



SAFETY RECOMMENDATION No: 55/2015

Text of Safety Recommendation:

It is recommended that the need for creation of training programs for the F/V Captains regarding work hazards, accidents prevention and proper use of the fishing equipment, in cooperation with the competent authorities, should be considered.

No of Safety Investigation Report:

08/2015: Death of one fisherman onboard F/V "LIVERIS FOTINI II", Flag Greece, Reg. no Kavala 313 on 13rd April 2015 at Keramoti, Greece

(See the full Report [here.](#))

Safety Recommendation addressed to:

The fishing vessels associations

Date of publication:

22/12/2017

Comments-Remarks:

INFORMATION OF ACCIDENT

Type of vessel: Fishing Vessel

Year of built: 1994

Death of one fisherman onboard F/V "LIVERIS FOTINI II", Flag Greece, Reg. no Kavala 313 on 13rd April 2015 at Keramoti, Greece.

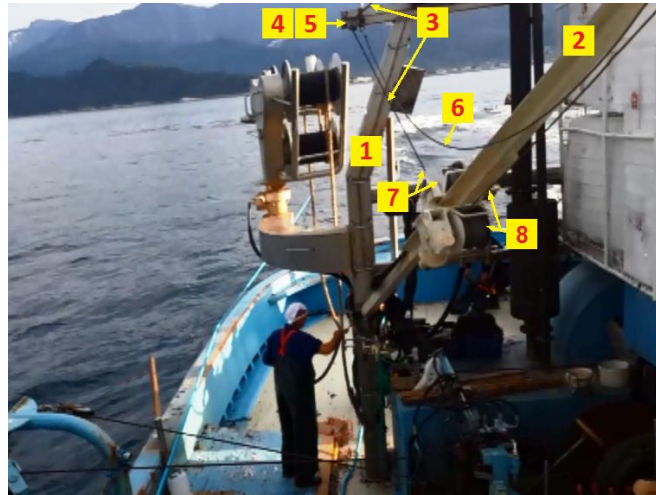
Course of events

On 13rd April 2015, F/V "LIVERIS FOTINI II", Flag Greece, Reg. no Kavala 313 was moored alongside at the port of Keramoti, Kavala, Greece. The vessel had paused temporarily her operation since 01st April 2015. During her stay at port and following an annual maintenance schedule, painting and fishing equipment maintenance works were being carried out.

The F/V carried one (1) Captain of Hellenic nationality and thirteen (13) fishermen of Egyptian nationality. At the day of the casualty the weather conditions were good with no winds and the sea was calm.

The F/V was a purse seiner and carried the required equipment for such operation. On her aft main deck area there was a «Π» shaped frame, with a winch for the fishing net and with a crane boom for the placement of the floating lights ("robots") at sea and for the lifting of the

catch from the net. The boom consisted of a steel beam mounted on a rotating base made of steel. Two winches mounted on the “Π” shaped frame, performed the beam and line movements. The beam was held against the frame via a line attached to a pad eye welded on the horizontal part of the frame. The crane boom was also equipped with a safety line attached to a second pad eye on the horizontal part of the frame, as well. (see Picture no 1).



Picture 1: Photo taken during the vessel's operation a few months prior to the casualty. The following crane parts are indicated:

1. The supporting frame of the crane, 2. The crane boom, 3. The boom holding line which also performed the lifting and lowering of the boom and its corresponding winch (no 7), 4. The line's guiding roller, 5. The line holding pad eye, 6. The boom safety line, 8. The hook line and its corresponding winch.

At approximately 10:00 am and while cleaning, painting and portable equipment adjusting operations were being performed by some of the fishermen, without the Captain's presence, the pad eye holding the boom line (item 5 of Picture 1), detached from the metal frame and the boom's upper end fell on one of the fishermen, aged 41, injuring him deadly on the head. The safety line was not in place as it had been removed by one of the fishermen during the crane's painting a few days prior to the casualty.

An ambulance was called and its crew declared the injured fisherman's death.

Consequences (to individuals, environment , property)

Death of one fisherman, aged 41.

Probable cause

1. The fisherman's fatal injury was caused by the fall of the crane boom due to the fracture of the welding of the pad eye which held the boom lifting line. The welding had defects due to its improper construction. The safety line pad eye welding was also found to be defective.
2. The technician who had performed the crane's construction was not qualified for such work.
3. On the day of the casualty the safety line was not at place, as it had been previously removed by the F/V fishermen, in order the crane to be painted.
4. The vessel's and its equipment's maintenance, with the use of the lifting appliances, were being performed mostly by the fishermen, without the Captain's presence.
5. No handling or maintenance manuals were available for the total of four (4) lifting appliances installed on the F/V. Those appliances were also not certified according to the existing legal framework.
6. The F/V Captain had not been properly trained regarding matters concerning workplace safety hazards onboard fishing vessels.
7. The vessel's fishermen were ignorant regarding basic parameters concerning the handling and maintenance of the crane involved in the casualty. Their failure to place

the safety line back in position and the possible use of the crane beyond its safety working conditions are considered to have contributed to occurrence of the investigated casualty.

Conclusions

1. Actions should be taken by the ship's Operator/Captain to:
 - Inspect the safety line pad eye welding by a competent technician.
 - Comply with the regulations provided by the national legal framework regarding the vessel's lifting appliances.
 - Inform / train the vessel's fishermen regarding:
 - the handling and maintenance procedures for the vessel's equipment,
 - the conduct of works onboard the vessel only under his supervision,
 - the use of personal protective equipment during their work.
2. Actions should be taken by the ship's certifying Organization in order the inspection process for the lifting appliances of F/V of less than 100 GRT to be amended and include load testing periodically after their installation.
3. The competent Authorities of the Hellenic Administration should consider:
 - The need for amending the existing legal framework concerning the lifting appliances in order its requirements to apply also to Fishing Vessels of less than 100 GRT.
 - The need for amending the existing inspection procedure concerning the lifting appliances onboard Fishing Vessels in order proper certification to be provided for them by a competent authority.
4. The fishing Vessels associations should consider the need for cooperating with the competent authorities in order training programs for the F/V Captains regarding work hazards, accidents prevention and proper use of the fishing equipment to be created.