vessels, promoting the use of advanced communication devices and life-saving equipment such as PFDs and EPIRBs/PLBs. These measures will help prevent similar incidents from occurring and ensure the safety of those operating small fishing vessels alone at sea. [MGE]

**CHAT GPT FEW-SHOT**

At about 0736 on 28 August 2021, the lone skipper of the UK-registered creel fishing vessel Harriet J was fatally dragged overboard while fishing approximately 2 nautical miles west of Fast Castle Head, south-east Scotland. The incident occurred during the deployment of a fleet of creels, when the skipper likely became entangled in a chain weight attached to the fishing gear and was pulled through the vessel's open shooting door into the sea. The vessel, unmanned, continued to move eastward at a speed of 5.4 knots until it was intercepted and boarded by the crew of a nearby vessel, Skua. Despite a coordinated search and rescue operation involving local vessels, lifeboats, and a rescue helicopter, the skipper was found unresponsive in the water and declared deceased after being airlifted to Edinburgh Royal Infirmary. The postmortem report confirmed drowning as the cause of death, with cold water incapacitation and a pre-existing heart condition identified as contributory factors.

The accident occurred due to the skipper's inability to segregate himself safely from the fishing gear on the working deck of Harriet J. The deck layout and stowage of equipment provided no effective barriers against the risk of entanglement with the gear. It is likely that the skipper was attempting to free a snagged creel or chain weight when his boot became trapped in the gear. Although the skipper succeeded in freeing himself from the entanglement, he was unable to reboard the vessel, which continued moving at speed. Furthermore, the skipper was not wearing a personal flotation device (PFD) or carrying a personal locator beacon (PLB)[MGE], which significantly reduced his chances of survival and delayed the search and rescue operation. The lack of a means to remotely stop the vessel's engine exacerbated the situation, as the vessel moved away from the skipper after he fell overboard. [UGE]

In response to the accident, the Maritime and Coastguard Agency (MCA) has undertaken studies to examine strategies to increase the wearing of PFDs within the UK fishing industry [UGE]. The Fishing Industry Safety Group (FISG) has expanded its Home and Dry safety campaign, focusing on vessels under 10 meters and providing man overboard awareness training. The Marine Accident Investigation Branch (MAIB) issued a safety flyer to highlight the lessons learned from this tragic incident.

To prevent similar accidents in the future, the FISG is encouraged to expedite the outcomes of its working group on lone-operated fishing vessels, ensuring that their recommendations address the risks associated with vessel design, deck layout, and fishing gear handling. It is vital for lone fishers to adopt the use of PFDs and PLBs at all times while working on deck. Improved dissemination of updated safety guidance, particularly for lone-operated vessels, is essential to increase industry awareness of best practices. Additionally, fishing vessel operators should prioritize risk assessments and implement physical barriers or modifications to reduce the risk of entanglement with fishing gear. These measures, combined with enhanced safety culture and adherence to regulatory requirements, could significantly improve the safety of lone-operated fishing vessels like Harriet J.[MGE]