SHERIFFDOM OF GRAMPIAN, HIGHLAND AND ISLANDS AT TAIN

[2021] FAI 11

TAI-B89-20

DETERMINATION

by

SHERIFF GARY AITKEN

UNDER THE INQUIRIES INTO FATAL ACCIDENTS AND SUDDEN DEATHS ETC.

(SCOTLAND) ACT 2016

into the death of

WILLIAM GEORGE SUTHERLAND

Tain, 5 February 2021

Determination

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

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

The late William George Sutherland, born 24 December 1967, died about 17.19 hours on 23 September 2019 at Raigmore Hospital, Inverness.

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

The accident resulting in death took place about 15.50 hours on 23 September 2019 at the

mouth of the Brora river, Brora, Sutherland while Mr Sutherland was engaged in his occupation as a fisherman.

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

The cause of the death of said William George Sutherland was 1(a) drowning.

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

The cause of the accident resulting in the death of said William George Sutherland, was an unusually high wave which struck the stern of the *Anna-Marie II*, causing the vessel to broach and capsize. As a result, Mr Sutherland entered the water.

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)

Had William George Sutherland been wearing a personal flotation device it might realistically have resulted in his death being avoided. There are no precautions which could reasonably have been taken which might, realistically have resulted in the accident being avoided.

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

William George Sutherland was engaged in fishing operations, namely returning to harbour, while not wearing a personal flotation device, and to that extent the system of work was defective.

In terms of section 26(2)(g) (any other facts which are relevant to the circumstances of the death)

There are no other facts relevant to the circumstances of the death of said William George Sutherland.

Recommendations

In terms of sections 26(1)(b) of the 2016 Act (recommendations (if any) as to (a) the taking of reasonable precautions, (b) the making of improvements to any system of working, (c) the introduction of a system of working, (d) the taking of any other steps, which might realistically prevent other deaths in similar circumstances)

There are no recommendations made.

NOTE

Legal Framework

[1] This inquiry was held in terms of section 1 of the 2016 Act and was governed by the Act of Sederunt (Fatal Accident Inquiry Rules) 2017 (hereinafter referred to as "the 2017 Rules"). This was a mandatory inquiry in terms of section 2 of the 2016 Act as Mr Sutherland died as a result of an accident in the course of his employment or occupation.

[2] The purpose of the inquiry is set out in section 3 of the 2016 Act as being to establish the circumstances of the death and to consider what steps, if any, might be taken to prevent other deaths in similar circumstances. It is not intended to establish liability, either criminal or civil. The inquiry is an exercise in fact finding, not fault finding. It is not open to me to engage in speculation. The inquiry is an inquisitorial process. The Crown, in the form of the Procurator Fiscal, represents the public interest.

[3] In terms of section 26 of the 2016 Act the inquiry must determine certain matters, namely where and when the death occurred, when any accident resulting in the death occurred, the cause or causes of the death, the cause or causes of any accident resulting in the death, any precautions which could reasonably have been taken and might realistically have avoided the death or any accident resulting in the death, any defects in any system of working which contributed to the death, and any other factors relevant to the circumstances of the death. It is open to the Sheriff to make recommendations in relation to matters set out in subsection 4 of section 1 of the 2016 Act.

Introduction

[4] This inquiry was held into the death of William George Sutherland. He was the owner and skipper of a fishing vessel, the *Anna-Marie II*. Mr Sutherland sadly died on 23 September 2019 following an incident while out fishing. About 15.50 hours that day the *Anna-Marie II* capsized as it entered the mouth of the river Brora after returning from creel fishing grounds. The skipper, Mr Sutherland, and the crewman both entered the water. The crewman was able to swim ashore, but sadly Mr Sutherland drowned.

[5] A preliminary hearing was held by Webex on 1 December 2020. It was clear that much of the evidence was not in dispute and the Crown were instructed to prepare a Notice to Admit Information in terms of rule 4.12 of the 2017 Rules.

[6] The inquiry proceeded, by Webex, on 26 January 2021. Ms Whyte, Procurator Fiscal Depute, represented the Crown. No other parties were represented. The Crown lodged a substantial Notice to Admit Information. I accepted the facts set out in the Notice to Admit Information.

[7] The Crown also lodged an inventory of productions as follows:

1. Intimation of death
2. Post Mortem Examination Report dated 17 October 2019
3. Toxicology Report dated 11 October 2019
4. Marine Accident Investigation Branch Report Number 12/2020 – Fishing vessel *Anna-Marie II*
5. Marine Guidance Note MGN 588(F) – Compulsory Provision and Wearing of Personal Flotation Devices on Fishing Vessels
6. Maritime and Coastguard Agency – Enforcement of Personal Flotation devices – 9 December 2020
7. Maritime and Coastguard Agency MCA/276/2A – Single Handed fishing

[8] The Crown lodged a list of witnesses as follows:

1. Dr William Tutton, Inspector, Marine Accident Investigation Branch

Much of Dr Tutton's evidence was contained in the Marine Accident Investigation Branch report, lodged as Production 4. However, I heard oral evidence from him to supplement said report.

The facts

[9] William George Sutherland, born 24 December 1967, residing in Brora, was the owner and skipper of a fishing vessel *Anna-Marie II*, registration number WK875.

[10] About 15.30 hours on Monday 23 September 2019, William George Sutherland and his son Liam John Alexander Sutherland, sailed from Brora harbour in the *Anna-Marie II*. They intended to lift, empty, re-bait and re-shoot one string of creels and lift, empty and bring ashore two other strings.

[11] About 15.40 hours having re-shot one string of creels and recovered another string of nine creels, William and Liam Sutherland noticed that the swell was causing waves to break over the marker buoys of the third string of creels and decided not to recover that string and instead return to Brora harbour. They thought the weather seemed okay but the waves were concerning. William George Sutherland spoke with Brian Sutherland, the skipper of fishing vessel *Sunny* over the radio and discussed the swell at the mouth of the Brora river.

[12] William George Sutherland steered the *Anna-Marie II* westward towards the Brora river entrance and waited for three sets of waves to pass before starting his run into the river. Once committed to entering the river, an unexpected large wave caught the *Anna-Marie II* from astern, causing the vessel to broach, turning it to starboard and heeling it to port, beam on to the waves. A second wave struck the vessel, rolling it further to port causing it to capsize and invert, trapping Liam John Alexander Sutherland under the hull. When he surfaced 10 to 15 seconds later he could not see his father, William George Sutherland. Liam John Alexander Sutherland was able to swim towards the side of the river mouth where he was helped out of the water. He watched whilst Brian Sutherland pulled William George Sutherland out of the water.

[13] At about 15.50 hours Brian Sutherland was told of the capsize and tried to contact William George Sutherland without success. He called "Mayday" at 15.53 hours, then took the *Sunny* from the harbour into the river to assist. As the *Sunny* moved towards the river entrance, Brian Sutherland saw William George Sutherland floating face-up in the water. He was not wearing a personal flotation device. Brian Sutherland received no response to his shouts but managed to manoeuvre the *Sunny's* stern towards William George Sutherland, pulling him on board using the *Sunny's* shooting ramp. Once aboard he

performed CPR on William George Sutherland whilst making his way back to the harbour and continued CPR until the arrival of the ambulance.

[14] At 16.08 hours David Alexander Scott, Paramedic with the Scottish Ambulance Service, arrived on the scene, examined William George Sutherland, secured and suctioned his airway, gained intraosseous access, administered adrenaline and continued advanced life support until the arrival of the Coastguard helicopter.

[15] At 16.35 hours a Coastguard rescue helicopter arrived. William George Sutherland was winched on board and flown to Raigmore Hospital, Inverness where advanced life support was continued by Michael Rennie, Consultant in Emergency Medicine until life was pronounced extinct at 17.19 hours.

[16] On 25 September 2019, Dr Mark Ashton, Consultant Pathologist, Raigmore Hospital, Inverness performed a post mortem examination and dissection on the body of William George Sutherland. The findings and conclusion of the post mortem examination are detailed in Dr Ashton's report (Crown Production 2). During said examination Mr Sutherland was found to have bruising to his scalp in keeping with a blow to the head. As a result of his examinations Dr Ashton certified the cause of Mr Sutherland's death as drowning.

[17] Toxicological analysis of samples taken during said post mortem examination are detailed in the Toxicology Report (Crown Production 3). That analysis did not reveal anything of significance.

[18] The Marine Accident and Investigation Branch (hereafter referred to as 'the MAIB') is the body in the United Kingdom charged with the investigation of marine accidents. The

statutory remit of the MAIB is to investigate marine accidents with a view to making safety recommendations and seeking to prevent a recurrence of a similar accident in the future.

[19] The MAIB carried out an investigation into this incident and produced a report (Crown Production 4) but made no further recommendations. Said report is available to the public free of charge on the MAIB website.

[20] The policy of the Maritime & Coastguard Agency (hereafter referred to as 'the MCA') on the wearing of personal flotation devices by fishermen and the reasoning behind it is set out in Marine Guidance Note 588(F) (Crown Production 5). The number of man overboard accidents from fishing vessels investigated by the MAIB in recent years clearly demonstrates a significant risk to fishermen. Incidents have occurred because fishermen have fallen, been washed or been dragged overboard after getting tangled in gear. Once in the water, cold shock and hypothermia will quickly make it harder for a person to stay afloat and alert. The risk of drowning is significantly higher if no personal flotation device is worn. The MCA will enforce the use of safety harnesses and/or personal flotation devices as a mandatory requirement where there is a risk of falling overboard. 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 personal floatation devices or safety harnesses. The measures preventing 'Man Overboard' must be documented in a written risk assessment.

[21] The MCA utilise maritime and coastal reconnaissance aircraft services to check fishermen's compliance with the requirement to wear a personal floatation device. This process and enforcement action is set out in a document lodged as Crown Production 6. At the end of each flight a report is produced, including photographic evidence, which is sent

to the MCA Marine Office closest to the area overflown. A Surveyor of Ships will review the report. If satisfied that no personal floatation devices are being worn by crew on deck a letter will be sent to the owner of the vessel, asking for an explanation, a copy of the personal flotation device risk assessment and certain crew details. If the information provided is not satisfactory a warning letter will be sent. A second transgression will result in a Prohibition Notice being issued. Any third transgression will be investigated with a view to consideration of criminal proceedings.

[22] A personal flotation device (hereafter referred to as a 'PFD') is a device which ensures that if the wearer falls into water they are turned over onto their back, with their head up to keep their head out of the water and improve the chances of their survival.

The evidence

[23] Ms Whyte read out the terms of the Notice to Admit Information. Paragraphs [9] to [21] above are derived from the Notice to Admit Information and the Productions.

[24] Dr William Tutton gave evidence that he is employed as a Specialist Human Factors Inspector with the MAIB. He joined the MAIB in 2019. He holds an MSc in Human Factors and a Doctorate in Design Efficiency and Human Factors. He is a Chartered Human Factors Practitioner with the Institute of Ergonomics and Human Factors and is a Fellow of that organisation. He is close to completing accreditation as an accident investigator by completing a post graduate course in Accident Investigation at Cranfield University. Dr Tutton explained that Human Factors is the study of human work. The field developed after the Second World War and looks at equipment, etc., to ensure the safety and well-being of workers.

[25] Dr Tutton advised that MAIB carried out an investigation into the circumstances of Mr Sutherland's death as MAIB has a duty to investigate all serious marine casualties, which clearly includes fatalities. Dr Tutton explained that he was the lead inspector in this investigation and was assisted by two other inspectors, both of whom were master mariners. The three inspectors gathered evidence and information which Dr Tutton collated and thereafter produced a report, lodged as Production 4, which he was referred to.

[26] Dr Tutton stated that their investigations had a look at possible causes for the capsize of the *Anna-Marie II* but determined that the only explanation was the weather conditions. A wave catching the stern of the vessel was the primary cause of the vessel capsizing. A wave hit the stern and turned the vessel side on. The force of the wave turned the vessel causing it to capsize.

[27] Dr Tutton explained that due to the strike from the wave Mr Sutherland had lost steerage and that it was very easy to lose control of a vessel in these circumstances. The investigation had not revealed any malfunction of the engine or anything else of that nature. He explained that as the wave rises it causes a loss of control of the vessel. Dr Tutton agreed that this could feel a little like a car being hit by a gust of wind, or perhaps more like trying to steer a car on ice. In his view there was very little Mr Sutherland could have done to control the vessel once the wave hit. He stated that Mr Sutherland was a very experienced fisherman.

[28] Dr Tutton noted that during the capsize Mr Sutherland was hit on the head. Had he been wearing a PFD it would have kept his airway clear and allowed him to breathe once on the surface of the water. Dr Tutton was referred to page 5 of the MAIB report (Production 4) and noted that Mr Sutherland had previously worn a PFD when fishing alone but had

stopped doing so due to concerns it would hamper his ability to cut himself free if he fell overboard and became tangled in fishing gear. Dr Tutton stated that Mr Sutherland had not been working alone on the date of his death and was not actively fishing but instead returning to harbour when the accident occurred.

[29] Dr Tutton commented that it is a commonly held belief in the creel fishing community that if wearing a PFD they would not be able to free themselves if trapped by fishing gear but there is very little data on that situation. He confirmed that even before it became a mandatory requirement, the advice from MAIB was that wearing a PFD was the best course of action.

[30] Dr Tutton accepted that fishermen report a number of concerns about wearing PFDs in relation to functional limitations. However, he explained that there are a number of different solutions. Wearing a PFD is mandatory, but there are different types of PFD available. He stated that manufacturers have gone to great lengths to make PFDs more usable. The European Union provided a grant which funded the provision of eight thousand PFDs of a design which addressed these issues. The term PFD covers a range of different applications including life jackets, collars which are inflated by air and foam filled collars. An important feature is a waist belt and crotch strap which ensure the PFD remains in the correct position. A PFD is designed to keep the wearer on their back in the water with their head up and their airway clear. Buoyancy aids are similar devices, usually in the style of foam waistcoats. However these are of lower value and have less buoyancy than a PFD. Nor do they prevent the wearer floating on their face. There are pros and cons to each and the decision to use a particular type of PFD or buoyancy aid should be made after a risk

assessment of the use to which the device is to be put. This will determine which type is most appropriate.

[31] Dr Tutton was referred to page 8 of the MAIB report (Production 4) and the circumstances of the capsize. Dr Tutton stated that assessing the stability of small vessels was a difficult area. The *Anna-Marie II* was an open vessel, meaning that if the vessel turned side on water could come over the side into the hull. Dr Tutton advised that the effort involved in assessing the stability of all small vessels may not provide much useful data. He accepted that the *Anna-Marie II* was a fairly typical small creel boat. He commented that it was clear that Mr Sutherland took a lot of pride in the vessel and it was very well maintained. Mr Sutherland had also fitted a more powerful engine and additional storage at the rear of the vessel. It was clear to Dr Tutton that Mr Sutherland was alive to the particular issues of crossing the bar and entering Brora harbour.

[32] Dr Tutton went on to comment that it was clear that Mr Sutherland was highly respected in the local community. He was a third generation fisherman. He lived very close to the harbour. Returning to Brora harbour was a very common operation for him to undertake. Waves striking the rear of a vessel on entry to Brora harbour are a recognised concern there and Mr Sutherland had clearly taken precautions by fitting a more powerful engine and altering the storage on the *Anna-Marie II*. Dr Tutton stated that Mr Sutherland understood that there was a risk of waves capsizing the vessel but the MAIB investigations suggest that the consequent risk of a person on the vessel entering the water may not have been fully appreciated.

[33] Dr Tutton commented that the rescue attempts by Brian Sutherland, the skipper of the *Sunny*, were very heroic. It was fortunate that the *Sunny* had been adapted to assist in

recovering persons on board from the water. Dr Tutton understood that Brian Sutherland had struggled to get Mr Sutherland on board but had been able to do so, despite injuring himself in the process. Dr Tutton commented that this incident demonstrated the importance of emergency planning for man overboard events and the means of recovering someone from the water. He commented that the Royal National Lifeboats Institution (hereafter referred to as the 'RNLI') are doing a lot of good work in promoting planning for the recovery of persons from the water and regular practise of man overboard drills.

[34] Dr Tutton stated that there are many publications about the benefits of the use of PFDs and a lot of dissemination of that information in the fishing industry.

[35] Dr Tutton was referred to the conclusions on page 10 of the MAIB report (Production 4). He commented that Mr Sutherland was an expert doing his job in the way he was used to doing it. Hindsight is not always helpful in looking back at situations. There were risks in not wearing a PFD and risks in entering the harbour. Not many harbours in the United Kingdom have a bar at the entrance but Brora does. That can make entry to the harbour tricky. Mr Sutherland was well aware of that and knew the harbour conditions well. Fishermen have to evaluate the risks they face on a day to day basis and adopt the appropriate countermeasures.

[36] Dr Tutton confirmed that no recommendations had been made in the MAIB report but a safety flyer had been issued. In his view various bodies involved in the fishing industry are well aware of the issues involved in the use, or lack of use, of PFDs. He accepted that there are some deeply held views in fishing communities against the wearing of PFDs and that such cultural issues can only be altered over time. He stated that the RNLI do an excellent job of making information available in an accessible way using social media

and public events. The Maritime and Coastguard Agency are carrying out more enforcement activity now that the wearing of PFDs is mandatory. He stated that the MAIB will continue to play its part in reinforcing the message that PFDs must be worn and can save lives. The safety flyers issued by the MAIB are a simple, condensed version of a full MAIB report, designed to get important safety information across.

[37] Dr Tutton concluded by hoping that the enforcement steps being taken by the Maritime and Coastguard Agency will hopefully help increase the wearing of PFDs by fishermen but there really has to be a cultural change. That may take time. People are naturally resistant to change. Dr Tutton used the wearing of seatbelts in cars as an example of a safety practice now very widely used with little thought but which had been resisted when first made compulsory.

Crown Submissions

[38] Ms Whyte helpfully produced written submissions, which I quote in full hereunder:-

> **"<u>Subsection (2)(a) – When and where the death occurred</u>**
> To find that William George Sutherland, who was born on 24 December 1967 and resided at Brora, died at 1719 hours on 23 September 2019. His place of death was Raigmore Hospital, Inverness.
>
> **<u>Subsection (2)(b) – When and where any accident resulting in the death occurred</u>**
> The accident resulting in the death of William George Sutherland occurred around 1550 hours on 23 September 2019 whilst crossing the bar at the entrance to the Brora river.
>
> **<u>Subsection (2)(c) – The cause or causes of the death</u>**
> A post-mortem examination carried out on 25 September 2019 established the cause of the said William George Sutherland's death as drowning. During said examination Mr Sutherland was found to have bruising to his scalp in keeping with a blow to the head.
>
> **<u>Subsection (2)(d) – The cause or causes of any accident resulting in the death</u>**
> The cause of the accident resulting in the death was the unusually high waves (developed quickly to a height of 3 to 3.5 m) created by an easterly swell which were

not evident in any weather forecast. The size and steepness of the waves encountered caused the Anna Marie II to broach, resulting in loss of steerage while attempting to cross the bar at the entrance to the Brora river resulting in a capsize with those aboard entering the water.

The MAIB investigation found that it is likely that William George Sutherland was conscious when he cleared the upturned hull but drowned as his ability to swim was affected by the blow to his head sustained during the capsize.

The Analysis section of the MAIB report which begins at page 8 of 12 provides a helpful analysis of why Anna Marie II broached and capsized, contributing factors, the decision to go to sea, attempt to enter the Brora river and preparation to survive a capsize.

Subsection (2)(e) – Any precautions which — (i) could reasonably have been taken, and (ii) had they been taken, might realistically have resulted in the death, or any accident resulting in the death, being avoided

Had the late Mr Sutherland been wearing a Personal Flotation Device (PFD) at the time he entered water, this may have kept his head above water and might have increased his chance of survival, especially given the immediate response from Sunny's skipper which resulted in a swift and remarkable rescue. The inquiry heard the reasons why Mr Sutherland had ceased to wear a PFD and heard the opinion evidence of the Dr Tutton in that regard.

Although issued after Mr Sutherland's death and acknowledged that Mr Sutherland was not a single handed fisherman, the MCA "single handed fishing leaflet" reference MCA/276/2A issued in January 2020 provides safety advice to fisherman and states "Always wear your PFD and make sure it has enough buoyancy to turn you on your back, keeping your mouth clear of the water, even if you become unconscious. Wearing a PFD will dramatically increase your survival time; Fisherman Reegan Green survived for one hour because he was wearing a PFD and was rescued safely. Without a PFD, cold water shock can kill in less than 5 minutes" It goes on to recommend a suitable type and regular checks of the PFD.

The Inquiry heard evidence from the MAIB inspector that Maritime and Coastguard Agency (hereinafter "MCA") regulations and an accompanying Marine Guidance Notes MGN 588(F) came into force in December 2018, making the wearing of PFDs or safety harnesses compulsory unless sufficient measures are in place to eliminate the risk of fishermen falling overboard.

Mr Sutherland was an experienced fisherman, he had been a fisherman for over 35 years, completed all the mandatory fishing vessel safety courses and had lived close to the mouth of the Brora river all his life. He was well respected by other local fisherman for his experience and knowledge of the local area.

The wearing of a PFD is a reasonable precaution which could have been taken which might have prevented Mr Sutherland's death.

Subsection (2)(f) –Any defects in any system of working which contributed to the death or any accident resulting in the death
No obvious systemic failings or defects have been identified in this case.

Mr Sutherland drowned because Anna Marie II capsized in bad weather.

Subsection (2)(g) – Any other facts which are relevant to the circumstances of the death
Many materials have been published by the MCA and also the MAIB and others for the benefit of fishermen that specifically relate to their safety. The MCA publications are detailed and they cross reference multiple pieces of legislation and other publications. These publications have been distributed to fishermen via various platforms including different fishermen federations and organisations.

Fishing vessels such as "Anna Marie II", are surveyed once every five years and safety awareness is highlighted to fishermen during the survey. The last inspection by the MCA surveyor had taken place on 13 November 2017, three deficiencies were identified which is detailed in page 5 of the MAIB report. Once rectified the MCA issued a UK Fishing Vessel Certificate valid until 26 November 2022. No PFDs were found on board Anna Marie II but these were most likely lost during the capsize.

Looking back over 6 Fatal Accident Inquiries which were conducted between 1 April 2017 and 31 March 2020, it is worthy of note that a recommendation regarding the wearing of PFDs was made in 5 of them.

The MCA have provided evidence in writing to the Court of the reconnaissance flights and enforcement action that they are taking to educate, promote and enforce the wearing of PFDs.

Subsection (1)(b) – Such recommendations (if any) as to any matters mentioned in subsection (4) as the sheriff considers appropriate
Since Mr Sutherland's death, further information has been disseminated and enforcement action is being taken by the MCA, it is too soon to tell whether these additional materials and action will reduce the high numbers of fishermen losing their life in the course of their employment when a contributory factor is not wearing a PFD.

It is hoped that the MCA, enforcement action now being carried out, will, over time, encourage and promote the wearing of PFDs."

Discussion and Conclusions

[39] I had no difficulty in accepting the information contained in the Notice to Admit

Information or in accepting the evidence of Dr Tutton. He gave his evidence in a clear and helpful manner. His evidence was of considerable assistance to me. The MAIB report, Production 4, is a clear and detailed account of the investigation into this incident. The report has been extremely useful in the course of this inquiry. It is publicly available on the MAIB website for anyone interested in this incident to refer to.

[40] There is clearly no dispute that Mr Sutherland sadly drowned after being thrown into the water from the *Anna-Marie II*, after the vessel was hit by an unusually high wave and capsized at the mouth of the river Brora about 15.50 hours on 23 September 2019. His life was formally pronounced extinct at Raigmore Hospital, Inverness at 17.19 hours that day. This is established by the information obtained in the course of the MAIB investigation and the conclusions of the autopsy carried out by Dr Ashton. I accept the Crown's submissions in relation to Section 26(2)(a), (b) and (c).

[41] It is equally clear that Mr Sutherland was thrown overboard from the *Anna-Marie II* due to extreme weather and sea conditions. In her submissions for the Crown in relation to Section 26(2)(d) Ms Whyte properly draws attention to the extreme sea conditions leading to the capsize of the *Anna-Marie II*. I accept the Crown's submissions in relation to Section 26(2)(d).

[42] So far as Section 26(2)(e) is concerned I concur with the submissions of Ms Whyte that the wearing of a PFD is a reasonable precaution which might have avoided the death of Mr Sutherland, for the reasons put forward by her. The accident which resulted in his death was caused by unusual weather and sea conditions. Mr Sutherland was an experienced fisherman who knew the local sea conditions well. He assessed the risk of returning to harbour and did so. With hindsight it might be considered that his decision was wrong but

I do not consider that there is any evidence to show that he should have known that at the time. There are no reasonable precautions that can avoid a freak wave and I am not in a position to make any findings in relation to precautions which might have avoided the accident, namely the capsize of the vessel.

[43] I am satisfied that Mr Sutherland's failure to wear a PFD while engaged in returning to harbour was part of his system of work for fishing and that accordingly there was a defect in that system of work. The point is essentially the same as that made under Section 26(2)(e).

[44] The matters raised by Ms Whyte in relation to Section 26(2)(g) are certainly relevant to the purposes of this inquiry in learning lessons for the future but I am not satisfied that they are sufficiently relevant to the circumstances of Mr Sutherland's death as to require to be included under this heading.

[45] I do not consider it necessary to make any further recommendations in this inquiry. The main point to be made, as has been made in several Determinations in the past, is the importance of wearing PFDs.

[46] I am obliged to Ms Whyte for her careful presentation of the evidence in this inquiry and to Dr Tutton for the assistance which his involvement gave to the inquiry.

[47] In closing this Determination, may I once again express my condolences to the family and friends of Mr Sutherland. He was clearly a highly respected member of the local fishing community and an experienced fisherman. I have no doubt that his loss is still keenly felt. This tragic incident must have been especially traumatic for his son, Liam, who was working with his father at the time of the capsize. I consider that it is also proper to recognise the efforts made by Brian Sutherland to come to the aid of William George Sutherland, at

considerable risk to himself. It is a matter of great regret that his efforts were not rewarded by a happier outcome.