SHERIFFDOM OF LOTHIAN AND BORDERS AT EDINBURGH

[2024] FAI 6

EDI B1081-23

DETERMINATION

BY

SHERIFF K J CAMPBELL KC

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

into the death of

JOHN WILSON

Edinburgh, 12 February 2024

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

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

The late John Wilson was pronounced dead at 09:55 on 28 August 2021, at the Accident and Emergency Department at the Royal Infirmary of Edinburgh, Edinburgh.

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

The death of John Wilson occurred due to an accident on board MFV *Harriet J*, at sea while heading on a westerly course along the coast of Berwickshire at a point

approximately 0.5 nautical miles off Meikle Poo Craig. The accident occurred at or shortly after 07:36 on 28 August 2021.

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

Mr Wilson's death was caused by:

1. Drowning.

2. Ischaemic heart disease.

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

Whilst working on the deck of *Harriet J*, Mr Wilson's foot became entangled in the chain weight attached to a fleet of creels on the deck which he was in the course of launching. Mr Wilson was pulled from the vessel, through the shooting door at the aft end of the working deck, striking his head on part of the rear structure of the vessel. He thereafter entered the water, and was unable to exit the water. He was in the water for approximately 1 hour, 20 minutes before being found.

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).

No such precautions have been identified.

6. 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).

No such defect has been 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).

There are no other facts relevant to the circumstances of the death of Mr Wilson.

8. Recommendations in terms of section 26(1)(b).

8.1 A Personal Locator Beacon should form part of the standard safety equipment on single person-operated small fishing vessels, and further that the Personal Locator Beacon should be carried on the person of the crew member whilst at sea.

8.2 Crew members of single person operated fishing vessels should wear Personal Floatation Devices at all times whilst the vessel is at sea.

NOTE

Introduction

[1] This Inquiry was held into the death of John Wilson. Mr Wilson was a fisherman, who lived in St Abbs, Berwickshire. A preliminary hearing took place by WebEx Video Conference on 3 November 2023. The Inquiry took place on 15 December 2023 by a WebEx Video Conference, and was continued for the Crown to seek further instructions on a matter which arose in the course of the hearing. The continued hearing took place on 19 January 2024 by WebEx Video Conference, and having heard submissions, I closed the Inquiry.

[2] At the Inquiry, the Crown appeared in the public interest, represented by Mr Kerr, Procurator Fiscal Depute. Mr Wilson's next of kin had been kept advised of the

Crown's Inquiries and had indicated prior to the preliminary hearing that they did not wish to be present or legally represented at the Inquiry. The Health and Safety Executive indicated on 16 October 2023, that they did not wish to participate in the Inquiry as an interested party.

[3] The Crown tendered a detailed Notice to Admit Information prior to the Inquiry. The Crown also lodged the following productions:

1. Final Post-Mortem Report prepared by Dr Kerryanne Shearer, dated 6 December 2021;
2. Toxicology Report by Dr Peter Maskell, dated 7 October 2021;
3. Marine Accident Investigation Branch Accident Report No. 2/2003, dated June 2003;
4. Marine Accident Investigation Branch Flyer, dated June 2023;
5. HM Coastguard Incident Log 030406, dated 28 August 2021;
6. Book of Photographs;
7. Redacted Medical Records from Eyemouth Medical Practice;
8. Redacted Medical Records from Borders General Hospital;
9. Redacted Medical Records from Eyemouth Medical Practice;
10. Redacted Statement of Chris Hopkins (HM Coastguard), dated 7 September 2023;
11. Statement of Aaron Middlemiss, dated 28 August 2021;
12. Statement of Jim Wilson, dated 28 August 2021;
13. Statement of David Wilson, dated 28 August 2021;

14. Statement of Edward Dougal, dated 28 August 2021;

15. Statement of Susan Barry, dated 28 August 2021.

The legal framework

[4] This Inquiry was held in terms of section 1 of the 2016 Act. Mr Wilson died in the course of his work as a fisherman, and therefore the Inquiry was a mandatory Inquiry held in terms of sections 2(1) and 2(3) of the 2016 Act. The Inquiry was governed by the Act of Sederunt (Fatal Accident Inquiry Rules) 2017 ("the 2017 Rules"), and was an inquisitorial process. The Crown appeared representing 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 Wilson, 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 (see section 1(4) of the 2016 Act). In terms of Rule 4.1 of the 2017 Rules, the manner in which evidence was presented to an Inquiry of this kind is not restricted, and the court is entitled to reach conclusions based on the information presented to it. I am satisfied that the procedure adopted in this case was an appropriate way to present the available evidence in the circumstances.

[6] Section 26 of the 2016 Act sets out what must be determined by the Inquiry, and for that reason it is convenient to set the terms of section 26.

> **26 The sheriff's determination**
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> (1) As soon as possible after the conclusion of the evidence and submissions in an inquiry, the sheriff must make a determination setting out—

(a) in relation to the death to which the inquiry relates, the sheriff's findings as to the circumstances mentioned in subsection (2), and
(b) such recommendations (if any) as to any of the matters mentioned in subsection (4) as the sheriff considers appropriate.

(2) The circumstances referred to in subsection (1)(a) are—
(a) when and where the death occurred,
(b) when and where any accident resulting in the death occurred,
(c) the cause or causes of the death,
(d) the cause or causes of any accident resulting in the death,
(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,

(f) any defects in any system of working which contributed to the death or any accident resulting in the death,
(g) any other facts which are relevant to the circumstances of the death.

(3) For the purposes of subsection (2)(e) and (f), it does not matter whether it was foreseeable before the death or accident that the death or accident might occur—
(a) if the precautions were not taken, or
(b) as the case may be, as a result of the defects.

(4) The matters referred to in subsection (1)(b) are—

(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.

(5) A recommendation under subsection (1)(b) may (but need not) be addressed to—

(a) a participant in the inquiry,
(b) a body or office-holder appearing to the sheriff to have an interest in the prevention of deaths in similar circumstances.

(6) A determination is not admissible in evidence, and may not be founded on, in any judicial proceedings of any nature.

[7] In this Note, I will set out the facts which I have found to be proved, followed by a brief outline of the submissions made by the Crown in the public interest. Thereafter I will consider each of the circumstances set out in sections 26(2)(a) to (g) of the 2016 Act and explain with reference to the information before the Inquiry, the conclusions I have reached.

[8] Because the Crown had obtained comprehensive information from a range of sources, recorded in the Notice to Admit Information, and contained in the documents produced to the Inquiry, and in the absence of appearance by the other interested parties, I was satisfied that oral evidence was not required. The hearing proceeded by way of submission from the Crown to the Inquiry based on the Notice to Admit, and the accompanying productions. It is in light of that information that I have made the following findings in fact set out in paragraphs 9-39.

Findings in fact

[9] John Wilson was born on 17 September 1956, and died on 28 August 2021, aged 64.

[10] At the time of his death, Mr Wilson was a self-employed fisherman, and skipper of the fishing vessel *Harriet J*.

[11] An accident at work in his youth had resulted in Mr Wilson's right arm being amputated below the elbow. He used a modified prosthetic arm whilst fishing. He was able to swim. In 2015, Mr Wilson had suffered a heart attack that necessitated the fitting

of three coronary artery stents. Since that heart attack he had had little in the way of significant medical problems. At the time of the accident there was no requirement for him to be medically assessed, or to hold a medical fitness certificate.

[12] At the time of the accident Mr Wilson was wearing a tee shirt and hooded jacket over waterproof trousers and size 8 boots.

[13] Mr Wilson had owned and operated the *Harriet J* since April 2012. He held a Seafish under 16.5m Skipper's Certificate (unrestricted), which was issued in 2009. Mr Wilson had completed all mandatory training required for a commercial fisherman.

[14] *Harriet J* is a 7.19 metre creel fishing vessel built in 1997. It was propelled by a single 32 kilowatt diesel engine sited in a compartment below the open rear working deck.

[15] The engine and rudder could be controlled either from inside the wheelhouse, by wheel or a heading control system, or by a set of controls located next to the hydraulic hauler and working table at the forward end of the deck. There was no means available to assist a person in the water to board the vessel.

[16] The hydraulic hauler on the port side was used to haul the creels onto the working table, where they could be emptied of the catch and rebaited before being stacked along the working deck in readiness for shooting. The catch was placed in plastic boxes, which were lined up along the port bulwark and which were prevented from being pulled overboard by an aluminium plate set into the working deck. A shooting door that opened inwards was set into the transom, flush with the deck and hinged on the starboard side. A short pound board of approximately 200mm height was

positioned on the starboard side of the deck and provided the only division of the working area. The area behind the board was stowed with equipment and did not afford easy access to the rear of the vessel when the working area was filled with creels and lines at the start of shooting. A mackerel stripper leading up to a reel arrangement on a raised frame over the stern was installed on the starboard side of the vessel for catching bait.

[17] *Harriet J* was equipped in accordance with the regulatory requirements for a vessel of its size and operation.

[18] A personal floatation device (PFD) in the form of a waistcoat with 50N of buoyancy, and a personal locator beacon (PLB) were both located in the wheelhouse. The PLB was registered with the Maritime and Coastguard Agency (MCA) UK Beacon Registry. A fixed VHF Digital Selective Calling radio was installed in the wheelhouse for ship-to-ship and ship-to-shore communication.

[19] The vessel's creel fleets were made up of several components attached to a backline. A marker float in a dan buoy arrangement was located at each end of the fleet and comprised a weight, made from a plastic bottle filled with cement, into which a 4m bamboo pole was set. The pole was fitted with a float halfway along its length and topped with an orange flag, which stood about 2 metres clear of the sea surface.

[20] Approximately 20 metres further down the backline from each marker float was a weight composed of two 16-link loops of chain attached to a shackle, which was 100 millimetres in length, and the whole assembly weighed about 14 kilograms in total. The

fleet comprised 24 creels, which weighed 14 kilograms each and were spaced about 10 metres apart along the length of the backline.

[21] The process of hauling the gear started with the manual recovery of the marker float. The backline was then placed on the hauler and the creels recovered in turn onto the working table for the catch to be removed and the creel rebaited. The fleet was then stacked from the forward end of the deck until the second marker float at the opposite end of the fleet was finally lifted on board.

[22] While shooting creels Mr Wilson manually jettisoned the first marker float and chain weight then, setting *Harriet J*'s throttle ahead, the creels would each be pulled through the shooting door one after the other by the forward motion of the vessel. After the second chain weight had been pulled from the deck, the skipper slowed the vessel down and manually jettisoned the second marker float into the water from the now empty deck.

[23] Mr Wilson's normal practice was to remain in the wheelhouse or at the controls at the forward end of the working deck as the weights and creels were being shot. Snags in the gear while on deck when shooting were not uncommon, and it was reportedly routine practice for Mr Wilson to enter the working deck and kick the gear while under load to free a snag.

[24] *Harriet J* held a small fishing vessel certificate, issued by the MCA following an inspection on 11 April 2017, which was valid until 26 July 2022. At the time the certificate was issued, the vessel was required to have a lifejacket for each person on board, but there was no requirement for a PLB to be carried.

[25] During that inspection, the MCA surveyor carried out an additional check related to the assessment and management of risks; this was termed a concentrated inspection campaign (CIC). The records of the CIC, though limited, stated that a PLB and PFD were used to mitigate the risk of a person falling overboard from *Harriet J*.

[26] In December 2018, the MCA amended MSN 1871 (F) – The Code of Practice for the Safety of Small Fishing Vessels of less than 15 metre Length Overall. The changes made the wearing of PFDs mandatory unless measures were in place to eliminate the risk of falling overboard. The code amendment also required *Harriet J* to carry an EPIRB, or a PLB for each crew member, from 1 October 2019.

[27] At about 04.00 on 28 August 2021, John Wilson left his home in St Abbs and drove to his vessel, which was berthed in St Abbs harbour. At the harbour he was joined by two of his relatives, the skippers of the small fishing vessels *Danny Boy* and *Skua* who were planning to fish in the same area during the day. *Danny Boy* was lone operated and *Skua* was manned by a skipper and one crew member.

[28] At 04.35, the vessels left St Abbs in the dark and proceeded west around St Abbs Head and along the coast towards Siccar Point. While *Skua* started hauling creels in the bay near Fast Castle Head, *Danny Boy* and *Harriet J* headed further west with *Danny Boy* working further offshore. The skippers of the three vessels talked over VHF radio throughout the morning.

[29] Between about 06.00 and 07.00, Mr Wilson worked three fleets of creels in the bay near to Siccar Point, hauling each fleet while heading broadly west at approximately 1 knot (kt), before reversing direction at roughly 5kts over the ground to shoot the fleet

in the same position. At about 07.00, having brought *Harriet J* closer inshore to a position 0.5 nautical miles (nm) north of Meikle Poo Craig, Mr Wilson started to motor the boat slowly on a westerly course along the coast while hauling the fourth fleet of creels. At about 07.30, *Harriet J* circled round to the south, picking up speed, and settled on a heading of 095° at 5.4kts. At 07.36, the track of *Harriet J* showed a notable dip in speed while shooting the fourth fleet, after which the vessel resumed its easterly course and speed.

[30] Jim Wilson, the skipper of *Skua* was working his boat to the west of Fast Castle Head. He noticed that *Harriet J* was approaching and attempted to contact Mr Wilson by VHF radio but received no response. He was concerned by both the unusual behaviour of the vessel and its heading. At 07.45, *Harriet J* passed *Skua* at a distance of less than 5 metres. The skipper and crew member on board *Skua* dropped the fishing gear they were working and set off in pursuit, raising the alarm by calling the skipper of *Danny Boy* by VHF radio as they did so.

[31] On receiving the call, David Wilson, the skipper of *Danny Boy* contacted the coastguard by VHF radio. He then used his mobile phone to call a friend who was the coxswain of the St Abbs independent lifeboat.

[32] At 07.54, *Skua* manoeuvred alongside the starboard side of *Harriet J* and pushed the vessel to the north to prevent it running aground. Aaron Middlemiss from *Skua* was then able to board *Harriet J* and take control. He confirmed that John Wilson was not on board. He found a woollen hat at the forward end of the working deck.

[33] At 08.06, the coastguard broadcast a "Mayday Relay" and began to activate the local search and rescue services, including lifeboats from Eyemouth to the south and a rescue helicopter from Aberdeen. The St Abbs independent lifeboat mobilised on receipt of the call from the skipper of *Danny Boy* and local vessels also converged on the bay to assist in the search as they became aware of the situation.

[34] David Wilson on *Danny Boy* proceeded to the position where he knew *Harriet J* had been working. On his approach he spotted a broken marker float from the end of a fleet lying in the water and started hauling in the backline. He found a boot trapped in the loop of chain as he recovered the weight and reported both this and his position to the Coastguard. He continued to haul up more of the fleet but, with no sign of *Harriet J*'s skipper, he dropped the gear back into the water and recommenced searching.

[35] At 08.51, the helicopter arrived on the scene. At 08.57, Edward Dougal, the skipper of the fishing vessel *Fiddlers Green* spotted John Wilson in the water approximately 1 nautical mile to the west of Fast Castle Head and called the Coastguard for assistance. Mr Wilson was not wearing a PFD and, although air had become trapped in his clothing and was keeping him afloat, his head was not supported above the surface.

[36] The St Abbs lifeboat closed on the position and its crew retrieved John Wilson from the water and started immediate first aid. By 09.06, Mr Wilson had been transferred onto the helicopter and was airlifted to Edinburgh Royal Infirmary where, at 09.55, he was declared deceased.

[37] On 3 September 2021, Dr Kerry Anne Shearer, Consultant Forensic Pathologist, conducted a post mortem examination of John Wilson at Edinburgh City Mortuary and prepared a report.

[38] The conclusion of Dr Shearer, following said examination, was as follows:

> There was an injury (laceration) to the forehead with underlying bruising of the scalp but no evidence of skull injury and no obvious traumatic brain injury. Features consistent with drowning as a cause of death were noted. These include an accumulation of fluid within the chest cavities, lung congestion and oedema, hyper expansion with lungs overlying mediastinal contours and crepitus. The rib fractures present could be related to resuscitation.
>
> Also present on examination was ischaemic heart disease comprising severe narrowing of all three main coronary arteries by longstanding atheroma in addition to a stent being present in one artery. There was also extensive scarring of the heart muscle.

[39] Toxicology undertaken showed only in blood and urine low levels of alcohol which may be solely from post-mortem production.

Submissions

[40] The Crown directed me to the Notice to Admit Information, and to the accompanying productions. The procurator fiscal depute invited me to make findings under the following heads in section 26 of the 2016 Act.

[41] Where and when death occurred: The late John Wilson was pronounced dead at 09.55 on 28 August 2021, at the Accident and Emergency Department of the Royal Infirmary of Edinburgh. That appeared from the post-mortem report and medical records.

[42] When and where the accident occurred: the Crown submitted the death of John Wilson occurred due to an accident on board MFV *Harriet J*, whilst heading on a westerly course along the coast, approximately 0.5 nautical miles north of Meikle Poo Craig, on 28 August 2021, at 07.36. The Crown founded primarily on the MAIB report, page 2 paragraph 3, which contains an analysis of GPS position data recorded in the plotter retrieved from *Harriet J* during the MAIB investigation.

[43] Cause of Death: 1. Drowning; 2. Ischaemic heart disease. The Crown relied on the post-mortem report.

[44] Cause of Accident: The procurator fiscal depute submitted the evidence indicated Mr Wilson was working on the deck of *Harriet J*, when his foot became entangled in the chain weight for the fourth fleet of creels. Mr Wilson was pulled from the vessel, through the shooting door at the aft end of the working deck, striking his head on part of the structure of the vessel in the process. The Crown relied on the section entitled "Analysis" in the Marine Accident Investigation Branch Report, page 9. The investigation had been conducted by specialists and the court was invited to place some weight on that fact. In addition, there was the evidence from the post-mortem about the nature of the deceased's injuries, namely a blunt force injury, plus crescentric laceration, red bruising, and abrasions over the chest, left upper arm and right knee. In addition, there was evidence from David Wilson of finding the damaged flag attached to a buoy and the deceased's boot entangled on the creel line.

[45] Precautions which might reasonably be taken, and if taken, might have prevented death. The Crown submission was that the use of a deck divider on the

working deck was a precaution which might reasonably have been taken. It was submitted that had it been taken it might reasonably expected to have prevented an accident of this kind. The Crown submission built on a statement in the MAIB report at page 11 that "There was no effective way of segregating Mr Wilson from the working area". It was submitted there was a risk of becoming entangled in the line. The use of deck dividers to keep the working area clear of the running back rope was a reasonable precaution, and, it was submitted, had it been taken Mr Wilson's death might reasonably have been prevented. That was because such a divider would create a physical barrier between the running rope and persons on the deck, who could have attended to the creel if it became stuck without coming into contact with the rope or chain weight.

[46] I raised with the procurator fiscal depute the practicality of such a precaution, and whether there was sufficient evidence about that. I suggested that was of some importance given the submission which was made by the Crown that the taking of this precaution might have prevented the death. The procurator fiscal depute undertook to obtain further information from the MAIB about this and it was for this reason that I continued the inquiry until 19 January 2024. When the inquiry reconvened I had the benefit of a short additional note from Mr Adam Nutt, the Technical Manager, UK Maritime Services, of the Maritime and Coastguard Agency. It was in the following terms:

> The MCA's overall in ensuring safety on board small fishing vessels, such as Harriet J, is driven by the Small Fishing Vessels Code of Practice (MSN1871, previously (MSN1813). Effective risk assessments including a specific risk

> assessment relating to man overboard and any control measures to eliminate this risk, as per MGN571, are presented to but not approved by the attending surveyor as part of the vessel's inspection. The Small Fishing Vessels Code of Practice does not require detailed review of the fishing operations undertaken on board. The MCA cannot comment on the practicalities or effectiveness of using deck dividers, or other means, of preventing entanglement on a vessel such as this.

[47] In relation to the heading in section 26(2)(f), defects in the system of working, the Crown did not seek any findings.

[48] Other relevant facts (section 26(2)(g)). The Crown invited the court to consider making a finding in relation to the carrying of a personal locator beacon. The evidence was that a PLB was stowed in the wheelhouse of *Harriet J*. There was no requirement to have a PLB on this vessel but one was in fact carried. Mr Wilson could have activated the beacon whilst on board, however as he was not wearing it, he was unable to raise the alarm when he went overboard. The procurator fiscal depute directed my attention to Merchant Shipping Notice MSN1871, Amendment 1(f) to the Code of Practice for the Safety of Small Fishing Vessels, which recommended that singlehanded stickers should carry both a PLB and an EPRIB (the latter being a fixed device on the vessel operated if the vessel submerged). The PLB is a personal device and requires to be manually activated. It can be activated on board or in the water, and transmits a distress signal and location coordinates. The Crown invited the court to determine that Mr Wilson was pulled into the water, the vessel continued on its course with the engine running, and Mr Wilson had no opportunity to re-board the vessel. Mr Wilson would only have had an opportunity to alert others if he had had a PLB on his person and had been able to activate it. The Crown submitted that is why it was some time before he was found in

the water. The Crown did not submit that this was a reasonable precaution which would have avoided his death, because on the available evidence that could not be said. However, the Crown invited the court to make a recommendation in terms of section 26(4)(d) namely that it would be for the better safety of fishermen to carry a PLB on their person when on board.

[49] In relation to the wearing of a personal floatation device, the procurator fiscal noted that Mr Wilson was not wearing one at the time he entered the water. The Crown referred to the MAIB report at page 10 under the heading "Personal Floatation Device and Survivability". The MAIB summary at page 11, bullet point 6 noted that the skipper's chances of survival would have been improved had he been wearing a PFD. Again the Crown was not submitting that was a precaution that reasonably could have been taken and would have prevented death, because again there was not a basis in evidence for that. Instead, the Crown invited a further recommendation 26(4)(d) that singlehanded fisherman should wear a PFD when on board as a matter of public safety and to help prevent fatalities in the event of similar accidents in future.

Findings and discussion

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

[50] I find that the late John Wilson was pronounced dead at 09:55 on 28 August 2021, at the Accident and Emergency Department at the Royal Infirmary of Edinburgh, Edinburgh. That is documented in the post mortem report and medical records.

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

[51] The death of John Wilson occurred due to an accident on board MFV *Harriet J*, at sea while heading on a westerly course along the coast of Berwickshire at a point approximately 0.5 nautical miles off Meikle Poo Craig. The accident occurred at or shortly after 07:36 on 28 August 2021. I accept the analysis of the evidence contained in the MAIB report, pages 9-10. In my view, the evidence about the track of *Harriet J* is compelling in this context. The speed dip noted at 07.36, and the fact that this occurred close to the point where the broken flag was later recovered by the skipper of *Danny Boy*, suggests very strongly that was the time and place where the accident occurred.

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

[52] Mr Wilson's death was caused by:

1. Drowning.
2. Ischaemic heart disease.

I accept the evidence contained in the post mortem report, and that is consistent with the finding I have made about the nature and location of the accident. There is nothing in the toxicology report which points in a different direction. I therefore determined that the cause of death was as documented in the medical certification of death.

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

[53] Whilst working on the deck of *Harriet J*, Mr Wilson's foot became entangled in the chain weight attached to a fleet of creels on the deck which he was in the course of launching. Mr Wilson was pulled from the vessel, through the shooting door at the aft end of the working deck, striking his head on part of the rear structure of the vessel. He thereafter entered the water, and was unable to exit the water.

[54] Again, in relation to this aspect of the Inquiry, I found the MAIB analysis compelling. From the vessel tracking data recovered by the MAIB, Mr Wilson was working on the fourth fleet of creels immediately before the accident. From the discovery of one of his boots entangled in the weighting chain, I consider that on the balance of probability his foot became caught in the chain, most likely as he was working to free a snag on some part of the line. As the MAIB report notes:

> the force needed to slow *Harriet J* was significant and is most likely to have arisen from the passage of the gear from the vessel during shooting being halted, then released. The force required to break the marker float's bamboo pole was discounted as being sufficient to cause such a reduction in vessel speed. It is therefore likely that either a creel or the second chain weight became snagged on the deck of *Harriet J*.

I accept that evidence.

[55] I also accept the evidence of the MAIB that the layout of the working deck, and the fact that equipment was stowed behind the pound board meant it was impossible for Mr Wilson to free a snag in the line without being on a part of the deck close to the line

and the fishing gear. I accept the evidence that the chain weights on the fleet of creels formed a snagging hazard when on the working deck in close proximity to the creels.

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):

[56] The Inquiry is required to consider two questions in relation to this point: whether there were any precautions which could reasonably have been taken, and secondly had they been taken, whether they might realistically have resulted in death or any accident resulting in death being avoided. The Crown submission was that the use of deck dividers on the working deck was both a precaution which might reasonably have been taken, and, had it been taken, might be expected to have prevented the accident and therefore death. The Crown position was founded in the passage in the MAIB report at page 11.

> There was no effective way to segregate the skipper from the working area on board Harriet J, due to the deck layout and the equipment stored behind the pound board; the risks of becoming entangled in the gear and dragged overboard had not been effectively assessed and mitigated.
>
> It was submitted that the use of deck dividers was a reasonable precaution because that would create a physical barrier and, by a necessary inference, as a result a crew member such as the late Mr Wilson could not come into contact with the rope or chain. This was the issue which I invited the Crown to

> investigate further, and for which purpose I adjourned the inquiry until 19 January 2024. At that time, a short email note was available from Adam Nutt, Technical Manager UK Maritime Services at MCA. He pointed to the scope of the safety risk assessment forming part of certification of vessels such as *Harriet J*. He also stated:
>
> The Small Fishing Vessels Code of Practice does not require detailed review of the fishing operations undertaken on board. The MCA cannot comment on the practicalities or effectiveness of using deck dividers, or other means, of preventing entanglement on a vessel such as this.

[57] I am grateful to the Crown for the further work carried out. However, I am not persuaded that the evidence before the Inquiry either on 15 December 2023 or 19 January 2024 would allow me to be satisfied that such a precaution could practically have been taken. It follows that I cannot reach a conclusion about whether or not that 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):

[58] On the evidence before the Inquiry, I have not identified any defect in the system of work as such.

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

[59] From the matters set out in the Form 4.12A, and the supporting evidence before the court, I do not consider there are other facts relevant to the circumstances of the death.

In terms of section 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):

[60] The Crown invited the court to consider making recommendations about three matters:

(1) Deck dividers on the working deck;

(2) Personal locator beacons; and

(3) Personal floatation devices.

I deal with each of these in turn.

[61] In relation to deck dividers, while there is a superficial attraction to this as an idea against the background of the likely mechanism of the accident which led to Mr Wilson's death, I have concluded I am unable to make a recommendation about the adoption of deck dividers. Essentially the reason for that is twofold; firstly, as I have already indicated in paragraph 57, I do not consider there is sufficient evidence about the practicability of that as a solution. Secondly, I am conscious that the court had no

evidence about the range of deck configurations operated on fishing vessels under 15m in length. I consider it would therefore be beyond the scope of the evidence in this Inquiry to make such a recommendation.

[62] Personal locator beacons (PLB). A personal locator beacon is a small, handheld device used to alert certain rescue services of the location of an incident. PLBs have to be manually activated in order to send a distress signal. This is achieved by releasing its antenna and pressing a button, usually under a protective cover on top of the beacon (Chris Hopkins statement paragraphs 8 and 10). When a PLB is activated, it begins to transmit a series of very short, digitally coded signals indicating a person who is in distress. The outbursts of signal are kept short, in order to prolong the life of the battery, and each sends a message that identifies the beacon, and may include information about the vessel, and the location of the person in distress. The signal is detected by a satellite network and relayed to a certain rescue authority, who in the UK are the joint rescue coordination centre. The rescue authority then contact the police or coastguard, who will initiate appropriate searches.

[63] In this case, a PLB was carried aboard the *Harriet J*. The beacon was stowed in the wheelhouse. There was in fact no regulatory requirement for one to be carried. The late Mr Wilson plainly had given some thought to safety precautions such as a PLB, since it was not a mandatory requirement. However, the value of having the PLB on board was substantially reduced by it not being on the person of Mr Wilson. It is impossible to reach a conclusion about why he was not carrying the device on his person, as opposed to having it in the wheelhouse. The range of possible events which

might occur so rapidly as to make it impossible to reach the PLB in time, lead me to conclude that it is appropriate to make a recommendation that a PLB should be carried on single person-operated small fishing vessels as part of the standard safety equipment, and further that the PLB should be carried on the person of the crew member whilst at sea.

[64] Personal Floatation Devices (PFD) The late Mr Wilson was not wearing a PFD at the time of the accident. The MAIB report quotes the MCA's Fisherman Safety Guide which identifies hazards associated with lone fishing as including "no help available if injured. If you fall overboard, there is no one to raise the alarm or stop the vessel, or help recover you to the vessel". The report goes on to note that suggested hazard mitigations include wearing a PFD, as well as using safety lines and rigging an overboard ladder (page 8). The report goes on to record that in the five years prior to Mr Wilson's accident, there were eight fatal accidents involving UK fishing vessels under 15m in length where a person went overboard. Of these, four were loan operated boats, and four were the result of entanglement in the gear. All were creel fishing vessels, and only one of the fishers who died was wearing a PFD (page 8).

[65] Even in the absence of this evidence, it seems to me clear from the evidence about the mechanics of the accident in this case and the difficulties associated with getting back on board the vessel, taken together with the likelihood that, in most cases, the arrival of help and assistance may take some time, points to the importance of a PFD as a life preserving measure. Accordingly, I recommend that crew members of single person operated fishing vessels wear PFDs at all times whilst the vessel is at sea.

[66] Finally, I would extended the court's condolences to Mr Wilson's family.