

SHERIFFDOM OF GRAMPIAN, HIGHLANDS AND ISLANDS AT FORT WILLIAM
UNDER THE FATAL ACCIDENTS AND SUDDEN DEATHS INQUIRY (SCOTLAND) ACT
1976 SECTION 6

DETERMINATION

of

Sheriff Paul V Crozier

in

FATAL ACCIDENT INQUIRY

Into the circumstances of the deaths of

THOMAS MARTIN SANDERSON,
TONY HAYTON and
PETER HILTON

FORT WILLIAM 19th MARCH 2012

The Sheriff having resumed consideration of the evidence, makes the following findings:-

(1) In terms of Section 6(1)(a) of the Fatal Accidents and Sudden Death Inquiries (Scotland) Act 1976 (the Act):

(i) Thomas Martin Sanderson, known as Martin, whose date of birth was 27th September 1956, latterly of 4 Brooklands Avenue, Maryport, Cumbria, died at some time shortly after 16.40 BST on 20th July 2009 at sea, to the East of Bo Fascadale Reef near Kilmory, Ardnamurchan. His body was recovered at a position approximately 56° 47.62' North, 006° 01.85' West, at approximately 18.50 BST on 20th July 2009.

(ii) Tony Hayton, whose date of birth was 8th March 1964, latterly of 9 Ismay Wharf, Maryport, Cumbria, died at some time shortly after 16.40 BST on 20th July 2009 at sea, to the East of Bo Fascadale Reef near Kilmory, Ardnamurchan. His body was recovered at a position approximately 56° 47.62' North, 006° 00.61' West, at approximately 18.30 BST on 20th July 2009.

(iii) Peter Hilton, also known as Peter Lightfoot, whose date of birth was 13th March 1957, latterly of 7 Moorside Drive, Maryport, Cumbria, died at sometime between 16.40 BST and 17.40 BST on 20th July 2009 at sea, to the East of Bo Faskadale Reef near Kilmory, Ardnamurchan. His body was recovered at a position approximately 56° 47.479' North, 006° 02.302' West, at approximately 20.35 BST on 20th July 2009.

(2) In terms of Section 6(1)(b) of the Act, that the causes of the deaths were:

(i) Thomas Martin Sanderson died from drowning. He suffered from severe coronary artery atheroma and this possibly contributed to his death.

(ii) Tony Hayton died from drowning. He suffered from coronary artery atherosclerosis and this possibly contributed to his death.

(iii) Peter Hilton died from drowning.

Thomas Martin Sanderson, Tony Hayton and Peter Hilton were, at the time of their deaths, self- employed fishermen working on board the FV Aquila, when it capsized while dredging for scallops to the east of Bo Faskadale Reef.

(2) In terms of Section 6(1)(c) of the Act , there were no reasonable precautions which could have been taken by the vessel's skipper/owner, Tony Hayton, whereby the deaths, and the accident resulting in the deaths, might have been avoided.

(4) In terms of Section 6(1)(d) of the Act that there were no defects in any systems of working on board the vessel which contributed to the deaths or any accident resulting in the deaths.

(5) In terms of Section 6(1)(e) of the Act there are other factors which are relevant to the circumstances of the death.

(i) The Air Rescue Co-ordination Centre (ARCC) should be responsible for the tasking of all Search and Rescue (SAR) helicopters. This will avoid the confusion, and subsequent delay resultant from that, caused by tasking of SAR helicopters by individual Coastguard stations.

(ii) The Co-ordination and control of live incidents should be retained by the Initial Action Station. If transfer is appropriate for whatever reason, that transfer should be

conducted following upon a full assessment of the location of the incident, the VHF radio coverage in the area of the incident and the staffing levels and capability in the respective stations. The Initial Station should retain control until all such checks have been carried out and it is agreed fully with the transfer station that they are prepared to accept the transfer. Any verbal transfer of co-ordination must be followed up as soon as possible with written confirmation of the transfer including full details of the incident and full reasons why the transfer is appropriate.

- (iii) The Maritime and Coastguard Agency (MCA) should review their training procedures to ensure that sufficient training is provided to watch managers and those who might act up as watch managers in Staff Planning and Risk Evaluation.
- (iv) Training is required to be given by the MCA to coastguard watch managers and officers in regard to the timing of the broadcast of Mayday relay signals, the circumstances in which such signals should be repeated and the circumstances in which a Mayday Silence should be broadcast.
- (v) The Sea Fish Industry Authority should review the training courses run for fishermen in particular in relation to health and safety risk assessments of fishing in particular conditions and the consideration of the effects of adding ballast to their vessels. The review should consider the requirement for compulsory attendance and re-attendance at such courses.
- (vi) The Marine Accident Investigation Branch (MAIB) of the Department of Transport should bring into effect a formal system of reporting to ensure that all actions identified as requiring attention have been taken and any undertakings given in that regard have been complied with.

.....Sheriff

STATUTORY FRAMEWORK

The Sheriff's remit under the Fatal Accidents and Sudden Deaths Inquiry (Scotland) Act 1976 Section 6(1) is to "...make a determination setting out the following circumstances of the death so far as they have been established to his satisfaction-

- (a) where and when the death and any accident resulting in the death took place;
- (b) the cause or causes of such death and any accident resulting in the death;
- (c) the reasonable precautions, if any, whereby the death and any accident resulting in the death might have been avoided;
- (d) the defects, if any, in any system of working which contributed to the death or any accident resulting in the death; and
- (e) any other facts which are relevant to the circumstances of the death."

Sheriff Principal Lockhart in his determination following the Fatal accident Inquiry into the deaths at the Rosepark Nursing Home (issued in 2011 and specifically at paragraphs 6-9) provided very helpful guidance as to the approach a Sheriff should take in respect of a determination:-

"6. Different considerations are relevant in deciding what determination, if any, is to be made under the various subparagraphs of section 6(1) of the Act. In considering the time, place and cause of the death in terms of 6(1)(a) and 6(1)(b) the court simply exercises its traditional fact finding functions. In relation to sections 6(1)(c) and 6(1)(d) I respectfully agree with Sheriff Kearney in his determination into the death of James McAlpine, issued on 17 January 1986, referred to at paragraph 8-99 of the third edition of Sudden Death and Fatal Accident Inquiries by Ian Carmichael. Sheriff Kearney there observes:

"In deciding whether to make any determination under s.6(1)(d) as to the defects, if any, in any system of working which contributed to the death or any accident resulting in the death the court must, as a precondition to making any such recommendation, be satisfied that the defect in question did in fact cause or contribute to the death. The standard of proof and the rules of evidence (apart from the consideration that evidence did not require to be corroborated) is that applicable to civil business (1976 Act, s.4(7)) and accordingly the standard of proof is that of the balance of probabilities.

- (b) In relation to making a finding as to the reasonable precautions, if any, whereby the death or any accident resulting in the death might have been avoided(s.6(1)(c)) it is clearly not necessary for the

court to be satisfied that the proposed precaution would in fact have avoided the accident or death, only that it might have done, but the court must, as well as being satisfied that the precaution might have prevented the accident or death, be satisfied that the precaution was a reasonable one.”

Sheriff Kearney goes on to say:

“The phrase “might have been avoided” is a wide one which has not, so far as I am aware, been made the subject of judicial determination. It means less than “would on the balance of probabilities have been avoided” and “rather directs one’s mind to the direction of lively possibilities.”

Sheriff Kearney’s observations and interpretations of the phrase “might have been avoided” have been referred to and adopted with approval in many determinations since then. I also adopt the view which he expresses in the James McAlpine determination in relation to section 6(1)(e):

“The provisions of section 6(1)(e) are very widely stated and, in my view, entitle and indeed oblige the court to comment on and, where appropriate, make recommendations in relation to any matter which has been legitimately examined in the course of the inquiry as to a circumstance surrounding the death, if it appears to be in the public interest to make such comment or recommendation.”

7. I adhere to the views I expressed in my determination in the Fatal Accident Inquiry arising out of the railway accident at Newton which I issued at Glasgow Sheriff Court on 20 July 1993:

“In my opinion a Fatal Accident Inquiry is very much an exercise in applying the wisdom of hindsight. It is for the Sheriff to identify the reasonable precautions, if any, whereby the death and any accident resulting in the death might have been avoided and the defects, if any, in any system of working which contributed to the death or any accident resulting in the death. The sheriff is required to proceed on the basis of the evidence adduced without regard to any question of the state of knowledge at the time of the accident. The statutory provisions are concerned with the existence of reasonable precautions or defects in the system at the time of the accident or death and are not concerned whether they could or should have been recognised. They do not relate to the question of foreseeability of risk at the time of the accident. The statutory provisions are widely drawn and are intended to permit retrospective consideration of matters with the benefit of hindsight and on the basis of the information and evidence available at the time of the inquiry. There is no question of the reasonableness of any precaution depending on the foreseeability of risk. The reference to reasonableness relates to the question of availability and suitability or practicality of the precautions at the time of the accident resulting in death.”

8. I respectfully agree with the conclusions reached by Sheriff Fiona Reith QC in her determination relating to the death of Sharman Weir issued on 23 January 2003:

“In my opinion, the purpose of a fatal accident inquiry is to look back, as at the date of the inquiry, to determine what can now be seen as reasonable precautions, if any, whereby the death might have

been avoided, and any other facts which are relevant to the circumstances of the death.....The purpose of the conclusions drawn is to assist those legitimately interested in the circumstances of the death, to look to the future. They, armed with hindsight, the evidence led at the inquiry, and the determination of the inquiry, may be persuaded to take steps to prevent any recurrence of such a death in future.”

The question of reasonableness is directed to the precaution which is identified. The issue is not whether an individual or an organisation behaved in a responsible or unreasonable way, but whether or not there is a precaution which is a reasonable one and which might have made a difference.

9. My predecessor Sheriff Principal J S Mowat QC opined in his determination on the Lockerbie Fatal Accident Inquiry:

“I have come to the view that any finding under section 6(1)(c) should avoid, so far as possible, any connotation of negligence. Accordingly, it should not contain any indication as to whether any person was under a duty either at common law or under statute to take a precaution identified in the finding.....”

In reaching my determination I have considered carefully my responsibilities under the Act and have taken into account the opinions expressed by Sheriff Principal Lockhart above, and the opinions expressed by others therein, with all of which I respectfully agree.

FINDINGS IN FACT

1. The FV Aquila was a steel hulled scallop dredger built in 1988; the vessel had been owned by the deceased, Tony Hayton, since 1997.

2. When the vessel was built, no statutory stability requirements applied to her. She was, however, constructed to the stability standards required by the Fishing Vessels (Safety Provisions) Rules 1975-these applied to larger vessels. The registered length of the vessel was 11.92 metres.

3. Between 1988 and 2009, the vessel’s lightship weight had increased as a result of the addition of ballast and other items of fishing equipment. As a result, the vessel no longer complied with the standards that she had been constructed to. On 20th July 2009 the level of non-compliance would have been marginal.

4. Had the vessel fully complied with the stability requirements she was built to, the capsizing on 20th July 2009 would still have occurred and no want of static stability caused the accident.
5. The vessel was inspected on 11th February 2009 by the Marine and Coastguard Agency, in compliance with the Code of Practice for the Safety of Small Fishing Vessels (MSN1813(F))(Production 1 for Sunderland Marine). No deficiencies were noted.
6. There was no evidence of any prior problems of sea-keeping or stability regarding the vessel. The vessel was kept in good condition and was well maintained.
7. The vessel fished in various grounds off the west coast of England and Scotland, usually making fishing trips of 10 days, returning to harbour to land the catch mid-trip. At or around the time of the accident the vessel had been fishing in grounds between Jura and Skye, landing at Oban or Mallaig.
8. The vessel landed at Mallaig on 16th July 2009 and went back to sea on the morning of 17th July 2009. The vessel was crewed by Tony Hayton, Thomas Martin Sanderson (Martin Sanderson), Peter Hilton and Timothy Rowley. All were experienced self-employed fishermen and had attended statutory courses in First Aid, Firefighting, Sea Survival and Safety Awareness.
9. Having gone back to sea on the 17th July 2009 the vessel fished off Coll, Muck and Eigg before moving to grounds at Bo Faskadale on 20th July 2009. Bo Faskadale reef is a rocky underwater plateau. It is known to be an area where there is a risk of snagging fishing gear.
10. The vessel's fishing method involved towing 2 sets of 7 dredges, one port and one starboard, attached to steel bars which were in turn suspended from steel wires or warps run from the vessel's winch. Each dredge had a toothed bar or sword at the front to dig out the scallops as the gear was towed across the seabed. On the morning of 20th July 2009 the crew had changed the "swords" or tooth bars on the dredges.
11. The vessel completed one tow on or near the Bo Faskadale reef, then had another tow closer to land.

12. At or about 16.30 BST the vessel started towing in approximately a south-easterly direction at Bo Faskadale. The weather conditions at the time were wind force 5 to 6 from a south-easterly direction with sea conditions described as “choppy”. The conditions were well within the vessel’s operational capabilities.

13. In the course of that tow, the vessel snagged her gear on the bottom of the sea bed. When the snagging occurred the vessel pulled to the side of the snag and leaned over. Snagging is part and parcel of scallop dredging off the west coast of Scotland and can happen in all weather conditions.

14. To free a snag a skipper will firstly take the vessel out of gear and she will generally right herself; sometimes the skipper has to put the vessel back into gear and the vessel pulls itself off the snag; sometimes the winch requires to be operated and the vessel is knocked out of gear and she is lifted off the snag with the winch. On this occasion Tony Hayton was able to free the vessel without requiring the winch to be operated.

15. Shortly afterwards, during the course of the same tow, the vessel snagged her gear again. Tony Hayton immediately knocked the engine out of gear to free the vessel, this was the correct action to deal with the snag. However she came hard fast, yawed and heeled (turned about and went) to starboard and immediately capsized. The time was approximately 16.40 BST.

16. The vessel’s starboard warp had become caught under an area of flat rock on the seabed approximately 3m x 1m and 150mm-200mm above the sand (Crown production 19). The snagging of the starboard warp caused the accident. The port warp was found in the sand under the same rock. The seabed in the vicinity of this flat rock was sandy and free from obstructions.

17. At the time of the capsize, Tony Hayton was in the wheelhouse and the other crew members were in the galley. None of the crew were wearing life jackets. All 4 escaped the vessel, Timothy Rowley through the open starboard accommodation door.

18. The vessel had on board an EPIRB and Life raft.

19. An EPIRB is an electronic signalling device which should, in the event of capsize, float free and emit a signal to alert the relevant authorities to the emergency. The Life raft should also float free in the event of capsize.

20. Both the EPIRB and the Liferaft were positioned appropriately on board the vessel, however, because of the speed of the capsize, both got caught up in the vessels rigging and mast arrangement having floated free from their retaining positions and were thus rendered useless in the circumstances.

21. When he surfaced Timothy Rowley saw Tony Hayton about 50 metres away, Tony was trying to keep himself afloat and was conscious, after a couple of seconds he lost sight of Tony.

22. Tony Hayton died from drowning. He suffered from coronary artery atherosclerosis and this possibly contributed to his death.

23. Mr Rowley then saw Thomas Martin Sanderson, who was face down in the water. He did not appear to be alive.

24. Thomas Martin Sanderson died from drowning. He suffered from severe coronary artery atheroma and this possibly contributed to his death.

25. Mr Rowley then saw Peter Hilton who was alive. He used 2 planks of wood to keep himself afloat, he then swam back to Martin and Peter, found some twine and tried to tie the 3 of them together. Martin Sanderson drifted off. Mr Rowley managed to tie some twine around Peter to try to keep him afloat, Peter was complaining about his back. Mr Rowley tried to keep Peter's head up out of the water. Peter died in Timothy Rowley's arms.

26. Peter Hilton died from drowning.

27. In the prevailing sea conditions at the time most people would only have survived for 30 minutes in the water.

28. In the prevailing sea conditions at the time the survival time expected would not be much beyond 1 hour unless the casualty was wearing a good fitting life jacket and was conscious enough to be able to make arm movements to keep their back to the waves.
29. Timothy Rowley was rescued by Christopher Pendlebury of the yacht “Arran Comrade” at or around 18.00 BST at a position approximately 56° 47.661’N 06° 01.907’W.
30. Timothy Rowley was the only survivor. He had spent approximately 1 hour and 20 minutes in the water thus placing him in the top 10 percentile of immersion victims not wearing life jackets.
31. The capsized was witnessed by James Lancashire from a road adjacent to Faskadale Beach. He cycled to the house of Mary Khan at Kilmory, Ardnamurchan, where he was staying.
32. At 17.02 BST Mr Lancashire made a 999 call and was put through to Peter Leyburn Coastguard watch assistant at the Maritime Rescue Co-ordination Centre (MRCC) at Clyde.
33. Mr Leyburn spoke with both James Lancashire and Mary Khan and was given a clear and detailed description of what Mr Lancashire had seen and the location at Bo Faskadale with specific reference to Kilmory, Ardnamurchan.
34. At 17:05:44 BST the watch manager at Clyde MRCC, Mr Tarik Yassin, contacted the Aeronautical Rescue Co-ordination Centre (ARCC) at Kinloss, to task a rescue helicopter. Helicopter R177 from RNAS Prestwick was then tasked.
35. No Mayday Relay broadcast was made by MRCC Clyde.
36. When R177 was tasked, Mr Yassin was aware of 2 Kilmorys within Clyde’s area of responsibility and thought that the location of the incident was one of these.
37. He then became aware that the location of the incident was in Kilmory, Ardnamurchan, which is within Stornoway MRCC’s area of responsibility and contacted ARCC Kinloss at 17:08:49 and asked that R177 be stood down.

38. At 17.12 BST the crew of R177 contacted MRCC Clyde direct, on VHF radio, to advise that if required they would be able to lift off in 2 minutes and also gave a revised Estimated Time of Arrival (approximately 45 minutes). They were told by Clyde that there was no requirement for a helicopter “as yet”.

39. At 17.09 BST, Peter Leyburn of MRCC Clyde contacted Stornoway MRCC and spoke with watch officer David Smith to ask Stornoway to take over co-ordination of the incident and told them the location of the incident and that the incident involved a capsized fishing vessel.

40. Stornoway agreed to taking over coordination of the incident. Clyde had told Stornoway that R177 had been tasked and was just getting airborne and during the course of that conversation the decision to stand down R177 was taken but not communicated to Stornoway.

41. MRCC Clyde should not have stood down R177 as the helicopter was almost ready for take-off and could have been provided with the new details of the location of the incident.

42. In terms of the Maritime and Coastguard Agency (MCA) guidelines in effect on the date of the incident, MRCC Clyde was the Initial Action Station and was responsible for initiating immediate search and rescue action and was required to take all necessary action to co-ordinate the response until the appropriate MRCC had assumed responsibility.

43. On the 20th July 2009 at 17.09 BST there were 5 coastguard officers on duty at MRCC Clyde, 1 of whom was on a meal break when the initial call was received. There were 3 coastguard officers on duty at MRCC Stornoway, 1 of whom was on a meal break when the incident was transferred to them for co-ordination.

44. The Watch Staffing Planning and Risk Evaluation for MRCC Stornoway (MCA production 25) showed that the suggested level of staffing for 20th July for Watch D (the watch on duty at the time of the incident) was 1 watch manager, 2 watch officers and 1 or 2 watch assistants. The staffing level identified as being required for the watch that day by the watch manager was 1 watch manager, 1 watch officer and 1 watch assistant. The staffing levels achieved on 20th July 2009 were 1 watch manager (who in fact was a watch officer acting up, as the watch manager was on annual leave) and 2 watch officers.

45. The Watch Staffing Planning and Risk Evaluation also identified that “During watches of reduced manning, in the event of incidents requiring search planning, this duty will be delegated to flank stations.”

46. No delegation of search planning took place until MRCC Clyde contacted Stornoway at 18.30 BST and asked if they could do anything to assist. They were asked to do the search planning as Stornoway had tried on 3 occasions to do the search planning but had been unable to do so because they were too busy.

47. MRCC Clyde should have retained responsibility for co-ordination of the rescue at the outset and any transfer of co-ordination should not have been made until a full evaluation of the incident and capabilities of the respective stations on the day had been made.

48. At 17.15 BST David Smith, the watch officer at Stornoway, prior to tasking SAR unit R100, telephoned Mary Kahn at Kilmory and obtained the same detailed information from her as he had from Clyde as to the location of the incident. There was no need to make this call.

49. At 17.21 BST Stornoway took the decision to request a helicopter from ARCC Kinloss and at 17.22 Helicopter R100 was tasked to attend. R100 is based at Stornoway and was 5 miles and 7 minutes in flying time, closer to the incident than R177, however because of the prevailing wind conditions at the time, R177 was as close to the incident in flying time as R100.

50. As a result of R177 being stood down and the failure by Stornoway to task R100 immediately upon transfer of the incident, there was a delay of 23 minutes in a rescue helicopter reaching the scene of the incident.

51. It is unlikely that the delay in tasking a helicopter to attend at the incident affected the outcome of this tragic accident.

52. At 17.28 BST the Mallaig lifeboat was tasked.

53. At 17.32 BST a Mayday Relay VHF broadcast was made by Stornoway giving the approximate position of the incident and requesting vessels in the vicinity to provide immediate assistance. This was not repeated and no Silence Mayday broadcast was made.

54. A Mayday relay should have been transmitted at a very early stage of the incident to alert shipping in the vicinity of the incident to the location of the capsized vessel in order that help could have been provided to the crew of the capsized vessel.

55. Throughout the incident MRCC Stornoway continued to deal with not only calls related to the incident but also routine, non-distress calls.

56. A “Silence Mayday” should have been transmitted by Stornoway so that routine radio traffic would cease broadcasting during the course of the rescue.

57. VHF reception in the area of the incident was poor and intermittent and the Mayday relay should have been repeated in order that all shipping in the vicinity of the capsized vessel would have been alerted to the incident and the need for assistance. There was no repeat of the Mayday relay.

58. Christopher Pendlebury, a yachtsman on board the sailing boat “Arran Comrade”, heard part, but not all, of the Mayday Relay. He tried to call Stornoway to get details of the location of the incident but there was no reply.

59. R100 was airborne at 17.35 BST and from 17.37 BST vessels in the area began to respond to the Mayday Relay broadcast offering to assist.

60. At or around 18.00 BST Mr Pendlebury, who was sailing single-handed, heard shouts from the water and saw someone approximately 30 metres from his yacht. He threw a lifebelt and a rescue line and Timothy Rowley was recovered from the sea.

61. Mr Pendlebury tried to contact Stornoway and managed to do so, on his 3rd attempt, at 18.11 BST. He advised that he had recovered a casualty from FV Aquila and that three other crewmen were unaccounted for. He gave his position and was advised that a lifeboat and helicopter were on route.

62. At 18.20 BST R100 and the Mallaig lifeboat arrived on scene. A second helicopter had been requested and at 18.24 BST R177 took off from RNAS Prestwick to proceed to the area.

63. At 18.30 BST Clyde confirmed that the Tobermory lifeboat had been launched and was on its way to the scene and asked if they could do anything to assist Stornoway. Clyde was asked to do the Search planning for the incident.

64. At 18.50 BST, R100 saw and recovered the body of Thomas Martin Sanderson from the sea and took his body to Broadford Hospital, Skye.

65. At 19.05 BST R177 arrived on the scene. The survivor, Tony Rowley had been transferred to Mallaig lifeboat and was lifted into R177 and taken to Fort William Hospital.

66. At 19.15 the Tobermory lifeboat arrived on the scene.

67. At or about 19.24 BST Alan Fyfe on board his yacht “Storm Wind” sighted Tony Hayton’s body, which was recovered by R177 from the sea and taken to Broadford Hospital, Skye.

68. At 19.51 BST MRCC Stornoway appointed Mallaig lifeboat as the “ On scene co-ordinator” of the surface search for the one remaining casualty.

69. By about 20.00 BST there were 2 lifeboats and 7 other vessels (a mixture of fishing vessels and yachts) on scene and 2 helicopters had been tasked.

69. No Search and Rescue plan had ever been issued to the on scene units or the helicopters by Stornoway.

70. At or around 20.20 BST Mallaig lifeboat located Peter Hilton in the sea and, at 20.35 BST, R100 recovered his body from the sea and took it back to Broadford Hospital, Skye.

71. At 20.52 BST MRCC Stornoway broadcast a “Mayday Silence Fini” message.

72. No Mayday Silence had ever been broadcast.

NOTE

The Inquiry

The hearing commenced on 21st February 2011. It had been set for 5 days however it soon became apparent that the evidence would not be concluded in that time scale. As it was, evidence was heard over a period of 18 days between 21st February and 20th July 2011. Due to the commitments of those involved in the inquiry the first date that could be identified for submissions to be heard, on the evidence that had been led, was 31st October 2011. As it was, due to the ill health of the Procurator Fiscal, submissions were not heard until 20th December 2011. Transcripts of all the evidence heard were produced and written submissions were lodged on behalf of each of the parties represented at the Inquiry. I do not intend, therefore to repeat the evidence heard in detail, or the submissions made, unless it is necessary to do so for illustrative purposes.

Representation

The Crown was represented by Alison Wylie, Procurator Fiscal; The Maritime and Coastguard Agency were represented by Mr William Park, Solicitor, McGrigors, Aberdeen; Sunderland Marine Mutual Insurance Company Limited, the vessel's insurers, were represented by Mr Keith MacRae, Solicitor, MacKinnons, Aberdeen; Mrs Lightfoot, long term partner of the late Peter Hilton, was represented by Mr Marcus Nickson, Solicitor, K.J.Commons and Co., Cumbria, England, who was present for days 1, 2 and part of day 3 of the inquiry and made submissions to the inquiry based on that attendance.

Witnesses

The Inquiry heard from the following witnesses called by the Crown:

1. Stephen Wilkinson, fisherman on the "Bonnie Lass 3" who knew the crew of the FV Aquila
2. Eric McIlwraith, skipper and owner of the "Saint Apollo" and friend of Tony Hayton
3. Nicholas McWhirter, naval architect
4. Timothy Rowley, crew member on the FV Aquila and sole survivor
5. James Lancashire, shore side witness to capsize
6. Christina Mary Kahn, shore side witness
7. John Beaton, managing director of Caldive Limited who carried out the underwater video survey of FV Aquila

8. Christopher Pendlebury, yachtsman on the “Arran Comrade”
9. Alan Fyfe, Yachtsman on the “Storm Wind”
10. Flight Lieutenant Michael Rodgers, controller at Aeronautical Rescue Co-ordination Centre Kinloss
11. Flight Sergeant Euan Gibson, winchman and state registered paramedic, formerly stationed at HMS Gannet
12. Lieutenant Commander Martin Ford, senior observer, formerly stationed at HMS Gannet
13. Robert Hunter, member Kilchoan Coastguard Rescue Team
14. Dennis Eddie, deputy coxswain, Mallaig lifeboat
15. Stuart Griffin, navigator, Mallaig lifeboat
16. Dr Rosslyn Rankin, consultant pathologist
17. Peter Leyburn, coastguard watch assistant, MRCC Clyde
18. Rose Ann Bowes, coastguard watch officer, MRCC Clyde
19. George Freeburn, coastguard watch officer, MRCC Clyde
20. David Eakin, coastguard watch officer, MRCC Clyde
21. Tarik Yassin, coastguard watch manager, MRCC Clyde
22. David Smith, coastguard watch officer, MRCC Stornoway
23. Simon Price, winchman paramedic, Canadian Helicopter Corporation, Stornoway
24. Carol Campbell, coastguard watch officer, MRCC Stornoway
25. Captain Mike Evans, Inspector for Marine Accident Investigation Bureau

The Inquiry heard from the following witnesses called by the Maritime and Coastguard Agency:

1. Douglas MacDonald, Deputy Chief Coastguard, Maritime and Coastguard Agency
2. Dr Francis St Clair Golden, expert on cold water survival

No other witnesses were called.

The FV Aquila

The Inquiry heard from a number of witnesses that the FV Aquila was a good fishing boat, both in construction and in the way that it was maintained. I heard from Professor Nick MacWhirter, a member of the Royal Institute of Naval Architects, who had been commissioned by the Maritime Accident Investigation Branch (MAIB) of the Department of Transport, to determine the stability of Aquila at the time of the accident. An extract of his report is included as annex B to Crown Production 15, which is the Report by the MAIB on the investigation of the capsize of the fishing vessel Aquila.. Professor MacWhirter told me that this was the tenth report that he had been commissioned to prepare for the MAIB. He explained that despite the fact that Aquila was under 12 metres in length and therefore not subject to the stability requirements set out in the Fishing Vessel (Safety Provisions) Rules 1975, that, at construction, Aquila complied with the stability requirements set out in those Rules. Ballast had been added to the vessel in the intervening years which meant that at the time of the accident she no longer complied with those stability requirements, however, her non-compliance was marginal. He concluded in his report, having taken account of the conditions at sea on the date in question and the extra ballast added to the vessel since construction, that even if “Aquila had fully complied with the stability requirements, it was very probable that capsize would still have occurred.” I found Professor MacWhirter’s evidence on this matter very persuasive and accepted same. Subsequent to the capsize and the investigation into same, a flyer was issued to the fishing industry (Annex D to Crown Production 15) reminding the fishing industry that: “When planning to add ballast or making other modifications to a vessel, the effect of such action on a vessel’s stability should be properly assessed by a competent person.”

I also heard from Caroline Raeburn, an assistant enforcement officer with the Maritime and Coastguard Agency (MCA) in relation to inspections of Aquila that had been carried out by the Department of Transport Ship Investigation and Survey Team, and in particular an inspection on the 12th of February 2009, subsequent to which no action was required to be taken in relation to the Aquila and that the inspection on 12th February was “clean”(crown production 14). Timothy Rowley, the surviving crew member of the Aquila, could not have spoken more highly of the condition of the vessel and told me that general maintenance of the vessel was very important so far as the skipper Tony Hayton was concerned. Before they had gone to sea on the 17th July 2009 there was some maintenance work carried out on the engine and it was running smoothly.

The vessel was equipped with life jackets, a liferaft and an EPIRB (Emergency Position Indicating Radio Beacon). Both the liferaft and the EPIRB were correctly situated on the vessel in accordance with Maritime and Coastguard Agency guidelines (Captain Evans and Crown Production 15- in particular annex C, MGN 267 (F)).

Aquila dredged for scallops by towing two wire warps, one from each side, attached to which were steel spreader bars which each held seven dredges. The dredges consisted of a frame with a toothed bar at the front, to dig the scallops out of the seabed, with a collecting bag behind it. The bag was made of chain links forming a chain mesh on the bottom with netting on top. The dredges were towed astern of the vessel by the two warps, which were set at differing lengths to avoid the steel bars fouling each other as they were dragged across the seabed. On Aquila, at the time of the accident, the starboard warp was set to be 20 metres longer than the port warp.(Crown Production 15, the evidence of Captain Evans and Mr Rowley). I was told by Mr Rowley that the crew had changed the “swords” or “tooth bars” on the dredges on the morning of 20th July.

I am satisfied that there was nothing in the condition of the FV Aquila, or the equipment on board and in use on the vessel, which contributed to the deaths or any accident resulting in the deaths.

The Crew of the FV Aquila

On the 20th July 2009 the FV Aquila was crewed by Tony Hayton, the owner/skipper; Thomas Martin Sanderson, deck hand and cook; Peter Hilton, deck hand; and Timothy Rowley, winch operator and deck hand. Tony Hayton was an experienced sailor and skipper; Timothy Rowley told the inquiry that of all the skippers that he had worked for in his 8-10 years as a fisher man, that Tony Hayton ran the best boat and that he made sure that everything was just right with the boat before going to sea and when out at sea. I was told by Captain Mike Evans(Inspector of Marine Accidents with the MAIB and lead investigator into the capsizing of FV Aquila) that Tony Hayton was an experienced fisherman who had owned Aquila for 12 years and had been a fisherman for 26 years. Mr Hayton had also attended the following statutory training courses:

Fire-Fighting, 24th March 1983

Sea Survival, 25th March 1983

First-Aid, 10th May 2001

Safety Awareness, 10th May 2007.

Timothy Rowley gave evidence that he had also attended courses on first-aid, fire fighting, sea survival and safety awareness. He had to produce certificates as proof of attendance on these courses to Tony Hayton prior to working with him on Aquila. He also confirmed that the remaining two crew members had also attended these courses and had certificates to confirm that (it was confirmed by Captain Evans in his report-Crown Production 15-that all the crew had attended the requisite statutory training courses). The four men were all self employed experienced fishermen and had sailed together on the Aquila for over 2 years.

Mr Rowley told the Inquiry that Aquila had fished in various grounds off the west coast of England and Scotland, usually making fishing trips of 10 days, returning to harbour to land the catch mid-trip. He told me that the skipper knew where the scallops were and when. At the time of the accident the Aquila was fishing in grounds between Jura and Skye, landing at Oban or Mallaig.

Eric McIlwraith told the inquiry that he was the skipper/owner of FV St Apollo, a scallop dredger, having owned the vessel for 14 years. He had been friends with Tony Hayton for nearly 20 years and they would fish together. Having discussed where to go they would leave port and return together. He had no concerns about Tony Hayton's seamanship and Mr Hayton was not known as a person who took risks.

I am satisfied that there was nothing in the actings or conduct of the skipper or crew of the Aquila which contributed to the deaths or any accident resulting in the deaths.

The Capsize of the FV Aquila

The FV Aquila had landed at Mallaig on the 16th July 2009 and went back to sea on the morning of 17th July 2009. The Inquiry was told by Mr Rowley that they fished off Coll, Muck and Eigg before moving to grounds at Bo Faskadale reef on 20th July 2009. At approximately 16.30 on that date the Aquila started towing in approximately a south easterly direction. The wind was force 5-6 from a south easterly direction and sea conditions were described as choppy by both Mr Rowley and Mr Lancashire. Mr Rowley told us that the conditions were of no concern to him and in fact that Mr Hayton had assessed the weather and sea conditions at the time and stated that if the conditions worsened they would seek shelter. Mr Rowley agreed with that assessment. Captain Evans made no criticism of Mr Hayton for either fishing on Bo Faskadale Reef or for fishing in the conditions that prevailed at the time.

The Inquiry was told by Mr Rowley and Mr McIlwraith that Bo Faskadale Reef was an area well known for snagging and that it was known as "Bo Fastadale Reef" because of the frequency of gear becoming snagged. Snagging can occur in any conditions and is part and parcel of scallop dredging off the west coast of Scotland. Mr Rowley and Mr McIlwraith described the actions that required to be taken when snagging occurs: to free a snag the skipper will firstly take the vessel out of gear, that generally rights the boat; sometimes the skipper will require to put the vessel back into gear and the vessel will pull off the snag; sometimes the winch requires to be operated and in those circumstances the vessel is knocked out of gear and she is lifted off the snag with the winch. I was told by Mr Rowley that the vessel had become snagged on an earlier tow at the reef that day and that Mr Hayton had taken the correct measures to free the gear from the snag.

Shortly after that earlier snag a further snag occurred. Mr Rowley was in the galley with the other crew members at that time having a coffee. He told me that the skipper knocked the engine out of gear to free the vessel, however she came hard fast, yawed and heeled to starboard and immediately capsized. Captain Evans told the inquiry that the actions of Tony Hayton were as he would have expected and that there was no criticism of Mr Hayton in this regard. MCA production 4 is a Marine Guidance Note 415F- Fishing Vessels: The Hazards Associated With Trawling including Beam Trawling and Scallop Dredging. That note states at Paragraph 5.1:

“ It is clear from speaking to experienced fishermen that there are no standard answers on what action a skipper should take when a vessel is restricted by snagging on a fastener. Only the experience of the skipper and his correct actions at the time and in the circumstances experienced will result in success.”

The nature of the snag that took place was extremely unusual. I heard evidence from John Beaton, the managing director of Caldive Ltd. His company had been instructed to carry out a video survey of the FV Aquila on the instruction of Sunderland Marine Mutual Insurance Ltd. The MAIB had also told Mr Beaton “the kind of things that they really needed to know”. The survey took place on 22nd July 2009. Crown production 18 is a series of photographs taken of the upturned FV Aquila and Crown production 19 is the report prepared by Caldive as a result of the survey. During the course of Mr Beaton’s evidence I was shown the video survey. What was apparent was that the cause of the snag was a very flat rock lying almost flush with the sand on the seabed. The slab was about 3 metres long, flush into the seabed at one end rising to about 200mm above the sand at the other end. The area around this rock was “sand sloping to the west” and both towing wires (warps) had become fouled on this “flat” rock.(Crown production 15, page 12, figure 5, shows a picture of the starboard warp snagged on the rock). There were no other rocks of any size in 30 metre radius from the snagging - “....it would be near perfect dredging, you know, scallop dredging seabed, because it is sand free of rocks and obstructions”. (More particularly shown in figure 12 on page 20 of crown production 15)

At the time of the initial dive Mr Beaton had only seen the starboard wire snagged on the rock but when he recovered the dredges from the seabed he discovered that the port wire had been buried under the starboard wire. He gave evidence that as the vessel had turned, the wires had slackened and a loop of wire had been created and been dragged along the seabed, before the tension had been taken back up on the wires, they had fouled on the raised section of rock (page 46). He had expected to discover that “the dredges, or one of the dredges, jammed into a rock fissure....” However the dredges were sitting on the sand and hadn’t snagged on anything.

He went on to say : “Even now I am staggered with the fact that this small raised section of rock was able to actually catch both wires. You know, it was.....it just happened to be in exactly the wrong place for the vessel making that turn at that time.” Captain Evans was questioned about the 2nd warp being found as this had not been mentioned in Mr Beaton’s report (crown production 19). He was asked whether the discovery of the second warp affected the MAIB conclusions as to the cause of the capsized. He was clear in his evidence that the cause of the capsized was as set out in the MAIB report (crown production 15) namely that “the cause of the accident was the snagging of the starboard warp” and that the other warp was most probably dragged around when the tide had turned. Captain Evans also told the Inquiry that the type of snag that occurred was so unusual that the MAIB had never come across anything like it before (page 128 day 14).

Mr Nickson, solicitor, did suggest that caution should be exercised by me in considering the evidence of Mr Beaton as he was only a diver and not a Marine Accident Investigator. I was however impressed by his evidence and when combined with the evidence provided by Captain Evans (which Mr Nickson had not heard) and the terms of the MAIB report, was satisfied that Mr Beaton’s evidence was reliable.

Mr Rowley described water gushing through the galley door and the vessel being upside down within seconds. He realised immediately how serious the situation was and said to Martin and Peter “we are not going to die here”. He was closest to the galley door and pushed himself out. The others must have followed. None of them were wearing life jackets and Mr Rowley gave evidence that if he had been his ability to escape from the upturned vessel would have been greatly hindered. When he surfaced he saw Tony Hayton in the distance, he was moving at that time and was conscious. Mr Rowley told the inquiry that the water was freezing but, because he was being dragged down, he kicked his boots, his trousers and socks off. He then saw Thomas Sanderson face down in the water, he had already passed away. He swam to Peter Hilton, he found two planks of wood and some twine floating in the water and tried to tie himself to Thomas and Peter. Thomas got loose and floated away and after a while Peter died in his arms. He explained that the capsized had happened so quickly that there was no time to transmit a May Day signal. The EPIRB and Life raft had failed to surface. The video taken by Mr Beaton showed that the EPIRB and the life raft had both released properly but had become tangled under the vessels wheelhouse roof.

Mr Rowley gave evidence that it seemed to him that it was about 15-20 minutes later that he heard a noise and turned and saw a man on a yacht. This was Mr Christopher Pendlebury on board the sailing yacht “Arran Comrade”. Mr Rowley was then rescued by Mr Pendlebury at about 18.00 BST, approximately 1 hour and 20 minutes after the vessel had capsized.

At around 18.50 BST Thomas Martin Sanderson's body was recovered from the sea by Rescue helicopter R100.

At around 19.24 BST Alan Fyfe on board the yacht "Storm Wind" sighted Tony Hayton's body, which was recovered from the sea shortly thereafter by Rescue helicopter R177.

At around 20.20 BST Mallaig lifeboat located the body of Peter Hilton and at 20.35 recovered it from the sea.

I heard evidence from Doctor Francis St Clair Golden an expert in cold water survival. A report was prepared by him to assist the inquiry and is MCA production 13. In that report the full details of his qualifications and expertise are noted and there is no need to repeat those here, it is sufficient for the purposes of this determination to state that he was an impressive witness and that his evidence was of great help to the inquiry. In his opinion each of the deceased had suffered from "Cold Shock"; that is the " sudden stimulation of the cold on the skin causes this very rapid, a gasp response followed by very rapid breathing, both associated with an increase in blood pressure, an increase in heart rate and the increased distribution of blood to the internal part of the body."(page 78 day 17) He felt that based on Mr Rowley's description of Mr Sanderson immediately after the capsizing that Mr Sanderson had been incapacitated by cold shock that led to aspiration and drowning. The problems experienced by him as a result of the cold shock combined with his heart condition were more likely to cause incapacitation. He concluded that Mr Sanderson only survived for about 5 minutes after the capsizing. In respect of Tony Hayton he acknowledged a mistake in his report when he had referred to him as being of "slight body build" and apologised for that. Mr Hayton had suffered some traumatic experience-evidenced by the bruising that he had sustained. Again the effect of cold shock combined with his coronary condition led him to the conclusion that he would not have survived for very much longer than Mr Sanderson. Peter Hilton also suffered from cold shock. From the evidence of Mr Rowley it was clear that Mr Hilton survived for a little longer but that despite the heroic efforts of Mr Rowley he too drowned. He concluded that he probably died within about 30 minutes. Most people would only have survived for half an hour and he would not have expected people to survive much beyond an hour in the conditions unless they had a really good fitting life jacket and were conscious enough to be able to make arm movements to keep their backs to the waves. (page 120 day 17)

The survival feat of Timothy Rowley put him in the top 10 percentile of immersion victims not wearing life jackets.

I heard evidence from Dr Rosslyn Rankin, consultant pathologist, who confirmed that she had carried out post mortem examinations on each of the deceased and her reports are fully set out in Crown productions 1, 3 and 5.

Thomas Martin Sanderson died from drowning. He suffered from coronary artery atheroma and this possibly contributed to his death. Tony Hayton died from drowning. He suffered from coronary artery atherosclerosis and this possibly contributed to his death. Peter Hilton died from drowning. Tests were carried out for the presence of alcohol in each of the deceased's blood and urine, and these were negative – crown productions 2, 4 and 6.

It was suggested to me by Mr Park on behalf of the MCA that a reasonable precaution which might have prevented the accident, would have been not to have trawled on the reef in the prevailing conditions and that it would have been a reasonable precaution to have a crew member standing by the winch on the vessel so that, in the event of a snag, the gear could be released quickly. It was suggested to me by Mr Nickson that the Aquila should not have been trawling Bo Fascadale reef in the prevailing conditions which were, in his submission, a following swell on an incoming flood tide. I did not consider that the evidence led could lead to such conclusions and I paid particular regard to the evidence given by Captain Evans and Mr Rowley in reaching that conclusion. Captain Evans was quite clear when he described as a nonsense the suggestion that fishermen should only fish into the wind. Captain Evans also pointed out that on the Maritime charts in use at the time there was no indication of the possibility of what are known as “standing waves” occurring at the location of the capsized. That has been rectified and the charts now reflect the possibility of “standing waves” occurring in the area. A Flyer was issued to the Fishing Industry subsequent to the capsized- Annex D of Crown Production 15-reminding them of the Safety Issues involved with scallop dredging.

The Rescue Operation and Coastguard Actions

On 20th July 2009 Mr James Lancashire was on holiday in the Kilmory area. He had noticed from time to time throughout the day a fishing boat going back and forward. Later in the day he noticed the vessel again, he thought that he saw a wave coming from the left hand side and the vessel pointing towards him, it was white and blue and then it went dark brown. It took him about 30 seconds to process what he had seen and then he realised that the vessel must have capsized. He had no phone signal on his mobile phone so got on his bike and pedalled as fast as he could to get back to the croft in which he was staying. There was nobody else about, this is a very remote area. On arriving at the croft He got his binoculars from the car, saw it was a boat and immediately dialled “999”. This was at 17.03 BST, about 15 minutes after he had seen the boat capsized. He was put through to the coastguard and told them that he was at Kilmory on Ardnamurchan and that he had seen a trawler capsized. He then passed the telephone to Mrs Mary Kahn, the householder, to give

clear instructions. This was all recorded and noted in crown production 12, a transcript of an extract of recordings made on the “Freedom Recordings” system, relating to communications between MRCC Clyde and MRCC Stornoway and various external agencies and persons in relation to the capsize of Aquila and subsequent rescue mission. Mary Kahn then gave a precise location of where they were and even took the time to spell out “Bo Faskadale”.

Having received this information MRCC Clyde immediately tasked rescue helicopter R177 to attend at the scene. R177 is based at HMS Gannet, a land based naval base at Prestwick Airport on the West coast of Scotland. They did this by telephoning the Aeronautical Rescue Coordination Centre (ARCC) at Kinloss. The Inquiry was told by Flight Lieutenant Michael Rodgers, one of the controllers at ARCC Kinloss and an RAF officer, that there was an overturned vessel off the village of Kilmory in the Sound of Jura to the east of Jura between Jura and the mainland; this despite the very clear location details provided by Mr Lancashire and Mrs Kahn. When Clyde discovered that the incident had taken place out with their area of jurisdiction, Tarrik Yassin, the watch commander at Clyde, stood down R177 and decided to transfer coordination of the incident to MRCC Stornoway. This was at 17.08 BST. The decision to stand down R177 was questioned by Flight Lieutenant Rodgers and he asked Clyde whether a helicopter would be required and was told “not at this time”. As it transpired, when ARCC Kinloss were given the correct co-ordinates at 17.16 BST they were able to calculate a flight time to the location. The Flight time for R177 was 49 minutes and for R100 (the rescue helicopter based at Stornoway) was 42 minutes. ARCC Kinloss were led to believe that having stood down R177, that MRCC Clyde had tasked R100 direct, however at 17.21 when ARCC Kinloss spoke to Stornoway R100 had not yet been tasked. At 17.21 R100 was tasked. Flight Lieutenant Rodgers told me that if MRCC Clyde had given him the new coordinates at 17.08 and had said that a helicopter was required, then he would have advised to keep R177 going. I also heard from Flight Sergeant Euan Gibson, the winchman on R177 on 20th July 2009. He told the Inquiry that whilst the target time for take off from point of scramble was 15 minutes, that was an outside time and that the take off time was in reality nearer 5 or 6 minutes. When R177 were told directly by MRCC Clyde to stand down they questioned this telling Clyde that they were about to lift off, within 1 or 2 minutes.

Lieutenant Commander Martin Ford told me that he had been in the Royal Navy for 31 years and been involved in search and rescue for 7 years and that on 20th July 2009 he was the aircraft commander on R177. When they were stood down he contacted Clyde for the new co-ordinates to allow a new ETA at the new location to be provided and to give Clyde the opportunity to review their decision to stand down. He was given a latitude and longitude and provided an estimated flight time of 45 minutes and told Clyde that he was 2 minutes from lifting off. Clyde still stood them

down. Lieutenant Commander Ford then used the scramble phone to contact Kinloss and give them the revised ETA, he kept the aircraft running and the crew on board but the stand down order was confirmed as Clyde had told Kinloss that R177 was no longer required. He gave evidence that he had been calculating as the incident was ongoing, that the actual incident was about mid-way between Prestwick and Stornoway and that whilst Stornoway's aircraft was faster that R177 had a tail wind, and from a standing start he felt that both aircraft would have arrived at the incident at about the same time. He was concerned that by 17.30 BST it appeared that R100 had still not been tasked. It was explained that at the time of the incident Stornoway's search and rescue helicopter was controlled by Stornoway and Kinloss required to request the use of a helicopter from the coastguard if required.

The work instructions for the Co-ordination and Termination of Search and Rescue (SAR) Action in force on 20th July 2009 are contained within the Maritime and Coastguard Agency (MCA) productions 8 and 9. Paragraph 1.1.2 of production 8 states:

“The Initial Action Station is the CO-ordination Centre, Sector Base, CRV or Coastguard Rescue Station observing or receiving initial notification of a casualty or potential distress situation. The Initial Action Station is responsible for initiating immediate search and rescue action. Depending on the type of casualty or incident, the Initial Action Station's response is to :

- a take immediate SAR action within the capability of local SAR facilities available and /or
- b pass the casualty information by the quickest means to a co-ordination centre.”

Mr Yassin at MRCC Clyde reacted promptly and appropriately in tasking R177. However, when he discovered that the vessel was out with Clyde's jurisdiction he stood down the helicopter.

Section 6(1)(e) (i)

The Air Rescue Co-ordination Centre (ARCC) should be responsible for the tasking of all Search and Rescue (SAR) helicopters. This will avoid the confusion, and subsequent delay resultant from that, caused by tasking of SAR helicopters by individual Coastguard stations.

Paragraph 1.4.1 read in conjunction with paragraph 1.2 made it clear that having tasked R177 that Clyde should not have contacted ARCC to stand her down. There was no foundation for the statement made through Clyde when questioned about the request to stand down that there was no requirement for a helicopter yet.

Mr Yassin in his evidence to the Inquiry told me that he had been with the coastguard for a total of 16 years and had been a watch manager for about 11 years, he was also qualified as a Search and Rescue Mission Co-ordinator (SMC). It was obvious in the manner in which he gave his evidence that he felt that, at the time of the incident, he was following correct procedure. On 20th July 2009 at

17.03 BST, Peter Leyburn, coastguard watch assistant, with 10 years experience, received the initial 999 call from Mr Lancashire. When a 999 call comes in a specific noise alert is made to warn all those on duty in the Operations room that a 999 call has been received. At that time Mr Yassin was already busy dealing with 2 other incidents. There were 3 other members of the watch team on duty that day at Clyde: Rose Ann Barnes, watch officer with 15 years experience, who was on a tea break when the call came in; George Freeburn, watch officer with 7 years experience, who was monitoring the channel 16 desk (the channel used for distress signals); and David Eakin, watch officer with a total of 24 years experience, who was dealing with the tail end of another incident, taking telephone calls and monitoring VHF channel "0" (the coastguard private frequency used by coastguard and SAR units). All of the officers on duty at Clyde on 20th July 2009 were experienced.

Mr Yassin was listening to one side of the call that Mr Leyburn was dealing with whilst at the same time dealing with 2 other ongoing incidents. Mr Yassin heard "Kilmory" and assumed it was Kilmory on Arran and David Eakin also pointed out on a chart Kilmory in the Kintyre area; Mr Yassin also heard the word "capsize" and immediately told Mr Eakin to task R177. Mr Eakin contacted Kinloss and tasked R177. It was Mr Yassin's intention to give the helicopter the exact location of the incident just as soon as it was known to him, however he told me that the important thing was to get the helicopter tasked. It was then discovered by Mr Yassin that the Kilmory in question was off the Ardnamurchan Peninsula. At 17.08 BST the grid reference for the incident was changed and Mr Yassin worked out that R100 at Stornoway was 5 miles closer to the capsized. He decided that as R100 was a faster unit, as the area of the capsized was a bad area for radio coverage for Clyde, as it was already a busy day for Clyde and there was the possibility that R177 might be needed by them and because the capsized was not in their jurisdiction, to stand down R177. He did so by telling ARCC Kinloss that a helicopter was not required yet. He did not provide details to Kinloss of the location of the capsized in order that they could assess whether a helicopter was required. He did not either directly task R100 through Kinloss or ensure that MRCC Stornoway were told that R177 had been stood down and that R100 would need to be tasked immediately. A telephone call was made by Peter Leyburn, at about 17.12 BST, to MRCC Stornoway in which he indicated that R177 was just getting airborne and Stornoway acknowledged that. During the course of that call Mr Leyburn was made aware that R177 had been stood down and although he tried to tell Stornoway about this, by the time he tried to tell Stornoway, they had hung up. Clyde should have made sure that Stornoway had acknowledged this situation to enable the tasking of R100 to take place. As it was R100 was not tasked until 17.22 BST and was airborne by 17.35 BST. This resulted in a delay of 23 minutes in a helicopter reaching the location of the capsized.

It was clear from the evidence given to the inquiry by Captain Evans and the MAIB report that R177 should not have been stood down by Clyde. I also heard evidence from the Deputy Chief Coastguard Douglas MacDonald; he is responsible in the MCA for, amongst other things, Search and Rescue standards and technical equipment. He gave unequivocal evidence that R177 should not have been stood down by Clyde (page 34 day 16).

As a result of the tragic events of 20th July 2009 a review has been undertaken by MCA and arrangements are now in place, with effect from 1st April 2010, to make ARCC the single tasking authority for SAR helicopters. It is hoped that this measure will ensure that the situation re the tasking and standing down of a SAR unit and subsequent delay in a SAR unit arriving at the scene of an incident will not be repeated.

Section 6(1)(e) (ii)

The Co-ordination and control of live incidents should be retained by the Initial Action Station. If transfer is appropriate for whatever reason, that transfer should be conducted following upon a full assessment of the location of the incident, the VHF radio coverage in the area of the incident and the staffing levels and capability in the respective stations. The Initial station should retain control until all such checks have been carried out and it is agreed fully with the transfer station that they are prepared to accept the transfer. Any verbal transfer of co-ordination must be followed up as soon as possible with written confirmation of the transfer including full details of the incident and full reasons why the transfer is appropriate.

Mr Yassin was the Watch Manager at Clyde and it was his decision to transfer co-ordination of the incident to Stornoway. MCA production 8 sets out the procedures in force on 20th July 2009 for transfer of co-ordination of ongoing incidents between coastguard stations. Mr Yassin gave evidence that he was familiar with this document and had received training during his Search and Rescue Mission Co-ordinator (SMC) course the previous year in relation to the procedures set out within MCA production 8. At paragraph 1.4.1 it states:

“It is not normally desirable to change responsibility for the overall co-ordination of an incident that is in progress.”

However circumstances can exist where transfer will be appropriate. It was clear from the evidence heard in particular from Douglas MacDonald, that this was not one of those occasions. He gave evidence that:

“In this case I would suggest that the best course of action would be to keep the Clyde helicopter deployed to the incident and use a Stornoway aerial to do the initial co-ordination. Then if it transpired....that it was appropriate to hand co-ordination across to.....Stornoway, it should have

been done in a measured way rather than the rushed way it was on the day of the accident.” (page 76-77 day 16)

The technology existed whereby Clyde could have utilised the “call connect system” to takeover Stornoway’s aerial near the location of the capsized, thus getting around any communication problems with SAR assets and allowing Clyde to co-ordinate the incident. Mr Yassin gave evidence that he was aware of that facility but was not comfortable with using it. Training of all watch managers in the utilisation of communication systems available to them should be constantly reviewed by MCA. Further technology was available to all coastguard stations in the UK Apart from Stornoway whereby one MRCC can dial into another MRCC’s communications system without the host MRCC having to do anything. The reason that Stornoway cannot utilise this is because 6 telephone lines require to work concurrently and the local BT exchange at Stornoway does not have the infrastructure to cope with this. This was addressed by the MCA in MCA production 26 and in particular I was told by Mr MacDonald that the system was being upgraded in order that they would not have to go through the BT exchange. I was told that the change would be comparable to the difference between “dial up” and “broadband”. There have been funding delays(page 39 day 17) but it was hoped that Clyde’s upgrade would happen in summer 2011 and Stornoway’s in Autumn 2011.

It was clear from MCA production 8 and the evidence led from Mr Yassin and Mr David Smith, the receiving coastguard watch officer at Stornoway, that procedures for transfer were not correctly followed and that time was clearly lost in the Search and Rescue operation as a result of those failures.

I was able to listen to the recordings of the various communications between Clyde, Stornoway, the on scene witnesses, the SAR units and others who assisted in the SAR operation. The impression gained from the initial communications was one of a desire by Clyde to transfer co-ordination to Stornoway as soon as it was discovered that the incident was out with Clyde’s jurisdiction- not with standing the evidence given by Mr Yassin that he considered a number of issues relevant to the transfer, it was apparent to me that the only consideration taken into account was that, as the incident was out with Clyde’s patch by 5 miles, it was Stornoway’s responsibility. David Eakin also confirmed in evidence that his understanding was that as soon as Mr Yassin found out from Mr Leyburn that the location was outside Clyde’s patch that he was asked to stand down R177. My view of the evidence given, and upon listening to the recordings, was that this consideration may well have been the only consideration in Mr Yassin’s mind at the time of transfer. I was not satisfied that either Mr Yassin or Mr Smith gave proper consideration as to whether the transfer of co-ordination of the Search and Rescue Mission was appropriate.

On the basis of the evidence given to the inquiry by Mr Leyburn, Mr Yassin, Mr Smith and the Acting Watch Manager at Stornoway Carol Campbell, combined with the recordings of the telephone calls I cannot understand why there was any confusion about where the location of the incident was. Neither Captain Evans or Deputy Chief Coastguard MacDonald could understand how any confusion could have arisen. Mrs Kahn had made the location very clear. Mr Yassin was aware of a number of Kilmorys and could not explain why he did not seek clarification from Mr Leyburn which Kilmory was being referred to. He should have done that immediately on hearing the place name Kilmory. Having taken the decision to transfer, Mr Yassin should have made sure that all the information about the locus of the incident and the tasking and standing down of R177 was transmitted verbally in clear terms to Stornoway and acknowledged by them. He should have followed the verbal transfer up with confirmation in writing of all the details of the incident known to Clyde as per the document annex A to MCA production 8. He did neither of these.

Peter Leyburn spoke with David Smith, the watch officer at Stornoway. Mr Smith agreed in that conversation to take over co-ordination of the incident. Very little information was sought by David Smith from Peter Leyburn but what was clear was the approximate location of the incident.

After verbal transfer had taken place a message was received by Stornoway that R177 had been tasked. This caused Mr Smith to telephone Clyde and question whether Stornoway had taken over co-ordination or not. It was confirmed in that call that Stornoway were the co-ordinators and Mr Smith concluded his side of the call and hung up before the information was given that Clyde had stood down R177. Mr Smith was subsequently told that R177 had been stood and rather than initiating an immediate SAR response he decided that he had to speak to Mrs Kahn to get confirmation of the location of the incident. No satisfactory explanation was provided by Mr Smith for adopting this course and wasting further time. The delay of 23 minutes in a helicopter reaching the incident was entirely due to procedures being followed incorrectly by both Clyde and Stornoway.

What was also clear to Mr Smith was that despite there being only 3 officers on duty at Stornoway, no consideration was given by him to asking Clyde to retain co-ordination as Stornoway were undermanned. Nor did he seek the advice of the acting watch manager prior to taking over co-ordination; in any event Ms Campbell gave evidence that she was happy to take over co-ordination even based on the restricted information sought and provided in relation to the incident. Stornoway normally had 4 or 5 staff on duty but on 20th July there were only 3 staff on duty, 3 watch officers one of whom, Carol Campbell, was acting up as watch manager.

As a result of the MAIB report the MCA reviewed their procedures on the transfer of incidents from one MRCC to another.

Section 6(1)(e)(iii)

The Maritime and Coastguard Agency should review their training procedures to ensure that sufficient training is provided to watch managers and those who might act up as watch managers in Staff Planning and Risk Evaluation.

Carol Campbell had been responsible for the review of the “Watch Staffing Planning and Risk Evaluation Form” (MCA production 27). This was a staffing and risk assessment for watch D at Stornoway on 20th July 2009. The suggested staffing level was for 4 or 5 members of staff to be on duty- 1 watch manager, 2 watch officers and 1 or 2 watch assistants. The staffing level required for the shift was 1 watch manager, 1 watch officer and 2 watch assistants. As mentioned before, the staffing level achieved was 3 watch officers with 1 acting up as watch manager. Carol Campbell very sensibly realised that the watch might be short staffed in the event of an incident and noted that:

“During watches of reduced manning, in the event of incidents requiring search planning, this duty will be delegated to flank stations.”

Mr Smith gave evidence to the Inquiry that he was unaware of the contents of MCA production 27. Ms Campbell also told us that in her training as SMC and Watch Manager she had received no training in risk assessment.

Ms Campbell gave evidence that Stornoway tried on 3 occasions to carry out search planning but because they were so short staffed they failed to do this. It was only when contacted by Clyde some 1 hour and 20 minutes (18.30 BST) after Stornoway had taken over co-ordination of the incident and asked if there was anything they could do to help did Stornoway ask Clyde to do the Search plans. Ultimately no final search plans were issued and each of the units on scene at the incident, to all intents and purposes, worked out their own search planning.

It was clear from the recordings heard and the evidence given that Stornoway were not coping well with the co-ordination of the SAR mission. It was not accepted by Ms Campbell that co-ordination of the incident ever got out of control. It was accepted by Carol Campbell that the watch was short staffed and she could not fulfil her role as Search and Rescue Mission Co-ordinator as she was having to do so many other things:

“Although I was SMC for the incident, it was almost impossible for me to fulfil that role because I was functioning as an operator, so in order to be an SMC you really need to stand back and not get

involved in the communications, but I was trying to fulfil both roles as best I could.” (page 112 day 12).

She went on to confirm that short staffing had been a “big problem”. She could not satisfactorily explain why then Stornoway firstly accepted co-ordination and secondly, having so accepted, why she had not sought greater help from flank stations. She did offer as a reason that she felt that Stornoway would be better placed to deal with communications in respect of tasking the various rescue units however, as it was, a great deal of communications and tasking was dealt with by Clyde because their communications were better and in any event Clyde could have utilised the “call connect” system to co-ordinate the SAR operation. She did ultimately accept that Clyde could have retained control and Stornoway could have provided assistance, however her evidence was that if the incident were to happen again she would not do anything differently.

This is a matter of concern that should be addressed by the provision of adequate training in relation to Watch Staff Planning and Risk Evaluation.

Section 6(1)(e)(iv)

Training is required to be given by the MCA to coastguard watch managers and officers in regard to the timing of the broadcast of Mayday relay signals, the circumstances in which such signals should be repeated and the circumstances in which a Mayday Silence should be broadcast.

A Mayday relay should have been sent immediately on receiving the report of the incident and should have been repeated at regular intervals to ensure that it had been picked up by other vessels in the area of the incident. A Mayday Silence should have been broadcast in order that routine radio traffic did not interfere with the search and rescue mission.

I heard evidence from both Captain Evans and Deputy Chief Coastguard MacDonald that one of the first things that should be done in an incident of this type is that a Mayday Relay should have been broadcast to alert other shipping in the area of the incident and of the need for help. As it was the Mayday was not transmitted until 17.32 BST. Not only should it have been transmitted at an early stage but it should have been repeated on a number of occasions until such time as there were sufficient units in attendance in the area of the incident. Mr Pendlebury told the inquiry that he had managed to pick up part of the Mayday relay broadcast but not it all and he had tried to get clarification of the details of it but because of poor VHF reception in the area had given up on that. It was only by good fortune that he had come across Mr Rowley in the water. If the Mayday had been repeated then perhaps Mr Pendlebury and others might have been able to reach the location

more quickly. Mr Yassin accepted in evidence that a Mayday relay should have been transmitted at a very early stage however neither Mr Smith or Ms Campbell accepted that a Mayday relay was one of the first things that should be done-notwithstanding the MAIB report. Captain Evans was quite clear that every minute counts when someone is in the water and that it was good practise to repeat a mayday transmission (page 208 day 14).

During the course of the incident Stornoway continued to receive routine non distress calls, calls from the press re the ongoing incident and the like. As mentioned previously, because Stornoway was undermanned on the D watch on 20th July 2009, it was finding it extremely difficult to cope with the volume of calls they were receiving and the tasks that they had to perform. Despite this, Ms Campbell did not then, or at the time of giving evidence, accept that she should have put out a “Silence Mayday”. The effect of such a signal would have been to cut down calls to those of an urgent type in relation to the incident. Both Captain Evans and Deputy Chief Coastguard MacDonald considered that a “Mayday Silence” should have been transmitted. Mr MacDonald went on to say that he accepted that training and re-training in the use of Mayday Silence was necessary. This should be dealt with in the SMC course and retraining should be mandatory however I was told by Mr MacDonald that Negotiation was required through the trade union in order to make such re-training mandatory. Mr MacDonald was of the view that if Ms Campbell had followed her own Risk assessment plan and broadcast a Silence Mayday that Stornoway would have been able to co-ordinate the incident despite their reduced manning level. It was of note that at the end of the incident, there having been a change of watches at 20.00BST, a “Silence Mayday Fini” was broadcast by the new shift on the assumption that a “Silence Mayday” had been broadcast by watch D.

As a result of the mis-management of the transfer of this incident the MCA issued an Operational Advice Note- MCA production 10. I do not propose to repeat here the terms of the advice note in full except to say that the purpose of this note was to emphasise that the MRCC receiving the distress/urgent call should initiate SAR response and maintain co-ordination if they have effective communications. However a flaw in this Advice note was pointed out to Mr MacDonald when he was giving evidence in that it did not actually instigate a new procedure. The Advice note Reads: “New Procedure

3. When an MRCC is notified about a distress/urgency incident and there is any doubt or ambiguity about whether the incident location is within the MRCC boundary, the first recipient MRCC shall initiate SAR response.”

It was accepted and noted by Mr MacDonald that for the “new procedure” to be “new” the words : “and there is any doubt or ambiguity about whether the incident location is within the MRCC boundary,”

would require to be deleted, making it mandatory for the initial MRCC to initiate the SAR response. The Advice note then satisfactorily deals with the remaining problems highlighted as a result of this unfortunate incident in relation to the transfer of incidents between MRCCs.

Mr MacDonald was questioned about what seemed to be a breakdown in compliance with procedures in existence at the time of the incident. He accepted that this breakdown had happened. He explained that part of the reason for that had been industrial action that had been ongoing for about 4 years; that action had meant that for about 4 years the MCA operational standards and assessment checks had not been participated in by coastguards. These checks would have consisted in a team going around coastguard stations to ensure compliance with procedures (known as OSTA- operational standards and training assessment). These should have been carried out every 18 months but had not been done since 2007 for Stornoway. It was hoped that the planned restructuring of the coastguard would bring an end to this disruption.(pages 155-160 day16)

The Investigation by the Marine Accident Investigation Branch of the Department of Transport and the Response of the Maritime and Coastguard Agency

Crown Production 15 is the:

“Report on the Investigation of the Capsize of the Fishing Vessel Aquila with the Loss of Three Lives, Bo Faskadale Reef, Ardnamurchan, on 20th July 2009.”

The United Kingdom Merchant Shipping (Accident Reporting and Investigation) Regulations 2005- Regulation 5 states:

“The sole objective of the investigation of an accident under the Merchant Shipping (Accident Reporting and Investigation) Regulations 2005 shall be the prevention of future accidents through the ascertainment of it’s causes and circumstances. It shall not be the purpose of an investigation to determine liability nor, except so far as is necessary to achieve it’s objectives, to apportion blame.”

Captain Mike Evans was the lead inspector in this investigation and his report is fully set out in Crown production 15. Various aspects of the report have already been referred to throughout the

course of this determination and I am satisfied that in conducting their investigations that the MAIB have satisfied the objectives as set out in Regulation 5 above.

A number of safety issues were raised by the investigation and in so far as the MAIB are concerned all of these have been addressed. It is suggested in the concluding remarks of the report (3.1) that the “risk of trawl gear becoming snagged should have been assessed to ensure appropriate control measures were developed.” I would like to make it clear that in this instance it was accepted in evidence that in light of the experience of the crew, the evidence of Mr Rowley, the actions of Mr Hayton at the time of the snags, and the “freak” nature of the snag, that Mr Hayton did all that was possible in the circumstances. It was accepted in evidence that Mr Hayton by his very conduct on the date in question was assessing potential risks throughout the fishing operations that day (eg indicating that if conditions worsened they would stop trawling).

Section 6(1)(e)(v)

The Sea Fish Industry Authority should review the training courses run for fishermen in particular in relation to health and safety risk assessments of fishing in particular conditions and the consideration of the effects of adding ballast to their vessels. The review should consider the requirement for compulsory attendance and re-attendance at such courses.

It was identified that further training of fishermen will be required in risk assessment and the effects of adding extra ballast to their vessels and on the adverse effects on stability when trawling downwind in heavy seas. A flyer was issued to all fishermen in light of these points and was produced at Annex D to the report and the Sea Fish Industry Authority (the statutory body which deals with, amongst other things, the safety of fishing vessels and the development, support for and running of training and accreditation courses for fishermen) has agreed to:

“Stress the importance of undertaking appropriate risk assessments of trawl gear becoming snagged to fishermen attending its safety awareness training courses.

Include in it’s(sic) stability awareness course the importance of ensuring that a vessel’s stability is assessed by a competent person when modifications or additions are made.

Highlight to fishermen attending it’s(sic) stability awareness course, the adverse effects on a vessel’s stability when trawling downwind in heavy seas.”

No warning of the standing wave phenomenon that occurred at Bo Faskadale on the date of the capsize appeared on Admiralty maps. This has been dealt with by the United Kingdom Hydrographic Office and The Admiralty (4.2).

I have already dealt in detail with the problems caused by the confusion re tasking of SAR assets and transfer of control of co-ordination of SAR incidents. The Inquiry was told by Mr MacDonald of the MCA that arrangements were now in place to make ARCC the single tasking authority for SAR assets and that the shortcomings in the effective transfer of information and co-ordination of SAR incidents had been addressed (albeit subject to the further correction required as pointed out to Mr MacDonald during the course of his evidence).

Some time was spent by the inquiry in looking at the effectiveness of VHF communications and radio coverage in the area of the incident. Tarrik Yassin told the inquiry that he dreaded the thought of incidents happening in certain areas because they were radio coverage blackspots. There was evidence led that R177 had difficulties communicating with Stornoway and that the yacht “Arran Comrade” had been unable to pick up fully the Mayday signal broadcast and thereafter had been unable to contact Stornoway for clarification of the broadcast. The inquiry also heard on the recordings examples of incomplete and incomprehensible communications. As a result of all of this the MCA were tasked with conducting a review of VHF coverage in the area. They did this by firstly checking that the aerials used by Clyde and Stornoway (at Arisaig and Drumfern) were working and having satisfied themselves of that by running computer predictions of radio coverage in the area. The results of their investigations can be found in MCA production 20 at Annex B with reference to MCA productions 21, 22 and 23.

In his memo of 17th February 2011 (4 days prior to the 1st day of evidence being heard in this Inquiry), Keith Oliver, SAR resources manager with the MCA stated:

“The geography of the Western Isles will always present areas where VHF maritime radio coverage may vary.”

He went on to say that based on the line of sight prediction and VHF radio propagation prediction for the various remote radio sites and the Arran Comrade, communications should have been possible. In the tests carried out there was no attempt to replicate the position of the Arran Comrade to actually test out the signal and the Arran Comrade’s communications systems were not tested out. It was a matter of concern to me that the memo from Keith Oliver was dated 17th February 2011 and the MAIB report had been issued in April 2010. Mr MacDonald gave evidence in relation to the question of possible black spots and with reference to MCA productions 20-23 was able to show that in relation to the positioning of the aerials that were in existence at the time of the incident, the VHF coverage was as effective as it could be in the area of the incident. There was no evidence before the inquiry as to how communications of the type covered by the review of VHF communications might be improved and in any event, as explained above, the MCA are satisfied that VHF communications coverage in the location of the incident are as good as they will get.

Section 6(1)(e)(vi)

The Marine Accident Investigation Branch (MAIB) of the Department of Transport should bring into effect a formal system of reporting to ensure that all actions identified as requiring attention have been taken and any undertakings given in that regard have been complied with.

The MAIB highlighted in Sections 3 and 4 of their report (crown production 15) Safety Issues raised which had been addressed (at section 3) and Actions Taken/To Be Taken (at Section 4). No formal recommendations were made by the MAIB and accordingly no formal requirements were in place whereby the parties concerned had to formally report back on actions taken. I was surprised to note from Captain Evans that there was no formal follow up of those matters identified at sections 3 and 4 of their report by way of a requirement to report back by the MCA and Sea Fish Industry Authority to the Department of Transport as to actions taken. Rather, this was left to verbal assurances having been given by the parties that the matters raised had been dealt with. This is an unsatisfactory state of affairs. Even where no recommendations are made there should be in place a system of formal reporting to the MAIB of the actions actually taken by any party.

Concluding Remarks

At or about 16.40 BST on 20th July 2009 the Fishing Vessel Aquila capsized off Ardnamurchan on the Bo-Fascadale reef with 4 crew members on board. Timothy Rowley was rescued and Thomas Martin Sanderson, Tony Hayton and Peter Hilton all perished as a result of this tragic accident. The Rescue operation commenced at 17.02 BST on the 20th July, when the capsized was reported to MRCC Clyde by Mr Lancashire, and concluded later that day at 20.35 BST when the body of Peter Hilton was recovered from the sea. Notwithstanding all of the issues raised by me as a result of this Inquiry it is not possible to conclude on the basis of the evidence led that even if the initial tasking of R177 had not been cancelled and that all of the other matters raised had been dealt with correctly, that the lives of Mr Sanderson, Mr Hayton and Mr Hilton could have been saved.

The MAIB conducted a thorough investigation and reached conclusions as referred to above in this determination. The MAIB are satisfied on the basis of the assurances given to them that the matters raised in sections 3 and 4 of their report have been dealt with. I have raised other matters which

should be addressed in terms of Section 6 (1)(e) and it is hoped that once all of these matters have been fully actioned that the problems encountered on 20th July 2009 will not be repeated.

Fishermen risk their lives on a daily basis to put food on our plates, their job is an extremely dangerous one and I am full of admiration for the way in which they conduct themselves in carrying out their work. This tragic event led to the loss of three fishermen's lives. There was a survivor, Timothy Rowley, and it would be remiss of me not to commend him for the actions that he took on the 20th July 2009 and the way in which he relived that day in giving evidence to this Inquiry. It is also appropriate that the Inquiry should recognise the contribution made by others in this rescue effort: by the seamen on board the leisure crafts that answered the call for help on that day, in particular the actions of Mr Pendlebury on board Arran Comrade; by Mr Lancashire in his prompt and accurate reporting of the capsizing, which in all probability saved the life of Timothy Rowley; and by the men and woman who gave and continue to give of their time to crew and service the lifeboats that attended on the 20th July 2009.

I would like to express my thanks to the Procurator Fiscal and Solicitors who appeared at the Inquiry for the very thorough and professional manner in which the Inquiry was conducted.

Finally, I would like to acknowledge that each of the deceased men were experienced fishermen whose lives have been cut tragically short by the combination of events that occurred on 20th July 2009 on Bo Faskadale Reef, I express my sincere sympathy to the families and friends whom they have left behind.

Paul V Crozier

Sheriff of Grampian, Highlands and Islands at Fort William

