INQUIRY UNDER THE FATAL ACCIDENTS AND INQUIRY (SCOTLAND) ACT 1976 INTO THE SUDDEN DEATH OF CRAIG ALEXANDER CORBETT otherwise DUFFY

SHERIFFDOM OF GRAMPIAN HIGHLAND AND ISLANDS AT STORNOWAY

Determination of

Sheriff Colin Scott Mackenzie

in causa

Petition

under the Fatal Accidents and Sudden Death Inquiry (Scotland) Act 1976

by the

Procurator Fiscal, Stornoway

relative to the death of

CRAIG ALEXANDER CORBETT otherwise DUFFY

STORNOWAY 28TH November 2005

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After due advertisement in terms of the legislation a Fatal Accident Inquiry was held on 24th November 2005 in Stornoway Sheriff Court into the death of Craig Alexander Corbett or Duffy. In addition to the Petitioner, Mr David S. Teale, Procurator Fiscal for the public interest, appeared Mr Macrae of Messrs. Mackinnons, solicitors, Aberdeen acting on behalf of Messrs "A K and D M Morrison" a company limited by shares, owners of the *MFV Audacious* SY 364.

I first of all expressed the sincere sympathy of the bench and agents to the relatives and friends of the late Mr Duffy. Any reopening of old wounds would be most unfortunate but it is necessary to lead evidence both to establish as best as we can what happened and also to see if any lessons can be drawn from the circumstances.

Evidence was led by the Procurator Fiscal from 8 witnesses and in addition affidavits relating to formal reports were lodged by him in process, namely:- 1) Post Mortem Report by Dr. Robert Dickie and relative letter, 2) Toxicology Report by Dr. Duncan Stephen together with various productions including 3) a marine Chart of the locus 4) copy Marine Guidance Note MGN 155(F),5) copy Operations Advice Note OAN 398, 6) copy of report to UK National Immersion Incident survey by E Howard N Oakley, 7) copy of The Fishing Vessels (Code of Practice for the Safety of Small Fishing Vessels) Regulations 2002, 7) copy of (Irish) Fishing Vessel (Personal Floatation

Devices) Regulations 2001 8) copy of a publication by the Marine and Coastguard Agency entitled Fisherman and Safety "A Guide to Safe Working Practices for Fishermen", 10) a copy pamphlet issued by the MCA on Mandatory Safety Training Course for Fishermen (MCA/SF/008) and 11-13) miscellaneous copy newspaper reports relating to safety at sea.

I found the following facts admitted or otherwise proved:-

- The late Craig Alexander Corbett otherwise Duffy (hereinafter referred to as 'Craig Duffy' or 'the deceased') was 26 years of age (d.o.b. 11.3.1978). He lived at the time of his death (19.12.04) at 6 Bayhead Gardens, Stornoway. He had been self-employed as a share fisherman for some years with the company owning the *MFV Audacious* SY364 (Messrs A K & D M Morrison Ltd). He was considered an honest, trustworthy, competent and very hardworking crewmember of the *MFV Audacious* and operated mainly out of Stornoway. He quickly rose to become, from 2002, skipper of the vessel. He had completed a YTS course at the Lews Castle College, Stornoway followed by a traineeship on the *MFV Audacious* herself. He thereafter studied for and obtained his 'ticket' as an Inshore Skipper. He was well qualified to act as a skipper and when appointed proved himself to be a successful one. He had been doing very well on the boat though the fishing had generally been very poor in the area round about the time in question. As skipper he took charge of all day to day arrangements and decided where fishing was to be carried out and when - going where in fact the 'hunch' took him. It was a flexible arrangement.
- The *MFV Audacious* was a well-found well-equipped fishing boat. The usual crew complement was four but on the date in question one crew member was off work with influenza leaving the deceased and two others namely John Malcolm Campbell of Vatisker Park (witness) and Alexander Richard Martin of Oban (witness) to cope with all necessary work. The boat was fully certificated and fitted with six life jackets which were kept in what the crew called a 'wendy' compartment on the port side of the vessel near to the wheelhouse. There were also sufficient survival suits and life belts for all crewmembers carried on board together with a life raft. As well as the usual navigational aids such as compass and auto-pilot and radar in the wheel-house it was equipped with a computerised fishing 'plotter' which recorded (and could display on its computer screen situated to the right of the boats wheel) where they had previously been fishing as well as the sea-bed in some detail and could thus assist in planning the boat's course and destination. The plotter could be operated by means of a 'mouse' situated on a dashboard shelf just to hand at the helm.
- The *MFV Audacious* and her crew had been on a fishing trip (which had been intended to have extended to just before Christmas 2004) but they had returned to Stornoway late on Saturday 18th December, according to the said witness Campbell, to take on board extra ice. When they arrived in port at about 11.30pm they discovered that the ice plant was out of order (or they were otherwise unable to obtain a supply) and rather than return immediately to sea the deceased decided to tie up there for the night. Having done so the three men decided to go to the nearby public house call the Star Inn for a drink. They stayed in there until closing time, (thought to be about 1a.m.) each having taken some drink - though the actual amounts involved could not established to any degree of accuracy. After they all left the Star Inn the said Mr.Cambell made

directly for the *MFV Audacious* where he went to his bunk and fell asleep. The said Alexander Martin went first of all to get wash and a change of clothes from a house where he had been staying when in Stornoway and then returned to the boat and his bunk, where he too fell asleep. No one said or probably knew when exactly the deceased returned to his boat.

- It seems that early the following morning while it was yet dark the deceased decided to continue with the interrupted fishing trip without troubling further about additional ice. Witness Campbell was wakened at about 6a.m. on Sunday 19th December 2004 by the sound of the boats engine being started up. He rose from his bunk and, noting that Witness Martin was fast asleep, went up on deck to cast off the mooring lines, take in the fenders and clear the deck. He then went briefly into the wheelhouse to speak to the deceased who was at the wheel taking the boat out. Mr Campbell next went to the galley to put on the kettle for a cup of tea. He thereafter went back to his quarters to change his clothes and having done so he had returned to the wheelhouse. By then he thought they would have passed the Reef Rock buoy lying to the east off the Arnish light on their way out of Stornoway harbour mouth. He reckoned they were steaming at about their normal speed of 8.5 knots. It was a still night with no wind but cold.
- It was also, however, a pitch-dark night. Witness Campbell was, in fact, not sure just how far they had travelled - it did not, indeed, seem very long to him since they had left the pier. The deceased was standing at the wheel looking at the fishing plotter screen which was zoomed out to show a large-scale picture. Witness Campbell asked his skipper the deceased where they were bound but he replied simply to the effect he didn't (yet) know. Mr. Campbell then went to sit on the wheelhouse seat to the left of the wheel and rolled a cigarette for a smoke leaving his skipper to make up his mind and attend to plotting a course. Mr. Campbell did not know if the autopilot had been switched on or not. It would not ordinarily have been switched on until after the vessel had cleared the harbour.
- Once clear of the harbour mouth there are no immediate hazards to navigation that need concern a navigator towards the south or south-east but the main bulk of the island of Lewis lies, of course, directly to the west, all as can clearly be seen on the chart forming Production No 1. It seems as if at one point once not far south and east of the buoy at the Reef Rock the *MFV Audacious* was directed on a course much too far to the west and ended up being steered more or less towards the narrow cleft or geo in the shoreline of the Arnish peninsula known as Downie's Harbour.
- Suddenly, and within minutes of Mr. Campbell sitting down to roll the cigarette, there was a loud bang - it was obvious the boat had hit something hard and solid. The deceased 'kicked' his engine briefly into reverse gear and ordered Mr. Campbell to go to check the hold to see if there was water coming in. Mr. Campbell on doing so reported instantly that water was coming in rapidly. The deceased checked on the matter personally, taking in the situation at once. Returning to the wheelhouse immediately, he sent a Mayday call to Stornoway Coastguard. While the deceased was attending to that Mr. Campbell hurried below to wake Mr. Martin. The sleeping quarters were already filling with water. Mr. Martin had not in fact been roused even with the impact and Mr. Campbell had to shake him awake. Mr. Martin had no time to do more than get out of his bunk nor had either of them any time to collect any possessions before running up the ladder to the deck. The deceased was still in the wheelhouse giving their

position to the Coastguards (which position was in fact given precisely and accurately) but he ordered his crew to go to collect lifejackets from the 'wendy' compartment while he remained in the wheelhouse. There was just time for that to be done by Messrs Campbell and Martin. They grabbed life-jackets and made their way back to the wheelhouse tossing one to the deceased but by then the boat was settling so quickly in the water that before they could don them water was rushing up the accommodation ladder, rising in the wheelhouse itself and even bursting through the latter's windows - to such an effect that Messrs. Campbell and Martin were, according to Mr. Martin, 'spat' out of the wheelhouse into the sea. At the same time they simply discarded their lifejackets, having been unable to put them on properly before being cast into the water. The deceased was not seen by them to come out of the door of the wheelhouse along with them and they did not see him again alive.

- Messrs Martin and Campbell were good swimmers and made it to the shore which they could now see was only a short distance away. Mr. Campbell said he had some difficulty getting past the nets which were floating up from the stern. The deceased was known to be able to swim but may not have been as good a swimmer as the other two. The *MFV Audacious* was initially settling rapidly on a even keel but finally sank by the head ending up on the seabed approximately 15 metres deep to the north-east of the entrance to Downie's Harbour, a bare five minutes after being holed. The time was then approximately 06.30 hours.
- Stornoway Coastguard alerted Stornoway Lifeboat which was launched within 15 minutes and arrived at the scene shortly after 0700hrs. When the lifeboat arrived there were several fishing boats already in attendance having been alerted by the Mayday call and which were busy searching for survivors. Once the lifeboat switched on its searchlights its crew picked out Messrs. Campbell and Martin on the shore. The latter shouted to the lifeboat crew that they would be wasting their time looking for the deceased whereupon the lifeboat picked them up before continuing with their search for the deceased. Shortly thereafter they found him lying face down in the water not far from the shore a short distance from where the boat had foundered. There was no sign of any life jacket or other floatation device being worn.
- When the deceased's body was retrieved by the lifeboat his lungs appeared to be full of water. Cardiopulmonary resuscitation (CPR) attempts were immediately commenced by the lifeboat crew and continued until they returned to harbour at 07.21hrs when the deceased was handed over to an ambulance from the Scottish Ambulance Service which had been detailed to assist. CPR continued in the ambulance whose crew noted that the deceased was markedly hypothermic and without ECG response. He was thereafter handed over to the intensive care unit at the Western Isles Hospital at about 08.00hrs when CPR was continued and his electrolytes controlled. His body temperature was then noted to be 22 degrees centigrade. When by 14.30hrs the deceased's body had reached a normal temperature further medication and defibrillation attempts were made to try to start his heart but at 14.45hrs the same day Professor Dr Alex. Blaicher (a locum from Vienna) had to admit defeat and life was declared extinct. Resuscitation had been continued for some seven hours to no avail.
- A post-mortem examination was carried out on 20th December 2004 at the Western Isles Hospital by Dr. Brian Michie, physician, Stornoway, whose autopsy report formed Production No 2. The deceased was not found to be suffering from any condition which would have led to his death save that of

drowning as confirmed by the known external facts. His lungs were found to be heavy, swollen, airless, haemorrhagic and oedematous. Death by drowning was accordingly certified by Dr Michie.

- Blood and urine samples from the deceased were taken post-mortem at the hospital and sent for analysis. These showed inter alia that when the samples were taken there was 167 mg of alcohol in 100 ml of his blood. Such a level of alcohol in the blood would mean that the deceased's judgement and decision making capacity would have been considerably adversely affected and his potential survival time in the water would have been dramatically reduced.
- On 28th December 2004 the hull of the MFV was inspected in situ on behalf of Leask Marine Commercial Diving Services of Orkney by a diving team headed by witness Johannes Engebretsen, Stornoway. A video of the inspection was taken forming Label no 1 and was shown at the Inquiry. It showed the vessel lying at rest some 10 to 20 metres from the shore pointing in a generally easterly direction at a depth of about 15 metres. She was lying on her starboard side with gross damage showing at the stem and along part of the keel, burst planking demonstrating the severity of the impact. The integrity of the vessel had very obviously been totally compromised when it ran onto the hard conglomerate edge of land probably to the north-east of the entrance to Downie's Harbour. The boat's rudder was noted on inspection to be hard to starboard. It could not, however, be tested for flexibility because of safety considerations. Neither it nor the propeller appeared damaged from visual examination though the latter did have a small piece of rope attached to the boss which was not of any significance. The diving team was unable safely to access the wheelhouse to confirm if the autopilot was on or off but it noted that the liferaft automatic release operated by water pressure had in fact come into play.
- Neither lifejackets nor buoyancy aids of any description were worn as a matter of course by the crew of the *MFV Audacious*.

The Inquiry was completed on 24th November 2005.

Note

I took the matter to avizandum. The actual circumstances of the fatality were straightforward enough and not in question and no evidence was adduced on behalf of either the representatives of the deceased or the owners of the MFV. A formal determination from the bench would have been perfectly competent at the conclusion of the evidence, but as several safety issues had been raised - both as to the desirability of constant wearing of a buoyancy aid on board any fishing boat when at work and also the general undesirability of going to work thereon while under the influence of alcohol, I preferred to make more detailed reference to my notes of the evidence and also to all the productions lodged before completing my final Determinations.

The nature and purpose of a Fatal Accident Enquiry is to bring with reasonable dispatch the whole circumstances surrounding certain deaths to judicial and public scrutiny and to enlighten those legitimately interested in the death - i.e. the relatives and dependants of the deceased - as to the cause of the death and the cause of the accident leading to the death (so far as these are known and can be established by

evidence). The general public too has an interest in learning whether any reasonable steps could or should have been taken whereby the death could have been avoided.

The terms of the statutory requirements in terms of Section 6(a) of the Fatal Accidents and Sudden Deaths Inquiry (Scotland) Act 1976 are:-

"The sheriff shall make a determination setting out the following circumstances insofar as they have been established to his satisfaction.

- where and when the death and any accident resulting in the death took place
- the cause or causes of the death and any accident resulting in the death
- the reasonable precautions if any whereby the death and any accident resulting in the death might have been avoided
- the defects if any in any system of working which contributed to the death or any accident resulting in the death, and,
- any other facts which are relevant to the circumstances of the death.

The Inquiry itself is not restricted in how or how far it may investigate the circumstances but as it is a summary process and although the standard of proof is on the lower standard of the balance of probabilities, the Sheriff is often wary of making recommendations unless the findings on which they are based are quite clear - or can be inferred from the evidence placed before him. However, inference does often have a large part to play especially when, as here, not only are the precise circumstances of the accident itself vague and uncertain, but some of the surrounding yet relevant facts and circumstances may not be directly spoken to. That said, a Fatal Accident Inquiry, possibly because it is not restricted in how precisely it may carry out its functions, is not the proper forum for the determination of liability, civil or criminal or even of blame, and Fatal Accident Inquiry Determinations, however detailed, may not be founded on in other proceedings.

I interpret the task of the Sheriff in such matters widely and in the present circumstances as not being restricted in any way - save by the exact terms of the statute - and that I am entitled to comment on and, if I deem fit, to make recommendations on *any* matter which has been legitimately canvassed or is raised inferentially before me, if it appears to me to be in the public interest to do so. Such recommendations as may be made are considered seriously by appropriate authority to which they are intimated as a matter of course. Accordingly, and not shrinking from occasionally referring to matters which might be described as being within judicial or local knowledge especially where the background evidence led was slightly thin, I have in addition to the statutory requirements incumbent upon me, looked at and commented and where it seems to me desirable speculated on the effect of the wider-ranging evidence presented or referred to at the Hearing.

The actual death of skipper Craig Duffy and its immediate cause is not, of course, in any doubt. From the evidence led, the late Mr Duffy undoubtedly drowned at the locus and on the day in question at about the time mentioned.

What is not clear is why the MFV was so far off course. She was a well-equipped wooden hulled 55-foot long vessel. No obvious reason for the sinking other than

human error presented itself. The question of whether the autopilot was on or off was indeed canvassed in evidence but no particular significance was attached thereto nor was the matter pursued further. Either condition, however, could, on reflection, have had certain consequences. It was understood from the evidence that it was the deceased's custom to switch on the autopilot only once he had cleared the mouth of Stornoway Harbour i.e. once past the Reef Rock buoy. I consider it fair to speculate here as to what is likely to have happened in spite of the fact that there was no direct evidence on the matter. No explanation was otherwise proffered. The major possibilities (which may in any event be considered background knowledge in any seafaring community) are two in number. If the deceased had thought he *had* switched it on but it did not *come* on (for any reason) then, if a mere, say, 5 or 10 degrees to starboard had been inadvertently left on the helm and remained unnoticed and uncorrected, that would in itself have brought the vessel around surprisingly quickly and thus into danger. On the other hand if the auto-pilot *had* come on, then, depending upon its type, it *may* have defaulted to the last course it had been programmed for - which would most likely have been the reciprocal of the one he now intended. As he had been heading *into* Stornoway Harbour the previous evening, and he was now making out of it he was, one might say, on a reciprocal. If that were not quickly noticed the autopilot would soon bring the vessel round - again into fairly immediate danger. Also, if it *were* on a reciprocal heading to that intended, it is understood that the pointer might not have shown up too obviously on the plotter screen and thus a mistake could be magnified greatly in its consequences. Either situation could account for the accident if the deceased was not paying attention to his basic instruments. These suggestions are and must remain very speculative and no formal finding can follow thereon and it may well be the case that the model of autopilot used was of a type which erased the previous settings on it being switched off - but they may be worth considering should the *causa causans* be of concern. Whether the autopilot was partly the cause of turning off course or not the deceased himself should in any event have noticed that the vessel was not on the correct course. It may also be surprising that, given the calmness of the sea, the inevitable heel of the vessel when turning did not alert those on board to the change of course.

It was not possible to say precisely where the vessel struck - there was no singular sea rock rising from the seabed in the vicinity which would account for the holing - but the shoreline consisting as it does of in the main of low conglomerate cliffs angling into the sea would present a different profile depending upon the state of the tide and it seems to have been from a shelf of the latter that the two surviving crew members were picked up from by the Stornoway Lifeboat. The cliffs to the south side of the entrance to Downie's Harbour are sheer and could not ordinarily be scaled. Having struck, the boat sank within about five minutes.

It appears that the deceased was unable to exit the wheelhouse at the same time as did his two crewmen. He obviously was not trapped in it, or at least not for long, as his inert and already apparently lifeless body was found in the sea near to but further inshore from the ledge forming the north-eastern side of the narrow entrance to Downie's Harbour where it is understood the two surviving crewmen were found - not, indeed, very far away from the wreck itself and that very soon after the sinking.

The deceased may not have succumbed all that long before his body was picked up and it is obvious that the lifeboatmen and the others who administered CPR considered that he still had a chance of revival. The two crewmen themselves were probably extremely lucky to have been rescued so quickly even though they had attained dry land through their own efforts. They would both have been soaked to the skin, and were very probably disorientated as it was a cold, black December night. Their relative youth would have helped them survive, no doubt - and that coupled with the fact that it was a still calm night and that they were picked up relatively quickly by the Stornoway Lifeboat meant that hypothermia, which would almost certainly otherwise not have been far away and their survival put into question, was avoided.

Quite how far the *MFV Audacious* was from land when she sank is not totally certain. Differing estimates were given by the witnesses. The inference is that she was driven directly ashore onto the coast most probably just to the north or north east of the entrance to Downie's Harbour - which in spite of its name is really not much more than a geo or large natural cleft in the cliffs and not in any event much of a safe harbour as the word is usually understood even for very small boats. It opens out a little at its landward end but it is unlikely that the MFV could even have entered it as it is so narrow not very far in, even if she had been steered straight into its mouth. Downie's Harbour is however, the only real break in these generally beetling cliffs or rugged shore for quite some distance after passing the Arnish light to starboard (until, that is, one reaches the small bay known as Tob Leireabhaidh lying to the south-west of the peninsula). Although she struck the shore she had been kicked into reverse briefly by the deceased which disengaged her from the rocks but also meant that when she sank she did so in deeper water.

She came to rest on the bottom only some 10 to 20 metres from the shoreline where the depth was already some 15 metres and these are the figures I have preferred. One would not have had to be a very strong swimmer to have managed that distance. Using local knowledge of the locus, I am aware that the conglomerate cliffs around the Arnish peninsula are not particularly high - especially those to the north or northeastern side of the narrow entrance to Downie's Harbour where they flatten out to form a platform of sorts - but they could in places be quite daunting enough in daylight for an average man even at the height of his physical powers if he had to haul himself out of the sea and scale them and probably in other places well-nigh impossible to climb very far in the dark..

Things seem to have happened pretty quickly after the vessel struck. The *MFV Audacious* was a well-found and well-equipped vessel but she could not recover from such an insult and she sank within a very few minutes - five at most. When she struck, she must have been heading in a generally *westerly* direction but when videoed several weeks later her bow was noted to be pointing generally *easterly*. There was no evidence led at the Inquiry of any currents which might have shifted her position on the seabed (though such may well exist) nor of any attempt by the deceased to swing her around before she sank so her final resting position is one of the many imponderables in this enquiry. The liferaft had been released though that may only have taken place the previous day (27.12.04)

There are, however, two matters which may be of much greater relevance than the immediate reason for the MFV being off course or the final position of the vessel.

The First is the state of sobriety of the deceased at the time the vessel struck.

Accounts were given by witnesses Campbell and Martin and also by barmaid Jacqueline Clayden (witness) of what the crew, including the deceased, had had to drink in the Star Inn the previous evening. Different quantities of different drinks were estimated. Whatever it was that Messrs. Campbell and Martin imbibed, the deceased had certainly consumed more than the three or four cans of cider and a gin with which he was credited as having taken in the Inn. Either he drank more in the Star Inn than was noted or he partook of more alcohol after he left the public house. Where he consumed it is, of course, only speculative and of no significance, but his blood/alcohol level from samples taken at the post-mortem examination was shown to be 167 micrograms of alcohol in 100 millilitres of blood which represents a somewhat higher intake of alcohol than that suggested above. As Dr. John A.J. Macleod (witness) said in evidence, that is more than twice the level at which a driver of a motor car is reckoned to be unfit to drive on the public road. He agreed with the bench that anyone with more than 150mg of alcohol per 100 ml of blood would essentially be inebriated and his ability to concentrate or make decisions would have been considerably impaired at the time. Moreover his body having been recovered at 7.20am, and resuscitation having been attempted continuously for some seven hours before the blood sample was taken during which time 'his electrolytes were controlled' by venous infusion which would inevitably have led to dilution of his blood and equally inevitably to the inference of an even higher reading at the time of death - though it is not possible to say what that would have been. There must, nonetheless, remain a serious question about the deceased's fitness or ability to carry out his work or to command his vessel at the time of the incident. To draw a further parallel with the situation ashore, many otherwise totally law-abiding motor-car drivers are genuinely astonished when they are stopped by the police on the morning after an evening of heavier than usual drinking to find that they have not eliminated enough alcohol from their system by the time they leave for work - in spite of having had what they thought was sufficient time abed to recover. I suspect that many fishermen who are partial to a pint or six do not realise just how long-lasting the effects of their previous evening's conviviality might be and who therefore are truly not aware that their reactions and decision-making capacity can be badly affected well into the next day. The consequences can be extremely sad.

The position on the roads has improved in recent years - not probably in actual numbers of road-traffic accidents or deaths (because more and more cars are on the roads) - but because the message 'don't drink and drive' does seem to be getting home to at least the younger driver - which is obviously a very good thing. It seems to me that a similar message, to the effect that one should not go to sea in any command (or even work) situation until one's body is clear of alcohol or at least no longer impaired by it, could and should be more strongly and more continuously disseminated amongst the sea-going community until the message really starts to drive home. Seamen may all too often ignore such advice but so once did many car drivers on land. Fishermen ply the most dangerous trade in the land as it is. *Anything* which can improve their situation should be attempted.

All fishermen nowadays have to undergo certain training courses including 'basic health and safety' and 'safety awareness and risk'. There was no evidence led as to the content of these courses but while I imagine that they will include plenty of good advice about not drinking while at sea I would suggest to those who devise them that more or even yet more emphasis is placed on an absolute requirement for those who are likely to be responsible for the safety of vessel or crew of not proceeding to sea while there is still the likelihood of their being still impaired by the previous night's drinking - however well they feel - because impairment will often last for far longer than most will imagine. In the present case it seems beyond peradventure that the deceased, who was according to the evidence ordinarily a good and competent seaman, was distracted from ordinary navigation possibly by the screen of his plotter and that coupled with the impairment of his abilities through a high blood/alcohol level meant that he did not set a safe course or keep a proper look-out. He could not have checked on his course by his compass once he rounded the Reef Rock buoy and must have inadvertently turned (or been turned by his autopilot - if that is in fact a possibility) towards the west. It was a still night with no wind to have blown the MFV off course and though we heard nothing about the possible effect of the tide that alone would not, I would have thought, have accounted for such an large navigation error over such a short distance at that particular locus. That he did not become aware of the loom of the land so close to him is surprising but it was a very dark night and the glare from the plotter screen (for there were no other lights on in the wheelhouse) might have affected his night vision - which may have a bearing on that particular failure. Some of the foregoing paragraphs are necessarily speculative but I hope they cover the main possibilities and provide at least some explanation as to what might have happened.

The Second matter which arises from the evidence, if only laterally in this case, relates to the question of buoyancy aids and their wearing.

Quoting from the Maritime and Coastguard Agency (MCA) Marine Guidance Note MGN 155 (F) (which was lodged as a production) viz:-

- *"Each year fishermen's lives are lost at sea due to drowning. Most fatalities are associated with the loss of the vessel but a number of lives are also lost when fishermen fall or are knocked overboard whilst working. Almost invariably they end up in the water without means of buoyancy. This significantly reduces their chances of survival.*
- *Many of the approved lifejackets carried on board fishing vessels are too cumbersome to wear while working on deck and could deteriorate with constant use. However the MCA considers that the wearing of constant wear buoyancy equipment (CWBE) whilst on deck could save fishermen's lives.*
- *In 1994 the Agency prepared a specification for equipment suitable for constant wear and subsequently carried out 'on board' and 'in water' trials of inherently buoyant garments (including the body-warmer and waistcoat type)*
- *The 'on board' trials of inherently buoyant garments indicated that these were cumbersome and restrictive for fishermen when working. The 'in water' trials found the buoyancy insufficient to support the weight of a fisherman when unconscious and wearing heavy clothing. There was also a*

tendency for garments of this type to roll an unconscious casualty onto his or her front thereby restricting the airway.

The Guidance Note continues for a further 13 paragraphs detailing examples of CWBE, their advantages and disadvantages and their correct use and maintenance.

The MCA strongly recommended that:-

- *A sufficient quantity of suitable CWBE (where suitable means that it can be comfortably worn without hindrance to the work of the fisherman.....) is carried on board every fishing vessel to ensure that one device is available at all times for each person working on deck.*
- ***That all fishermen wear suitable CWBE whilst working on deck***

Dr. J. A. J. Macleod, witness, is a recently retired General Medical Practitioner in North Uist who has had a deep interest in preventing drowning for many years and has tried to interest fishermen in wearing buoyancy aids for at least twenty years. Apart from his medical expertise he has had many years practical experience in operating a small boat from which he sets creels and on occasion shoots nets. He gave evidence that he always wears a buoyancy aid when on board his boat or accessing it at anchor and insists upon any passenger doing likewise. He finds that the version of inherently buoyant vest he uses is neither restrictive nor cumbersome and allows him to work on deck without getting too hot. If the weather were mild then he would discard a sweater rather than the buoyancy aid. He totally agreed that one could not work in either a DTI approved lifejacket or for all practical purposes in a survival suit - the former in fact being nothing but a colossal handicap in working situations and the latter proving far too hot if physical exertion were required. These last mentioned aids were really only of value in an 'abandon ship' situation where there was time to prepare for it.

Self-inflating vests are not, said Dr. Macleod, always suitable. They require constant maintenance but they or their lanyard can get in the way and become entangled in, say, a creel line or net with possibly disastrous consequences. They can also sometimes inflate unexpectedly if they are inadvertently wetted (an occupational hazard one would have thought) which could unbalance a crewman at an inopportune time and were for that reason not recommended by Dr. Macleod. Dr. Macleod agreed with the general tenor of the MCA Guidance note quoted from above except that he suggested that in their 1994 trials they had started from the false premiss that the majority of those who fell overboard were unconscious when they did so. That he said was simply not the case. Most who fell into the water were fully conscious and uninjured. What was required in these more general of circumstances was a simple inherently buoyant device or aid (known generally as a Personal Floatation Device - or PFD for short) which would provide sufficient support at the initial stage of contact with cold water when the casualty is more likely to suffer shock - resulting in cardiac irregularity leading to what used to be called 'dry drowning'. Too much buoyancy on the other hand can actually prevent the casualty from swimming - DTI lifejackets and survival suits come into that category and those varieties of buoyancy aids which provide both jackets and trousers can be particularly dangerous if the casualty has taken off the jacket for any reason - such as becoming too hot after sustained physical work - before falling or being knocked

overboard as he will then float upside down. Wearing an inherently buoyant personal floatation device which may provide a lesser degree of buoyancy will, however, protect the wearer to a considerable degree from hypothermia and quite dramatically increase potential survival time. If one is worn beneath oilskins the less bulky of them are much less likely to get in the way when working.

On a grimmer note Dr Macleod pointed out that such personal floatation devices could enable easier recovery of bodies from the water - which might make difficult times easier to bear for grieving relatives ashore who all too often had no one to bury.

Dr Macleod brought to the attention of the court the existence of a trial of some 70 different kinds of buoyancy aids presently being undertaken in the UK apparently under the aegis of the RNLI and "Seafish" wherein some professional seamen and fishermen have each undertaken to constantly wear when working differing versions of PFDs and to report upon efficiency and comfort in due course. These trials were, Dr. Macleod said, only at the half-way stage as at the date of the hearing but a report was expected in May 2006 at a Scottish Fishermen's exhibition to be held then. So far he said, no one had returned his or her equipment as being unsuitable for use in a working environment. Dr. Macleod also referred without further comment to the fact that the Republic of Eire had as long as four years ago made it compulsory on fishing vessels registered in Eire for all persons when on open deck to wear personal flotation devices at all times (*vide*: Irish) Fishing Vessel (Personal Flotation Devices) Regulations 2001 (SI No. 586 of 2001). The implication seemed to be that the Irish authorities must have managed some time ago to persuade *their* fishing industry of the suitability of some kind of floatation devices and the desirability of their being worn at all times. The Irish authorities have in fact issued guidance on the selection of PFDs in their Marine Note No. 7 of 2002

It was gratifying to note how well equipped the *MFV Audacious* was safety-wise - the owners of the vessel cannot be criticised in any such respect. It was noted, however, that no buoyancy-aids were worn by the crew as a matter of course - though such would not, it is understood, be the general practice in local or indeed most UK fishing boats. In this instance it has to be said, of course, that even if the Irish rules had applied no one was actually on deck save in the immediate situation of crisis. It is, however, generally well understood that the majority of fishermen do not like wearing anything which they think may restrict them in their work - which is hard and often dangerous enough without having anything additional to impede their free movement. That attitude is quite understandable. Their working conditions can be atrocious - the weather may be terrible - cold and wet with rough seas - and yet they may be sweating inside their oilskins. It cannot be easy when heavy physical exertion is involved to find the correct balance or layering of clothing to wear to achieve the best working conditions. Anything like a traditional buoyancy aid could easily be seen in such circumstances by the fishermen simply to be an additional problem which could well be done without - and it has to be acknowledged that different types of fishing activity may require very different types of personal floatation gear to avoid these very problems.

However all these problems have been known about for a very long time. The general unsuitability of the old-fashioned bulky Board of Trade lifejacket for use in

anything but an abandon ship situation has been well known for many decades. It may well be *their* long-established reputation which has turned the faces of so many experienced and intelligent fishermen against even contemplating the use of such personal floatation devices as are now available. It is good to know that trials are currently being carried out to find the most suitable version of available floatation devices for constant wear in any work situation. There was no evidence led before this Inquiry as to why matters had taken so long to reach even that position in this seafaring nation and of course there may well be perfectly acceptable explanations somewhere - even if these are not immediately obvious and were not canvassed. However, it is surely beyond peradventure that better and more suitable floatation devices should have in fact been developed and perfected long before now and not just left to commercial firms and the market place to try to fill the gap - excellent and well-intentioned though much of that work may have been.

This FAI has not, of course, been in any way a full public enquiry into any possible failure on the part of those responsible for progressing the development of such essential life-saving devices and my comments have to be read with that caveat. However, for all that these questions now raised may only be incidental to the principal purpose of the FAI they are still matters which should be addressed and not glossed over. That full-scale trials for the most suitable personal floatation devices are at last being carried out seemingly more determinedly than in the past is certainly heartening but they are certainly not before time. Whatever else, a positive and speedy conclusion is needed - even if that should find that no personal floatation device currently available is, in fact, suitable, unlikely though that may be.

If at the end of the day nothing presently being trialled can meet general acceptance in the industry then it will be past time for the authorities to take forward the urgent development of something that will meet such general acceptance (or can properly be imposed upon the industry) - and provide the resources or more resources for that to be done and urgently. It is really an utter disgrace and a most shameful thing that the UK has been overtaken by the much smaller nation of Eire in such a matter. Marine safety of this specific nature for the inshore fishing fleet seems to have for far too long taken far too low a priority in development - or else for whatever reason light is being hidden under a bushel or two - but the time has surely come when something positive has to be done, and that done now, to reduce the all too high death-rate from drowning at sea. If nothing is in fact done or if heels continue to be dragged, more *avoidable* tragedies will occur every year and more families devastated and lives ruined.

If a suitable device for constant wear in all working conditions is to be developed (if indeed that has not already been done) it seems to me that all crew members including the skipper should be obliged to wear one *whenever* on duty *or* on deck - at least on craft where all members of the crew can be expected to have to appear on deck at a moment's notice. Large ocean-going trawlers whose deck-officers rarely appear on deck might want to be exempted but smaller vessels where there is no such distinction and where all hands might have to turn to on deck at any time could benefit immediately from such a ruling. Even in this case, had the deceased been wearing an unobtrusive comfortable personal floatation device in his wheelhouse the tragedy of his death might well have still been avoided in spite of his inebriation. To continue the earlier analogy with the situation on the roads, many car-users

complained bitterly when compulsory wearing of seat-belts was introduced - but eventually all got used to it and countless lives have been saved in the meantime. Some fishermen - particularly those who operate small boats single-handedly - have in recent times been seen more frequently using floatation devices quite regularly - so there may be a wind of change starting to blow amongst those who go down to the sea in small ships - but that is but a start and the trend needs to be encouraged. Compulsion may be viewed as yet another inroad into personal freedoms and enforcement might prove difficult but if a proper device is found or developed it would not take long I am quite sure for everyone automatically to wear one when at sea. Fishing is the most dangerous trade carried out in the United Kingdom and tragedies such as is illustrated here periodically hit the fishing communities hard up and down the length of the United Kingdom. The problem is not just a local one affecting a remote area but is of nationwide application.

In arriving at my foregoing Findings in Fact I considered the Procurator Fiscal's submissions to the effect that a formal verdict be returned outlining just the basic facts as also that the deceased was at the time of his death under the influence of alcohol to the extent that his decisions and judgement were affected and that he died at Downie's Harbour at 6.30am on the 19th December 2004.

Mr Macrae on behalf of the owners of the MFV Audacious sought to follow the Crown's submissions save that he wished to emphasise that the deceased was self-employed and that there was nothing in the evidence to tell us what went wrong with the navigation. The deceased was, he said, a well regarded young skipper who had worked in the same firm for ten years. He had a good track record. The sinking of the *MFV Audacious* came as a dreadful shock to everybody. The vessel had been well found and well certificated in terms of the regulations. There has been some evidence as to where the life-jackets had been kept but no criticism had been levelled as to that or suggestion made where they might better have been kept. He submitted that Dr. Macleod's evidence was clear as to the desirability of wearing personal buoyancy devices but that that was of doubtful relevancy in this case he felt. On the other hand he felt that the opportunity might be taken to emphasise the dangers of going to sea having taken an excess of alcohol.

For the reasons already outlined above I felt that something more than a formal determination was required here and that where inferences could be drawn they should be drawn. I considered that the issue of personal buoyancy devices must almost always have a significance in drowning cases and that it has such here as has any question of inebriation. I agreed with Mr Macrae, however, when he suggested that where the life jackets were kept on board the MFV was not an issue in this instance.

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Having considered the foregoing facts, circumstances and submissions I formally determine in terms of the Fatal Accidents and Sudden Death Inquiry (Scotland) Act 1976 as follows:-

1) In terms of Section 6(1)(a) of the said Act that Craig Alexander Corbett or Duffy died on 19th December 2004 while engaged as a self-employed fisherman and skipper on board the MFV Audacious SY 364.

2) In terms of Section 6(1)(a) that the death took place in the sea at Downie's Harbour some 10 to 20 metres from land in the Arnish Peninsula and Parish of Stornoway.

3) In terms of Section 6(1)(b) that the cause of death was death by drowning as a result of the MFV Audacious SY364 being run onto rocks or the rocky shore at Downie's Harbour foresaid and sinking while under the command of the said deceased.

4) In terms of Section 6(1)(c) that while there is no compulsion on crew members to constantly wear suitable personal buoyancy devices as recommended by the MCA had the deceased been wearing one it may be that his chances of survival might have been increased considerably.

5) In terms of Section 6(1)(c and e) that the said Craig Duffy had at the time of his death a minimum blood/alcohol level of 167 mg of alcohol per 100ml of blood which would have meant that his ability to concentrate and perform certain tasks was adversely affected. Furthermore such a reading would have adversely affected his ability to survive sudden immersion in the cold water of a December night. Had he not gone to sea while his blood alcohol level was still high enough to impair his reactions or his decision-making processes he may not have steered his craft onto the shore in the first place but if he still would have done so through inadvertence he would have been much more likely to have been able to survive immersion in the sea and also swim the short distance to the shore as did his crew.

6) In terms of Section 6(1)(e) that all fishermen would benefit by the development of suitable personal floatation devices which can be worn at all times when working on board any fishing boat without hindrance to the wearer. Had such devices been approved and regulations been in place to make their use compulsory (*and* the same had been observed and worn by the deceased) the fatality might not have occurred.

7) In terms of Section 6(1)(e) that while official advice is no doubt freely and copiously available to all crew members of all sea-going vessels as to the inadvisability of going to sea when under the influence of alcohol, if there is not already in place a *very* high profile warning about the very considerable danger which results from still having too high a blood-alcohol level in the bloodstream the morning after a heavy drinking session preventing proper and safe functioning particularly in anyone who has to work in that condition (even when the person involved may feel perfectly fine after a few hours sleep) then such a warning should be emphasised in such advice. That should apply especially to those who may be is in a position of command or who have responsibility for the safety of others. Such amplified advice should always be included in any safety course or in any reminders or 'refreshers' which may take place in training courses, in the hope that constant dripping away at the stony intransigence of some might eventually have a beneficial effect for all in the industry.

Sheriff C Scott Mackenzie

At Stornoway 29th November 2005