

MAIB

MARINE ACCIDENT INVESTIGATION BRANCH

FLYER TO THE FISHING INDUSTRY

KERLOCH:

GROUNDING AND FOUNDERING



Kerloch

The Jersey-registered 15.45m crabber *Kerloch* (J235) was returning to port late on the afternoon of 20 February 2010, when she ran aground on Crow Rock, off the Pembrokeshire coast.

During the week prior to the accident, the vessel had been potting off Lundy Island and landing every 2 to 3 days at Milford Haven. The crew had been working up to 18 hour shifts; the skipper in the wheelhouse operating the winch, while the three deckhands attended to the gear. Each of the crew also took a lone 1.5 hour watch in the wheelhouse, either during overnight breaks at the grounds, or as the vessel steamed to and from port.

The day of the accident saw lovely clear weather, and the crew had been potting since the early hours. At lunchtime, the skipper decided to head in to land and re-store, and elected to take the entire 6 hour navigational watch back to port; he thought the deckhands seemed tired, while he felt fresh.

The voyage was initially uneventful, but as the vessel approached the Welsh coastline, a combination of the warm, unventilated wheelhouse, the low sun and slight sea, contributed to the skipper falling asleep in his chair. A functional watch alarm was reported to be in the wheelhouse, but this could be cancelled from the skipper's chair.

The heavy impact of the grounding immediately woke both the skipper and the crew below in their bunks. They quickly mustered on the shelterdeck top and donned lifejackets, as *Kerloch* began to adopt a significant bow trim. One of the liferafts was manually deployed, which they abandoned into as the vessel rapidly sank. The skipper then contacted the coastguard using a mobile telephone while one of the crew deployed a flare. A nearby fishing vessel immediately proceeded to the scene, recovering the liferaft and crew, who were transferred to a lifeboat and then taken to Milford Haven. The EPIRB activated over 3 days later.

The Lessons

Although this accident resulted in the vessel's loss, it is fortunate that the crew were uninjured. With a different set of circumstances, the outcome could have been far worse. This accident highlights a number of safety lessons:

1. The crabbing industry, like many sectors, has been hard hit by rising costs and lower market prices, which has led to a culture of long working hours and limited rest. Such pressures are real, but owners, managers and skippers still need to consider all possible opportunities for ensuring crew are properly rested and fit to work, whether this is through compensatory rest, or revised manning.
2. It is not difficult to envisage the skipper falling asleep after a hard week's work, while sitting in the comfort of his chair in the warm, stuffy wheelhouse in the late afternoon sunshine. It is important to ensure there are stimuli present to assist watchkeepers in staying alert, and not to remain seated for extended periods.
3. An effective bridge watch alarm is one such way of providing a stimulus. The alarm on *Kerloch* was however clearly ineffective; a good alarm should require the watchkeeper to move from his chair to deactivate it, and when not cancelled on the bridge, should alert other crew members in the vessel.
4. Best practice was evident on board the vessel, with the stowage of the lifejackets in a dedicated container on deck adjacent to the liferafts. This allowed the crew to quickly don their lifejackets in the face of the developing crisis without having to waste valuable time searching for and retrieving them.
5. The abandonment, although successful, could have been improved in a number of areas. The vessel's DSC radio alert was not activated, and neither a hand-held VHF radio nor the EPIRB were removed and taken to the liferaft. The latter would have provided positional data to emergency services. It was fortunate that the mobile phone used to make the 999 call had network coverage and battery power. During the abandonment, the liferaft painter was cut and held onto by one of the crew before they boarded; if this had been inadvertently released, the raft could have drifted away without them. Training and regular drills are both key to ensuring emergency preparedness.
6. The reasons for the failure of the EPIRB to transmit immediately after the sinking are not known, as the unit could not be recovered. Although fitted in a proprietary stowage, apparently clear of obstructions, the fact that the EPIRB appears not to have floated clear of the vessel when she sank emphasises the importance of considering carefully its installation position.

This flyer and the MAIB's investigation report are posted on our website:

www.maib.gov.uk

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