SHERIFFDOM OF GRAMPIAN HIGHLAND AND ISLANDS AT BANFF

[2021] FAI 24

BAN-B24-20

DETERMINATION

BY

SHERIFF ROBERT McDONALD

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

into the death of

ANTHONY MASSON

Banff 15 January 2021

Determination

The Sheriff having considered the information presented at the inquiry, determines in terms of section 26 of the Act that:

1. In terms of section 26(2)(a) that the late Anthony Masson, date of birth 30 March 1951 who resided in Macduff, Aberdeenshire, was confirmed deceased at 1355 hours on 27 March 2019 at Aberdeen Royal Infirmary.

2. In terms of section 26(2)(b) that the accident resulting in the death of Anthony Masson occurred between 1215 and 1233 hours on 27 March 2019 in an area of water within the Moray Firth, 0.2 nautical miles from Macduff Harbour, Aberdeenshire.

3. In terms of section 26(2)(c) the cause of the death of the late Anthony Masson was drowning as a consequence of him falling overboard into the sea from the single-handed creel boat *Sea Mist*.

4. In terms of section 26(2)(d) the accident resulting in the death was caused by the late Mr Masson becoming entangled in a back rope while shooting creels from the stern of the *Sea Mist*. Once in the water Mr Masson was pulled under water by the weight of the creels and was unable to free himself and swim back to the surface before he drowned.

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

a. Had Mr Masson been wearing a Personal Flotation Device (PFD) or similar at the time he entered water, this may have kept his head above water and may have increased his chance of survival.

b. Had there been method of separating the deceased from the fishing gear on Sea Mist's working deck, the likelihood of this accident occurring would have been significantly reduced.

6. In terms of section 26(2)(f) there were no defects in any system of working which contributed to the death or the accident resulting in the death.

7. In terms of section 26(2)(g) the following facts are relevant to the circumstances of the death:

a. The Maritime and Coastguard Agency (MCA) among other things has a role in regulating and producing guidance for fishermen such as the late Mr Masson.

b. The MCA produce the *Fishermen's Safety Guide* which is the principal guidance on safe working practices and emergency procedures for fishermen.

c. Fishing vessels, such as the *Sea Mist*, are surveyed by the MCA **once every five years and the surveyor highlights safety awareness to fishermen during the survey.**

d. **Mr Masson had completed the MCA mandatory fishing vessel safety awareness training in 2015.**

e. In December 2018 the MCA changed its safety regulations to provide that unless measures are in place to eliminate the risk of fishermen falling over board all fishermen must be issued with and wear a PFD or safety harness at all times.

Recommendations

In terms of section 26(1)(b) I would make the following recommendation:

The MCA should be asked to review the methods by which it makes fisherman and other relevant stakeholders aware of the relevant safety legislation and guidance and any significant changes and updates to such legislation and guidance. In particular the MCA should be asked to consider how best to ensure

that sole fisherman have made been made aware of any significant changes in safety legislation and guidance in the period between each five year survey.

NOTE

Introduction

[1] The Inquiry was held under the Fatal Accidents and Sudden deaths etc. (Scotland) Act 2016 ("the Act") into the death of Anthony Masson ("Mr Masson")

[2] The Inquiry was a mandatory Inquiry under section 2(3)(a) and (b) of the Act as Mr Masson died as a result of an accident which occurred in Scotland in the course of his employment.

[3] The circumstances surrounding Mr Masson's death were investigated by the Marine Accident Investigation Branch.

[4] The first notice in the Inquiry was lodged by the Crown on 19 August 2020.

[5] There were preliminary hearings on 9 October 2020 and 6 November 2020 and the hearing of the Inquiry took place on 20 November 2020.

[6] At the Preliminary hearing on 9 October Mrs Patricia Masson the widow of the late Mr Masson advised that she did not wish to be a participant in the Inquiry. Accordingly from that date the Procurator Fiscal was the sole participant in the Inquiry and was represented by Ms Lixia Sun, Procurator fiscal Depute.

The evidence

[7] On 5 October 2020 the Crown lodged certain productions including the post-mortem report and a report from Marine Accident Investigation Branch (MAIB)

[8] On 5 October 2020 the Crown also lodged a Notice to Admit Information in terms of Rule 4.12 of the Act of Sederunt (Fatal Accident Inquiry Rules) 2017 which contained evidence that I was satisfied was uncontroversial. There was no objection to this and I accepted the facts set out in the Notice to admit.

[9] The hearing of the Inquiry on 20 November 2020 was conducted by means of a Webex video conference. The Crown led parole evidence from a single witness, namely Captain Emma Tiller of the Marine Accident Investigation Branch. Miss Sun then made submissions on behalf of the Crown following which I made avizandum.

The statutory framework

[10] The Inquiry is held under section 1 of the Fatal Accidents and Sudden Deaths etc. (Scotland) Act 2016 ("the Act") and is governed by the Act of Sederunt (Fatal Accident Inquiry Rules) 2017 ("the 2017 Rules"). The purpose of such an Inquiry is set out in section 1(3) of the 2016 Act and is to:

1. establish the circumstances of the death, and;
2. consider what steps (if any) might be taken to prevent other deaths in similar circumstances.

[11] Section 26 of the 2016 Act states, among other things, that:

"(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, and

(b) such recommendations (if any) as to any of the matters mentioned in subsection (4) as the sheriff considers as 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 on 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 deficits 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."

[12] The procurator fiscal represents the public interest. An Inquiry is an inquisitorial process and it is not the purpose of an Inquiry to establish civil or criminal liability.

Issues for the inquiry

[13] In the Notice of The Inquiry lodged by the Procurator Fiscal on 19 August 2018 the Crown indicated that it was anticipated that the Inquiry would give consideration to the following issues:

a. the cause of the accident which resulted in the death;

b. whether there were any precautions which could reasonably have been taken and which might realistically have resulted in the death having been avoided; and

c. whether there were any defects in any system of working which contributed to the death or any accident resulting in the death.

Summary of facts

I found the following facts admitted or proved.

[14] Anthony Masson, born 30 March 1951, resided in Macduff, Aberdeenshire and was the owner and skipper of a creel fishing boat *Sea Mist*, registration number BF918.

[15] At about 0930 hours on Wednesday 27 March 2019, Mr Masson and his son Duncan Masson, the skipper of the creel boat *Ocean Lee*, arrived at MacDuff harbour to start a day's fishing.

[16] 27 March 2019 was a clear dry day at Macduff. The winds were light and the sea was calm. The depth of water at the fishing ground was between 16 metres and 17 metres.

[17] Mr Masson generally fished for crabs in shallow waters to the north of Macduff. He owned approximately 70 creels of various sizes. For fishing purposes the creels were arranged in strings or "leaders" of between 7 and 10 creels. Each creel in the group was connected to a rope known as the back rope by a short rope known as a leg line. Each of Mr Masson's leaders had a flagged float that displayed *Sea Mist's* fishing number at one end and two buoys at the other end. The back rope had weights at either end.

[18] The creels were stowed on the deck of the *Sea Mist* end-on to the stern of the vessel. The process of placing the creels in the water for fishing is known as "shooting". To shoot a leader Mr Masson would bring the vessel to a stop. He would then go on to the deck and throw the flagged float into the sea followed by the weight. He would then return to the wheelhouse of the vessel and place the engine ahead so that as the vessel moved forward the creels would be pulled off the stern of the vessel through the shooting gate by the back rope. This is a self-shooting process which would not normally require the skipper or any crew member to be on deck during that procedure.

[19] Typically Mr Masson would recover, empty, rebait and then re-shoot between three and five leaders a day.

[20] At 0940 hours on the day in question Duncan Masson notified the harbourmaster that both vessels were leaving harbour. Once clear of the harbour, Mr Masson headed for his usual fishing grounds to the north of Macduff while Duncan Masson headed towards Banff Bay to start fishing. At 1215 hours, same day, Duncan Masson called his father using his mobile phone and told him that he had finished fishing for the day.

Mr Masson replied that he was recovering his last leader and would have it shot away in about 10 minutes.

[21] Between 1215 and 1233 hours on 27 March 2019 Mr Masson was shooting off a leader of creels. While the leader was shooting Mr Masson went on to the deck where the creels were stowed. Mr Masson's leg became entangled in the back rope as a result of which he was pulled overboard.

[22] Once he was in the water Mr Masson was pulled under the water by the weight of the creels and was unable to free himself and swim to the surface before he drowned.

[23] At some point after becoming entangled Mr Masson had tried to free himself by cutting the back rope with a knife but he had not managed to cut all the way through the rope.

[24] At about 1233 hours, the *Ocean Lee* was about half mile away from the *Sea Mist* and Duncan Masson noticed that the *Sea Mist* was circling, with no sign of his father either on the fishing boat or on the sea's surface.

[25] At 1235 hours, Duncan Masson contacted the Macduff harbourmaster and requested assistance from coastguard. Leaving his own creels, Duncan Masson headed towards the circling *Sea Mist*. As he approached, he saw that one of *Sea Mist's* back ropes had become caught around the bow, causing the vessel to turn in circles. To stop the fishing vessel, Duncan Masson drove his boat into *Sea Mist* on its starboard side and boarded the vessel. Once on board, he placed the engine throttle to neutral, stopped the engine and dropped the anchor.

[26] Duncan Masson then returned to his own vessel and confirmed to the harbourmaster that his father was missing. At about the same time, the Macduff RNLI (Royal National lifeboat Institution) lifeboat was tasked by the coastguard and members Robert Smith, John Cox, James West, Ritchie Wallace, Jonathan Sim and Connor Matthew were deployed.

[27] Thinking that his father must have become entangled with his fishing gear and dragged overboard while shooting his last leader Duncan Masson began to recover his father's creels in an attempt to find him. As he did know which leaders had been laid that day he started with the closest one searching for newly baited creels. A short while later he saw his father's baseball cap floating in the water.

[28] At 1257 hours, the Macduff RNLI lifeboat arrived on scene and approached the *Ocean Lee*. A rescue helicopter was launched at the same time. Duncan Masson informed the RNLI lifeboat crew that his father was wearing a red Personal Flotation Device (PFD) in addition to his usual fishing clothing. The RNLI lifeboat began an expending square search pattern using the *Sea Mist's* anchored position as the datum point.

[29] At 1307 hours the Macduff harbour launch with the harbourmaster, port engineer and two additional RNLI crewmen on board joined the search.

[30] At 1309 hours Duncan Masson recovered a leader that had one of his father's wellington boots caught in it. He informed the RNLI lifeboat crew, who re-started their expanding square search using the position of this leader as the datum point.

[31] By 1314 hours the rescue helicopter was at the scene and at 1321 hours the helicopter's crew spotted a male matching the description of Mr Masson floating face down just under the sea surface. The male was not wearing a PFD. The RNLI lifeboat crew recovered and transferred him to the helicopter, which then proceeded to Aberdeen Royal Infirmary.

[32] Sea Mist was recovered by the two RNLI crewmen, Robert Smith and John Cox on the harbour launch. When they boarded the fishing vessel, they noticed a red PFD hanging up in the wheelhouse.

[33] At approximately 1345 hours on the same day, at the Emergency Department within ARI, the said male was assessed by Consultant Dr Sarah White and was found to be in cardiac arrest. Ongoing CPR was discontinued subsequently due to futility. The male was pronounced dead at 1355 hours on 27 March 2019. The male was later identified as being Mr Anthony Masson.

[34] On 29 March 2019, Dr G.A. Conlon MB ChB, Histopathology Registrar performed a post mortem examination and dissection on the body of Anthony Masson. The examination was corroborated by Dr L.M. Deboys MB ChB FRCPath DMJ(Path) Dip FMS, Pathologist and Senior Lecture in Forensic Medicine at Aberdeen University. The findings and conclusion of the post mortem examination were consistent with death by drowning. Toxicology reports confirmed that Mr Masson was not under the influence of alcohol or drugs at the time of the accident

[35] The leader in which Mr Masson's boot had become entangled had seven creels of varying sizes. Following the accident this leader was inspected and a cut in the back rope was found between the fourth and fifth creel.

Submissions

[36] The Procurator Fiscal depute made submissions inviting me to make findings under section 26(2) (a) to (f) of the Act. I had no difficulty in accepting those submissions and my determination largely reflects those proposed by the procurator fiscal in her submissions.

[37] The procurator fiscal depute also made certain submissions in proposing that I should make a recommendation in terms of section 26(1) (b) of the Act. She submitted that as can be seen from the various statistics detailed in the MAIB report that despite the recent publications of improved safety guidance, the frequency of serious and fatal accidents involving single-handed fishermen shows no sign of reducing and significant high numbers of fishermen are losing their life during the course of their employment. It is recognised that one of the main reasons for these tragic events is that fishermen are not wearing PFD.

[38] She therefore submitted that the MCA should be asked to consider the methods by which it makes fishermen and all other relevant stakeholders aware of relevant legislation and guidance, including any significant changes or updates, with a view to determining whether any other methods may ensure important information is provided

and clearly understood particularly when the five yearly surveys provide a limited opportunity to keep up to date.

[39] She pointed out that while MAIB provide information by way of safety flyers there may therefore be merit in MCA being asked to consider or review how it makes all relevant personnel aware of key messages and whether any improvements can be made to ensure the information is clearly understood by all concerned.

[40] I agreed with this submission and as can be seen I have made a recommendation to that effect.

[41] The procurator fiscal depute also invited me to recommend that all small fishing vessel owners, operators and managers, employers of fishermen, and skippers and fishermen on small fishing vessels should make themselves aware of the terms of the following and ensure that the terms are followed namely Marine Guidance Note 588 (F) Compulsory Provision and Wearing of Personal Flotation Devices on Fishing Vessels.

[42] I did not follow that suggestion as I considered that it would be more appropriate and effective to recommend that the MCA target this particular matter.

Discussion

[43] The procurator fiscal was the only person who participated in this inquiry and there were no matters in dispute in relation to the factual circumstances surrounding this tragic accident.

[44] Taking into account the factual circumstances and the post mortem report it was clear that Mr Masson's death had been caused by drowning.

[45] Although there was no evidence from any eye witness to this accident at the inquiry the Court had the benefit of expert evidence from Captain Tiller. Captain Tiller was a clear and even-handed witness and I had no difficulty in accepting her evidence. She was the lead investigator into this accident and was the initial author of the MAIB report. She confirmed in evidence that she was in agreement with the terms of the final report. The MAIB report was also clear and helpful in its terms. My findings in fact are therefore to a large extent based on the evidence of Captain Tiller and the findings of the MAIB report spoken to by her.

[46] As part of the MAIB investigation it was noted that shortly before the accident occurred Mr Masson was in telephone contact with his son confirming that he was about to shoot his last leader before heading for home. It was obvious that he had commenced this procedure because when Mr Duncan Masson went on board the *Sea Mist* shortly after the accident he had to put its engine into neutral indicating that Mr Masson had placed the engine in the ahead position to shoot off the leader.

[47] Mr Masson was a person who regularly wore a PFD and his son had described him as wearing a red PFD when giving a description of his father to the coastguard. Following the accident his PFD device was found hanging up in the wheelhouse of the vessel. Captain Tiller stated that it seemed likely that having set up this leader for shooting Mr Masson returned to the wheelhouse and put the engine in the ahead position to shoot off the leader. As this was intended to be his last leader of the day it is likely that he would not have expected to have to go back on deck that day and therefore removed his PFD. However he did go back on deck for some reason. Captain Tiller

suggested that the creels had perhaps become entangled during the shooting process and Mr Masson had gone on deck to free them up. In any event his leg then became entangled in the back rope as evidenced by his boot being found in the water tangled up in the back rope. The weight of the back rope with some of the creels already in the water pulled Mr Masson overboard.

[48] The MAIB Report spoken to by Captain Tiller explains that sudden immersion in cold water can be fatal in several ways and in particular by either cold shock response or cold incapacitation.

[49] In relation to cold shock response the Report explains that on immersion in cold water the sudden lowering of skin temperature causes a rapid rise in heart rate, and therefore blood pressure, accompanied by a gasp reflex followed by uncontrollable rapid breathing. The onset of cold shock occurs, peaking within thirty seconds and lasting for two to three minutes. If the head goes underwater during this stage, the inability to hold breath will often lead to water entering the lungs in quantities sufficient to cause death. Cold shock is considered to be the cause of the majority of drowning deaths.

[50] In relation to cold incapacitation the Report explains that cold incapacitation occurs usually within two to fifteen minutes of entering cold water. The blood vessels are constricted as the body tries to preserve heat and protect the vital organs. This results in the blood flow to the extremities being restricted, causing cooling and consequent deterioration in the functioning of muscles and nerve ends. Useful movement is lost in hands and feet, progressively leading to the incapacitation of arms

and legs. Unless a PFD is worn death by drowning occurs as a result of impaired swimming.

[51] It was evident from the cuts in the leader rope that Mr Masson fought hard to free himself by cutting the rope around his leg but was unable to sever it completely before being overcome. It is unknown whether Mr Masson attempted to cut the rope before or after he entered the water.

[52] The MAIB Report concludes that once Mr Masson was in the water it is most likely that he was pulled under the water by the weight of the creels and was unable to free himself and swim back to the surface before he drowned. The Report, however makes the point that had Mr Masson managed to free his foot from his entangled boot and made it to the surface alive it is likely that in sea temperatures of 9°C he would have experienced the effects of cold water shock on entering the water and cold water incapacitation within minutes. In such circumstances, without the buoyant support of a PFD, the rapid onset of drowning would have been inevitable.

[53] Captain Tiller explained that the risk of becoming entangled in this way can be reduced if there is a physical barrier on the deck to prevent a skipper or crewman coming into contact with the ropes and creel while they are shooting. She stated that it was best practice to have such a barrier perhaps in the form of a board running along the deck, which could be up to a metre in height. This would allow a person to identify and deal with a problem in the shooting process without standing in the midst of the creels and ropes.

[54] Captain Tiller explained the role of the Maritime and Coastguard Agency (MCA) in regulating and producing guidance for fishermen. The MCA produce the *Fishermen's Safety Guide* which is their principal publication on safe working practices and emergency procedures for fishermen and in Captain Tiller's view contains some very good guidance. It is published on their website and is highlighted to fishermen when a vessel such at the *Sea Mist* is given its routine inspection.

[55] Captain Tiller stated that fishing vessels, such as the *Sea Mist* are surveyed by the MCA **once every five years. As part of the inspection the MCA surveyor will talk through the operation of the vessel with the captain in effect going through a risk assessment of his operation. The surveyor will also highlight any changes in health and safety regulations.**

[56] **The MCA publishes any change in health and safety procedures on its website, notice of which will be given in newsflashes. Changes are also highlighted by industry bodies such as Seafish or in the trade press such as the Fishing News. However it appeared from the evidence of Captain Tiller that the most effective way of communicating information and advice in relation to health and safety is as part of the five year inspection. It is therefore important to consider how best to communicate that type of information to fishermen in the five year intervals between inspections.** In December 2018 the MCA changed its safety regulations to provide that unless measures are in place to eliminate the risk of fishermen falling over board all fishermen must be issued with and wear a PFD or safety harness at all times.

Mr Masson had completed the MCA mandatory fishing vessel safety awareness training as part of his five year inspection in 2015.

[57] **Following this accident the MCA issued a Safety Flier to the fishing industry highlighting lessons to be learned from this accident. As recommended by the MCA, the Fishing Industry Safety Co-ordination Group which was set up to promote best practice within the industry has carried out a safety study and come up with several recommendations.**

[58] **The MAIB report notes that single handed fishing is particularly hazardous where even a slip or a trip can have serious consequences and that despite the recent publication of improved safety guidance, the frequency of serious and fatal accidents involving single handed fishermen shows no sign of reducing. The report recognises that there is a continuing need for effective education programmes, targeting those contemplating single-handed fishing and prompting them to review their operation and adopt all relevant hazard reduction methods. The MCA have recognised this as an issue and I have therefore recommended that the MCA** review the methods by which it makes fisherman and other relevant stakeholders aware of the relevant safety legislation and guidance and any significant changes and updates to such legislation and guidance. In particular the MCA should consider how best to ensure that sole fisherman have made been made aware of any significant changes in safety legislation and guidance in the period between each five year survey.

[59] Captain Tiller emphasised the importance of PFD and explained that there had been a culture of resistance to wearing PFD among fishermen. At first PFD was quite

bulky but designs have changed significantly over the years and there is now no reasonable excuse not to wear PFD at all times. The MCA have therefore been active in patrolling fishing vessels and photographing fisherman who were not wearing PFD as required by law.

[60] Notwithstanding the terms of my determination and recommendation I accept the evidence of Captain Tiller and the MAIB report that Mr Masson appeared to be safety conscious captain and had taken many of the recommended precautions. He carried a knife and was known as someone who regularly wore PFD. Although this accident was avoidable its circumstances were most unfortunate and I extend my condolences to Mr Masson's family.