MCIB
Marine Casualty Investigation Board

REPORT INTO

A FATAL ACCIDENT ABOARD

THE "MARK AMAY"ON 20TH

FEBRUARY, 2002.

The Marine Casualty Investigation Board was established on the 23rd, May 2002 under The Merchant Shipping (Investigation of Marine Casualties) Act 2000

CONTENTS

1. SYNOPSIS.

1.1 On the 20th February, 2002 the fishing vessel "Mark Amay" arrived in Galway to discharge her catch. At approximately 0930 hours discharging operations commenced.

1.2 At approximately 1045 hours Mr. Alan Patrick Flaherty fell from the shelter deck into the hatchway and landed in the fish hold incurring fatal injuries.

2. FACTUAL INFORMATION

2.1 DESCRIPTION OF VESSEL

VESSEL NAME:	MARK AMAY
CONSTRUCTION:	2002.
PLACE OF CONSTRUCTION:	DENMARK
REGISTERED LENGTH:	32.75 metres
GROSS TONNAGE	756 Tonnes
CREW:	6 Irish Nationals 4 Russian Nationals 1 Spanish National

2.2 The deceased, Mr. Alan Patrick Flaherty was aged 49 and was an experienced fisherman having crewed aboard the "Mark Amay" since its launch.

3. EVENTS PRIOR TO THE INCIDENT

3.1 The vessel "Mark Amay" had been at sea fishing for approximately six days.

3.2 The vessel arrived in Galway Docks at approximately 0900 hours on the morning of 20th February 2002.

3.3 The vessels crew made ready the vessels crane and discharge of the catch commenced between 0930 and 1000 hours.

3.4 The day was fine. The Skipper reported it was somewhat windy in the bay but calm in the docks.

3.5 Prior to discharge of the catch it is necessary to remove the shelter deck hatch and open the main deck fish room hatch. (See Appendix 8.1)

3.6 The crane used to discharge the catch is located on the portside of the deck. The crane is located approximately 6 metres aft of the access hatch on the shelter deck. (See Appendix 8.2)

3.7 One of the crewmembers, Mr. Sean Arrow, was operating the crane and Mr. Flaherty, who was in place at the shelter deck hatchway, was giving directions.

3.8 In the normal course of events the operation of the crane would be a one-man operation (See Appendix 8.3) but the remote control for the crane that enables the operator to stand at the hatchway was not operational.

4. THE INCIDENT

4.1 At approximately 1045 hours Mr. Flaherty reached out to guide the wire lifting fish boxes out of the fish-hold and slipped and fell.

4.2 The persons present in the fish-hold did not witness Mr. Flaherty fall but heard the 'thud' as he fell into the hold. There were no other witnesses to the fall.

4.3 The emergency services were called and Mr. Flaherty was removed to hospital where he died a short time later.

5. EVENTS FOLLOWING THE INCIDENT

5.1 Mr. Flaherty was an experienced fisherman.

5.2 Mr. Flaherty was not wearing a hard hat at the time of the accident. Mr. Flaherty was not wearing working shoes or boots at the time of the accident. It is believed that Mr. Flaherty was wearing clogs when he fell into the hold.

5.3 The Hatchway on the shelter deck has a small coaming of approximately 0.7 of a metre.

5.4 The hatchway on the shelter deck had a facility with stanchions and ropes that could be rigged to afford personnel protection against falling into the space. This protection was not in place at the time of the accident.

5.5 There were no warning signs to indicate to the crew that protective ropes should be in place.

5.6 The crane used to discharge the catch was in good working order. The remote control option to operate the crane was not operational.

5.7 The day was fine and as the vessel was in a dock basin the vessel would have experienced very little movement alongside the quay.

6. CONCLUSIONS AND FINDINGS

6.1 The accident to Mr. Flaherty could have been prevented if the protective stanchions and ropes were in place.

6.2 The policy of using proper safe working gear on board at the time of the accident was either not in place or not being followed.

N.B. since the incident warning signs are now in place to indicate to the crew that protective stanchions and chains should be in place prior working. The vessel has developed a detailed safety statement indicating areas and degree of risk.

7. RECOMMENDATIONS

7.1 The owners of fishing vessels should introduce written safety procedures on board the vessel in languages that are understood by all crew regarding potentially high risk operations. These procedures should be supplemented with warning signage where appropriate.

7.2 The Safety Statement on any fishing vessel should be an evolving document and risk assessment should be carried out to highlight areas of high, medium and low risk. Precautions and procedures to be followed to negate risk should be contained in the Safety Statement.

7.3 A Marine Notice should be issued warning fishermen regarding the dangers of not adhering to proper procedures when working on deck near open hatchways.

8. APPENDICES

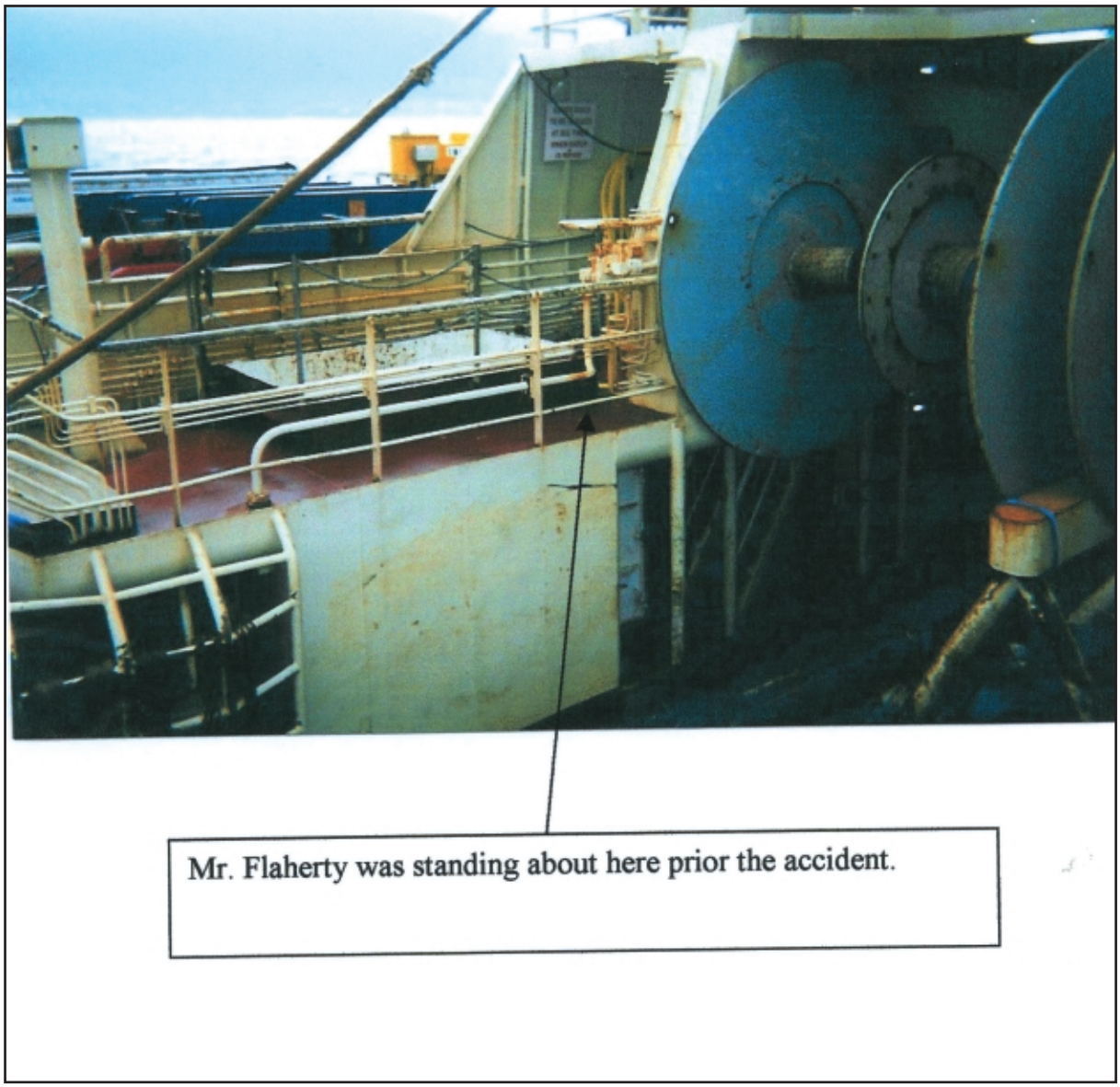
8.1 Photo of shelterdeck hatch and main deck fishroom hatch

8.2 Position of Crane

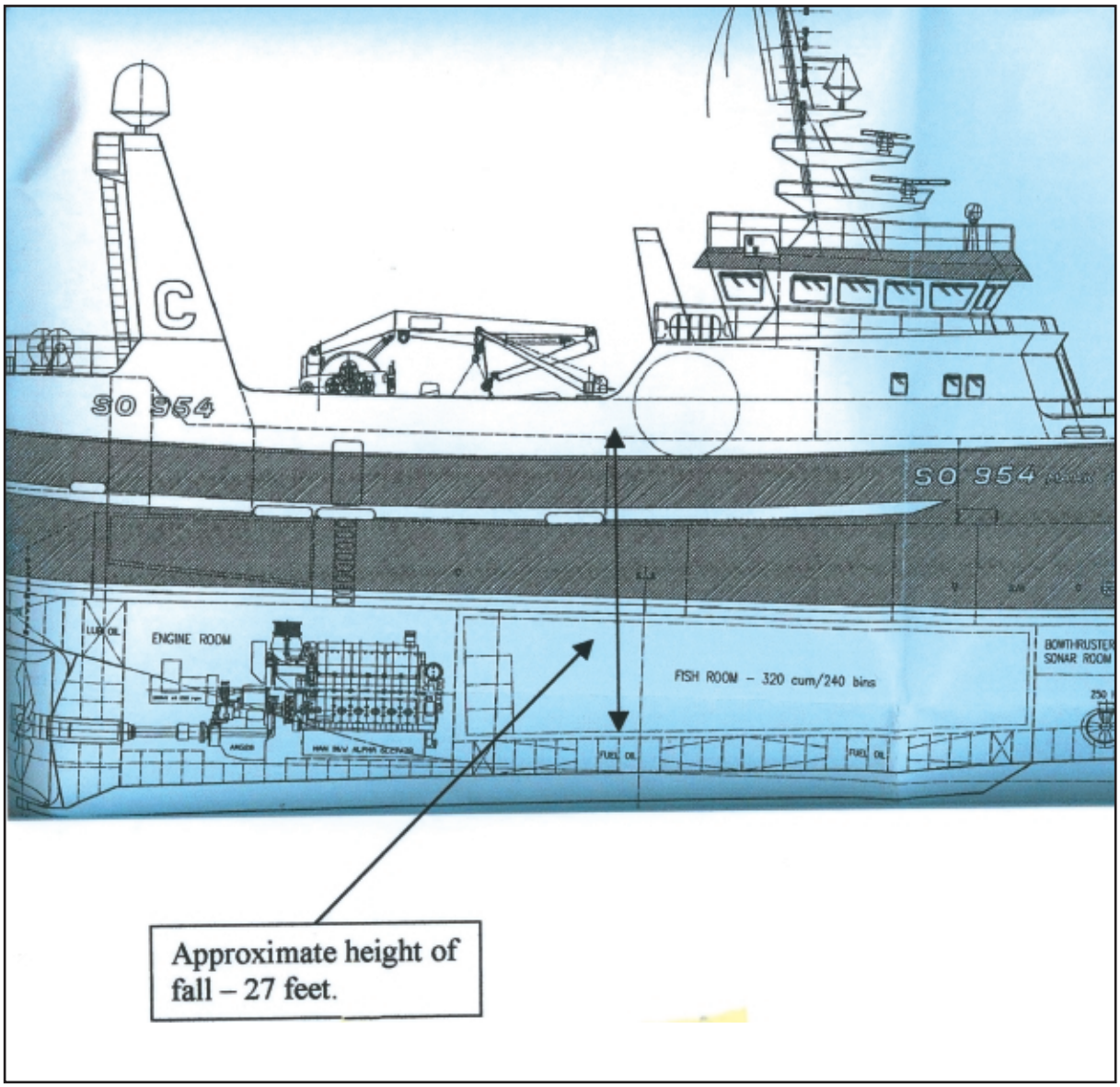
8.3 Photo of one-man operation crane.

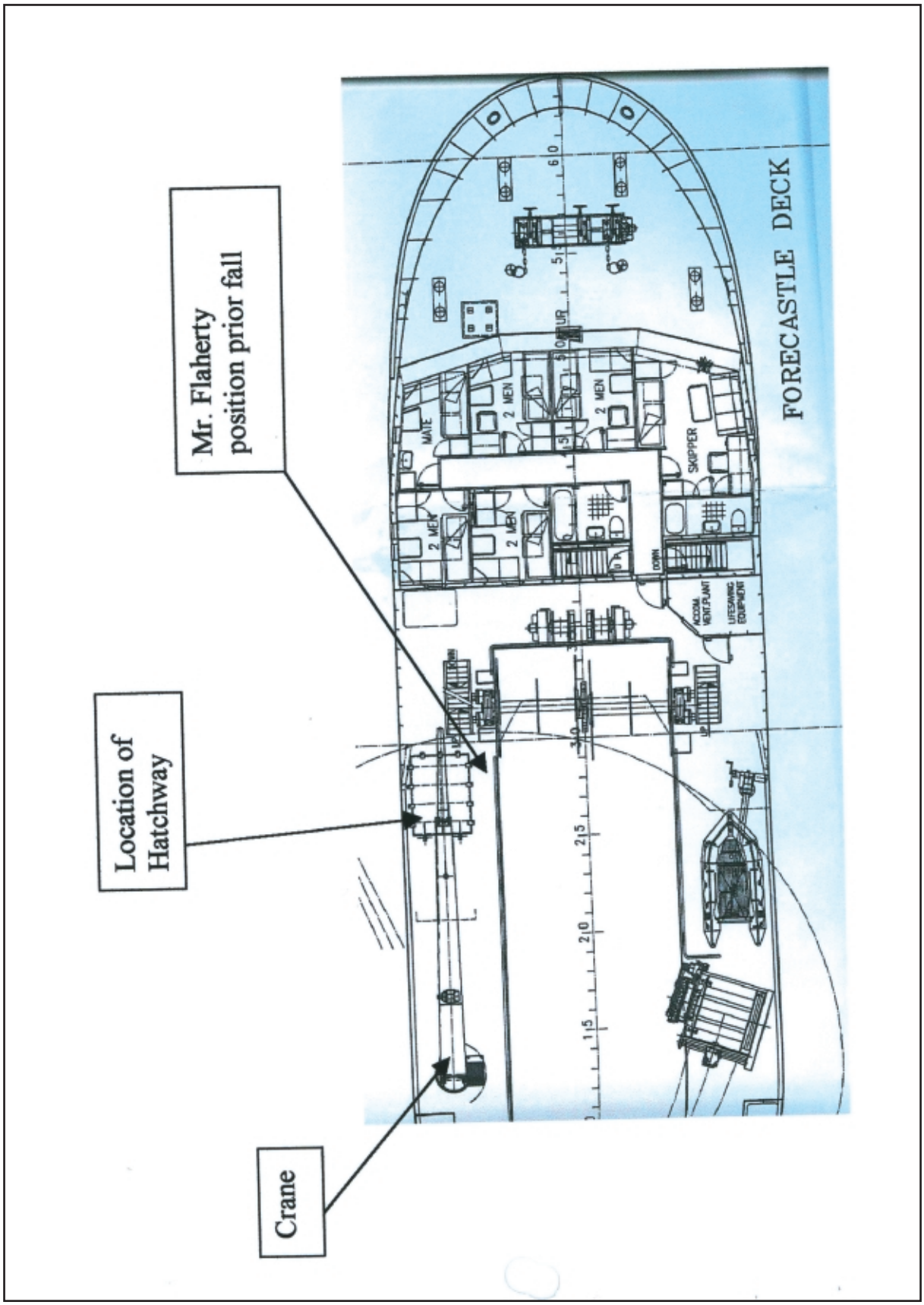
APPENDIX 8.1

8.1 Photo of shelterdeck hatch and main deck fishroom hatch



8.2 Position of Crane




Mr. Flaherty
position prior fall
Location of
Hatchway
Crane
FORECASTLE DECK
MATE
2 MEN
2 MEN
2 MEN
2 MEN
SKIPPER
DOWN
LIFESAVING
EQUIPMENT

8.3 Photo of one-man operation crane.

MFV Mark Amay

Picture shows discharging crane with one-man locally operating the crane (in background) with a clear view of the fish room below.

9. INDEX OF CORRESPONDENCE RECEIVED

Letter from Health Safety Authority on 26th Nov. 2003.

HEALTH AND SAFETY AUTHORITY

ACHIEVING A HEALTHY AND SAFE WORKING LIFE - TOGETHER

10 Hogan Place, Dublin 2, Ireland
Telephone: 01-614 7000 Fax: 01-614 7020 Website: http://www.hsa.ie

John G O Donnell
Chairman, MCIB
29-31 Adelaide Road
Dublin 2

Your Ref: MCIB 32

Our Ref: deptmarine25nov.ltr.fk 26th Nov2003

RE: draft report into a fatal accident aboard the ' Mark Amay ' on the 20th February 2002.

Dear Mr O Donnell

I refer to your letter of the 5th November 2003, concerning a fatal accident and the attached draft report prepared by the MCIB.
The Authority notes that the causes of the accident identified in the report are in broad agreement with the findings of an investigation report prepared by the Authority.
You will be aware that the Authority forwarded this report to your Board in June 2002 which set out the identified alleged breaches of the Safety, Health and Welfare at Work (Fishing Vessels) Regulations, 1999.
However the Authority is concerned at the apparent failure by the Dept of the Marine or its agencies to fully embrace the enforcement role as envisaged under Regulation 9 of the above Regulations.

Yours Sincerely

Michael Henry
Assistant Chief Executive
Health and Safety Authority

EXCELLENCE THROUGH PEOPLE

NATIONAL AUTHORITY FOR OCCUPATIONAL SAFETY AND HEALTH
AN t ÚDARAS NÁISIÚNTA UM SHÁBHÁILTEACHT AGUS SLÁINTE CEIRDE

MCIB Response

THE MCIB RESPONSE TO THE LETTER FROM THE HEALTH AND SAFETY AUTHORITY DATED 26TH NOVEMBER 2003

The MCIB notes the comments received.

In view of the last paragraph of this letter the MCIB has sent a copy of same to the Department of Communications, Marine and Natural Resources.

The MCIB does not have an enforcement role.

The purpose of an MCIB Investigation is set out in Section 25 of The Merchant Shipping (Investigation of Marine Casualties) Act, 2000 to establish the cause or causes of a Marine Casualty with a view to making Recommendations for the avoidance of similar Marine Casualties. It is not the purpose of an Investigation to attribute blame or fault.

Letter from Island Trawlers on 08th Dec. 2003

Island Trawlers Ltd.

The Glebe, Killybegs, Co. Donegal, Ireland.
Phone: + 353 74 9732150 Fax: + 353 74 9731230
Email: islandtrawlers@eircom.net

8th December, 2003.

Attn. Mr. Dick Heron, Secretary.

Marine Casualty Investigation Board,
Leeson Lane,
Dublin 2.

Dear Mr. Heron,

In relation to the Draft report into a fatal accident on board MFV Mark Amay, I wish to advise you that the safety stanchions were on board the vessel at the time of the accident and the crew members had been instructed several times since the MFV Mark Amay came into operation about the importance of using these by the skipper.

Yours faithfully,

Shaun Conneely.
Shaun Conneely.

MCIB Response

THE MCIB RESPONSE TO THE LETTER FROM ISLAND TRAWLERS LTD. DATED 08TH DECEMBER 2003.

The MCIB notes the comments received.

Galway Harbour Company on 10th Nov. 2003

Galway Harbour Company

Tom O'Neill CHIEF EXECUTIVE OFFICER
Capt B T Sheridan HARBOUR MASTER

Harbour Office
New Docks
Galway
Ireland

Tel 00 353 91 561874 / 562329
Fax 00 353 91 563738
E-mail: info@galwayharbour.com

10th November 2003

Mr. John G. O'Donnell,
Chairman,
MCIB
29-31 Adelaide Road,
Dublin 2.

Your Ref: MCIB 32

RE: DRAFT REPORT INTO A FATAL ACCIDENT ONBOARD THE FISHING VESSEL "MARK AMAY" ON THE 20TH FEBRUARY 2002

Dear John,

Thank you for your letter of the 5th inst.

Having read through the draft report in the fatal accident onboard the Mark Amay on the 20th February 2002 I have the following comment:

- It is not noted in the investigation which side alongside the vessel was moored in Galway. Although its omission would have probably no impact on this accident.
- It states that *'the day was fine'* but there is no mention whether the deck was wet or dry which may have been an additional factor in Mr. Flaherty loosing his footing.
- It hasn't been stated that whether Mr. Flaherty reached the grab wire before he fell. He may have lost his balance when trying to handle a greased wire.
- Was Mr. Flaherty wearing gloves? Again the accident may have been prevented if gloves were worn when handling a greasy crane wire.
- Was it ascertained how many hours sleep Mr. Flaherty had in the previous 24 hours before the accident occurred. Was fatigue a factor.
- I attach a photocopy of a fax which was sent to the Marine Survey Office on the 25th February 2002, the content is self explanatory.

Yours sincerely,

Captain Brian Sheridan
Harbour Master & Pilotage Superintendent

MCIB Response

THE MCIB RESPONSE TO THE LETTER FROM GALWAY HARBOUR COMPANY DATED 10TH NOVEMBER 2003

The MCIB notes the comments received and notes the following:

1. As fish was being discharged, the deck would have been wet.
2. It is not known if Mr. Flaherty reached the grab wire before he fell. We cannot speculate on this.
3. It is not known if Mr. Flaherty was wearing gloves.
4. It is not known how many hours sleep Mr. Flaherty had in the previous 24 hours. The Skipper did state that Mr. Flaherty was well rested and that fatigue was not a contributing factor.

NOTES