SHERIFFDOM OF GRAMPIAN, HIGHLAND AND ISLANDS AT PORTREE

[2019] FAI 11

Case ref: POR-B43-18

DETERMINATION

BY

SHERIFF EILIDH MACDONALD

UNDER THE INQUIRIES INTO FATAL ACCIDENTS AND SUDDEN DEATHS ETC (SCOTLAND) ACT 2016

into the death of

ALASDAIR FINLAY MACLEOD

Portree, February 2018

Determination

The Sheriff, having considered the information presented at the inquiry, determines in terms of section 26 of the Inquiries into Fatal Accidents and Sudden Deaths etc. (Scotland) Act 2016 (hereinafter referred to as "the 2016 Act"):

1. **In terms of section 26(2)(a) of the 2016 Act (when and where the death occurred)**:

   That the late Alasdair Finlay Macleod, who was born on 18 April 1960 and who resided in Applecross, Strathcarron, was confirmed deceased at about 11.50 hours on 9 December 2017 at Staffin Bay, adjacent to Quiraing Lodge, Staffin, Isle of Skye. Said Alasdair Finlay Macleod's death occurred on 20 November 2017 in an area of sea near to Eilean nan Naomh, a small island to the west of Camusterrach, Applecross.

2. **In terms of section 26(2)(b) of the 2016 Act (when and where any accident resulting in death occurred)**:

   That the accident resulting in said Alasdair Finlay Macleod's death occurred between 14.00 and 14.15 hours on 20 November 2017 on board his fishing vessel 'Varuna' near to said Eilean nan Naomh, whereby he fell overboard into the sea.

3. **In terms of section 26(2)(c) of the 2016 Act (the cause or causes of death):**

   That the cause of death was drowning.

4. **In terms of section 26(2)(d) of the 2016 Act (the cause or causes of any accident resulting in death):**

   That the cause of the accident resulting in death was said Alasdair Finlay Macleod falling overboard from said fishing vessel *Varuna* whilst he was returning to his mooring at Poll Creadha, Applecross from his fishing grounds.

5. **In terms of section 26(2)(e) of the 2016 Act (any precautions which (i) could reasonably have been taken, and (ii) had they been taken, might realistically have resulted in death, or any accident resulting in death, being avoided):**

   That the precautions which could reasonably have been taken that might realistically have resulted in death being avoided, were:

   (a) the wearing of a personal flotation device (PFD) by Mr Macleod, whilst on the deck of the vessel, which would have provided Mr Macleod with buoyancy after entering the water and

   (b) the carrying of a personal locator beacon (PLB) by Mr Macleod, whilst on the deck of the vessel, which may have allowed Mr Macleod to be in a position to raise an alarm and summon emergency assistance after entering the water.

6. **In terms of section 26(2)(f) of the 2016 Act (any defects in any system of working which contributed to the death of the accident resulting in death):**

   None could be identified.

7. **In terms of section 26 (2)(g) of the 2016 Act (any other facts which are relevant to the circumstances of the death):**

   The slot-in door had not been fitted to the 'shooting gate' in the transom of the *Varuna* after the creel shooting was completed, which increased the risk of said Alasdair Finlay Macleod falling overboard through said shooting gate and entering the water.

RECOMMENDATIONS

In terms of section 26(1)(b) of the 2016 Act the court recommends that:

(a) all fishermen should make themselves aware of and follow the terms of ***Marine Guidance Note (MGN) 588 (F)*** which states that "failure to ensure the provision and wearing of PFDs and/or fall restraint harnesses by all fishermen working where there is a risk of falling overboard will be considered by the MCA to be a breach of health and safety legislation " and that "the only exception to this is where the fishing vessel owner can demonstrate, through a documented risk assessment, that the risk of falling overboard has been eliminated by other measures".

(b) all fishermen engaged in single-handed operations should consider the guidance contained within the Maritime and Coastguard Agency ("MCA") publication, '**Fishermen's Safety Guide**' in relation to Single Handed Operations, and carry out a detailed risk assessment of their systems of work, in accordance with that guidance, to enable them to identify possible risks, apply solutions and adopt safer working practices.

NOTE

Introduction

[1] This inquiry was held into the death of Alasdair Finlay Macleod. Mr Macleod died whilst in the course of his employment. The inquiry took place at Portree Sheriff Court on 21 January 2019. Mr Main, Procurator Fiscal Depute, represented the Crown. No other interested parties were represented.

[2] Mr Main on behalf of the Crown submitted a list of three witnesses and a list of productions.

[3] The evidence of one witness, Dr Mark Ashton, pathologist was submitted by way of affidavit. I heard oral evidence from two witnesses as follows:

1. Shonagh Laing, Detective Constable, c/o Police Service of Scotland (Reporting Officer)

2. Robert Cranstone, Inspector of Marine Accidents from the Marine Accident Investigation Branch ("MAIB"), Southampton.

Mr Cranstone had prepared a detailed MAIB accident report (***MAIB report no. 13/2018***) and he referred to that report during his evidence. The report is Crown production number 2.

The Legal Framework

[4] This inquiry was held in terms of section 1 of the 2016 Act. Mr Macleod died in the course of his employment or occupation, and, therefore, the inquiry was a mandatory inquiry held in terms of section 2 of the 2016 Act. The inquiry was governed by the Act of Sederunt (Fatal Accident Inquiry Rules) 2017 and was an inquisitorial process. Mr Main, for the Crown, represented the public interest.

[5] The purpose of the inquiry was, in terms of section 1(3) of the 2016 Act, to establish the circumstances of the death of Mr Macleod, and to consider what steps (if any) might be taken to prevent other deaths in similar circumstances. It was not the purpose of the inquiry to establish civil or criminal liability. The manner in which evidence is presented to an inquiry is not restricted. Information may be presented to an inquiry in any manner and the court is entitled to reach conclusions based on that information. Section 26 of the 2016 Act sets out what must be determined by the inquiry.

Summary

[6] I found the following facts admitted or proved:

1. That Alasdair Finlay Macleod was born on 18 April 1960 and resided in Applecross, Strathcarron.

2. Mr Macleod worked as a self-employed fisherman. He owned and operated the fishing vessel *Varuna*. The *Varuna* was used for creel fishing. On 20 November 2017 he was working on the *Varuna*.

3. At approximately 09.00 hours on 20 November 2017 Mr Macleod left home to prepare the *Varuna*, for a day's fishing. The vessel was routinely moored near Aird-Dubh pier at Poll Creadha, Applecross.

4. On 20th November 2017 Mr Macleod was alone on the *Varuna* when it departed the mooring. Whilst on board the *Varuna*, Mr Macleod was not wearing a personal flotation device and was not carrying a personal locator beacon. A personal flotation device is a lifejacket, buoyancy aid or wearable buoyancy device that provides a person with buoyancy in the water, and which is intended to be constantly worn when on the deck of a boat, in case of falling overboard. A personal locator beacon is a small electronic device which can be

held or carried on a person and which sends out a signal on a particular frequency. This signal is monitored by emergency services including the Coastguard and, if GPS enabled, allows the rescue services to identify the location of the personal locator beacon and consequently the person carrying it.

5. At 10.17 hours on 20th November 2017 the radar echo of the *Varuna* appeared on the BUTEC range control radar, which, shortly afterwards, was temporarily shut down for maintenance. The radar echo at that time showed that the *Varuna* had departed the Mooring. BUTEC is the British Underwater Test and Evaluation Centre, which is a range used to evaluate submarine acoustics, operated on behalf of the Ministry of Defence by Qinetiq.

6. Mr Macleod's normal fishing grounds were 3 to 4 miles north-west of *Varuna*'s mooring. During the morning of 20 November 2017 Mr Macleod worked three strings of creels in that area, over a period of approximately 2 ½ hours.

7. At 13.32 hours, *Varuna*'s radar echo appeared again on the BUTEC Range Control Radar, which had been reactivated. At that time, the *Varuna* was travelling south-easterly, in the general direction of its usual mooring at Poll Creadha. At 13.48 hours the *Varuna* altered its direction approximately 20° to the south. Thereafter it gradually returned to its original track direction. At approximately 14.00 hours the boat's track again altered approximately 20° to the south. Mr Macleod was still on the boat at that time.

8. At approximately 14.15 hours, the *Varuna* was seen by a helicopter pilot, employed by PDG Helicopters Kyle of Lochalsh, who was flying a helicopter over the area of sea west of Applecross, transporting passengers to Applecross Bay. The *Varuna* was seen to be grounded on the rocks at Eilean nan Naomh, a small island to the west of Camusterrach, Applecross. The engine was still running. No person was seen on the vessel. BUTEC Range

control confirmed that they had not received any distress alerts from the vessel. The Range Control operators reported the situation to Coastguard Operations Centre Stornoway.

9. At 14.42 hours Coastguard Operation Centre, Stornoway, tasked the RNLI's inshore lifeboat from the Kyle of Lochalsh and the Coastguard rescue helicopter from Stornoway to assist with a search. Both the Kyle lifeboat and the Stornoway helicopter arrived on the scene by 15.15 hours. At 16.05 hours, the RNLI's Portree all-weather lifeboat also arrived on scene and assumed coordination of the sea search. A search was undertaken in the sea around the area where the vessel had run aground. Concurrently, police kayakers together with a coastguard rescue team carried out coastal searches.

10. Formal searches were suspended after three days. Mr Macleod had not been found at that time.

11. The vessel was boarded after grounding, at Eilean nan Naomh on 20th November 2017. At that time, the throttle control was found to have been set at about two thirds ahead, which would have resulted in a speed of between 4 and 5 knots through the water, prior to the boat coming to rest on the rocks. At the time the vessel ran aground, there were no creels on board but there was one box containing recently caught prawns, a bucket of tailed squat lobsters and some unused bait. The chart plotter on the vessel did not contain any information relating to Mr Macleod's fishing pattern that day, but a handwritten notebook found in the wheelhouse had been used to record the positions of his strings of creels.

12. The *Varuna* was inspected by the Marine Accident Investigation Branch ("MAIB") following the accident. The vessel had been last surveyed by the Maritime and Coastguard Agency ("MCA") on 21 September 2012 when it was checked for compliance with the requirements of the Fishing Vessels (Code of Practice for the Safety of Small Fishing Vessels) Regulations 2001. At that time a small fishing vessel certificate was not issued, pending

Mr Macleod's registration of his VHF radio. Mr Macleod had not completed the annual self-certification declarations required in accordance with those regulations.

13. Inspection of the *Varuna* following the accident found significant amounts of debris and detritus around the working areas on the deck. Some of the remote controls were defective. Items of life-saving equipment were found to be overdue for replacement or service. No personal flotation devices were seen on board but two inherently buoyant 'statutory' lifejackets were found in the wheelhouse. 'Statutory' lifejackets are defined as items required to be carried on the vessel by statute that are designed, tested and maintained to a standard appropriate to the vessel type and area of operation. These were bulky, foam filled lifejackets not designed to be worn while working, but designed to be used as a last resort when abandoning ship.

14. The *Varuna* was configured to operate as a single-handed creel boat with a hydraulic hauler and remote engine and steering controls. It had a cut-out 'shooting gate' in the transom to facilitate shooting the creels. There was a slot-in door secured to the port bulwark, which could be fitted into the shooting gate on completion of shooting. On inspection following the accident, the door was found secured to the port bulwark, and there was no evidence to indicate that it had ever been used to fill the gap in the shooting gate.

15. *Varuna*'s navigational aids included a Simrad CP31 chart plotter, a Simrad AP35 autopilot and a Suzuki color sounder ES-2035 fish finder. The boat was also fitted with a Vespermarine XB8000 AIS transponder which, although switched on, was not functioning during the period leading up to and following the accident.

16. The body of said Alasdair Finlay Macleod was found on 9 December 2017 on the high-tide line at Staffin Bay, adjacent to Quiraing Lodge, Staffin, Isle of Skye, by a member of the public.

17. The Police were called on that day and on arrival at Staffin Bay, Police Constable Lesley Campbell, of the Police Service of Scotland, examined the body and pronounced life extinct. That was at approximately 11.50 hours on 9th December 2017.

18. The body was subsequently identified as being that of Alasdair Finlay Macleod, by a comparative dental examination performed by Dr Kevin Leeming of Castle House Dental Practice, Inverness. A post-mortem examination was carried out on 11 December 2017 by Dr Gavin Laing, Speciality Registrar, who concluded that Alasdair Finlay Macleod died from drowning whilst creel fishing. Mr Macleod died from drowning.

19. Mr Macleod fell overboard shortly before *Varuna* ran aground. On that day the sea was calm, there was good visibility, the air temperature was 5 degrees Celsius, and the sea temperature was 9 degrees Celsius. On entering the sea water at a temperature of 9 degrees Celsius, Mr Macleod would have suffered the extremely debilitating effects of cold water shock. If he had survived the cold shock, he would then have been subject to the rapid onset of cold incapacitation that would have impaired his ability to swim or tread water and keep his head above water. The wearing of a personal flotation device would have assisted Mr Macleod in remaining buoyant in the sea. The carrying of a personal locator beacon would have assisted Mr Macleod's ability to raise the alarm for the attention of the emergency services, whilst in the water.

20. Mr Macleod did not have either a personal flotation device or a personal locator beacon on his person on 20th November 2017 and, therefore, his chances of survival and being rescued after entering the water on that day were significantly reduced.

21. On the 20th November 2017 there was no statutory requirement for Mr Macleod to wear a personal flotation device or carry a personal locator beacon.

22. In November 2018, the MCA published a Marine Guidance Note ***MGN 588(F)*** – ***Compulsory Provision and Wearing of Personal Flotation Devices on Fishing Vessels***. At paragraph 6.1 this Guidance Note states that " …the MCA requires that, unless measures are in place which eliminate the risk of fishermen falling overboard, all fishermen must be provided with and must wear PFDs or safety harnesses. The measures preventing Man Overboard must be documented in a risk assessment." ***MGN588(F)*** makes it clear that a failure to follow the above requirements, will be considered by the MCA to be a breach of current health and safety legislation.

23. The MCA publish a '**Fisherman's Safety Guide'** which is a guide to safe working practices and emergency procedures for fishermen. This includes reference to safety guidance for fishermen whilst working on single handed operations.

Submissions

[7] Mr Main for the Crown lodged written submissions in this case. The conclusions that I have drawn, as set out at the beginning of this determination, are entirely in keeping with what was submitted to me by Mr Main.

DISCUSSION AND CONCLUSIONS

[8] In this inquiry there was no dispute as regards the cause of death. In accordance with the post-mortem examination which was carried out on 11 December 2017 by Dr Gavin Laing, it was confirmed that Alasdair Finlay Macleod died from drowning. I have concluded

that this was as a result of an accidental fall overboard from the vessel *Varuna*. The cause of Mr Macleod falling overboard is unknown.

[9] The bulk of the relevant evidence in this inquiry came from Robert Cranstone, the Marine Accident Investigation Branch officer who prepared a detailed accident report, ***MAIB report no. 13/2018,*** which was produced in evidence as Crown Production number 2. The conclusions of that report were that Alasdair Macleod probably fell overboard shortly before the vessel *Varuna* ran aground. This is because the radar track obtained from the BUTEC (The British Underwater Test and Evaluation Centre) range control which monitored the passage of the *Varuna,* indicated that the vessel changed direction at 13.48 hours and then again at 14.00 hours. This suggests that Mr Macleod was on board the *Varuna* when this happened and manually altered course at these times. His reason for doing so is unknown. The *Varuna* was observed aground and unmanned by the helicopter pilot at 14.15 hours, and it is therefore likely that Mr Macleod fell overboard at some point between 14.00 hours and 14.15 hours, when the vessel was seen on the rocks.

[10] The slot-in transom door on the *Veruna* had not been fitted into the shooting gate following creel shooting and there was no means of fall prevention in use, therefore there was an increased risk of Mr Macleod falling overboard through the shooting gate in the transom. However, it is not possible to tell if that was how the accident happened. There is simply no direct evidence available, from which to reach an appropriate conclusion, without speculation, about how or why Mr Macleod fell overboard.

[11] Mr Macleod was not wearing a personal flotation device (PFD) and was not carrying a personal locator beacon (PLB), so his chances of survival or being rescued after entering the water were significantly reduced.

[12] Evidence at the Inquiry, principally from Mr Cranstone using analysis of the MAIB database of marine accidents, suggests that fishermen do not routinely wear PFDs and do not fully appreciate the dangers from cold water shock when entering the sea water. The chances of survival for fishermen entering the water when wearing a PFD are significantly increased. I have therefore made my recommendations largely on that basis.

[13] I have based my findings in fact mainly on the investigations and conclusions as set out in Mr Cranstone's report, which was comprehensive, unchallenged, and highly persuasive.

Postscript

Mr Macleod will be greatly missed by his family, friends and in the local community of Applecross. I offer my condolences to all those who have been affected by the death of Alasdair Finlay Macleod.