SHERIFFDOM OF GRAMPIAN, HIGHLAND AND ISLANDS AT FORT WILLIAM

[2025] FAI 7

FTW-B27-24

DETERMINATION

BY

SHERIFF ROBERT FRAZER

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

into the death of

LACHLAN RODERICK EWEN ROBERTSON

FORT WILLIAM, 24 December 2024

Determination

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

1. In terms of section 26(2)(a) of the Act (when and where the death occurred): That Lachlan Roderick Ewen Robertson (hereinafter referred to as "Lachlan Robertson") born 29/08/59, was pronounced dead on 24 June 2021 at approximately 20.35 hours whilst at sea in the Sound of Rum between the islands of Rum (to the north) and Eigg (to the south), the coordinates being 56 degrees, 56.683 N and 006 degrees 12.873 W.

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

   That Lachlan Robertson died following an accident at sea between 17.00 and 19.25 hours on 24 June 2024 whilst on board his vessel, *Reul A' Chuain* (the boat), of which he was the skipper at the above location, namely the Sound of Rum at the coordinates as specified above. The accident occurred as result of Mr Robertson falling overboard from the boat whilst attempting to rescue a member of crew who had already fallen overboard.

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

   That the cause of Mr Robertson's death, as recorded in the post-mortem report, was from the effects of immersion in water.

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

   That the cause of the accident was the result of the boat's senior deckhand initially falling overboard whilst attempting to haul the main fishing net back onto the boat in deteriorating weather conditions. The boat was rolling heavily in the sea as the crew attempted to haul the net in with the use of a manually operated winch. The boat rolled heavily causing more of the net to slip into the sea along with the senior deckhand, who lost his footing whilst standing on part of the net still on the deck. Mr Robertson

along with the junior deckhand, attempted to pull the senior deckhand back onto the boat but as the boat rolled again Mr Robertson also fell into the water. The senior deckhand subsequently managed to secure a rope around Mr Robertson's waist so allowing Mr Robertson to be winched from the water. Mr Robertson was unconscious and unresponsive. The two deckhands immediately commenced CPR on Mr Robertson. An all-weather RNLI lifeboat and another vessel responded to the boat's distress call. On arrival at the locus the RNLI crew, together with the search and rescue paramedic, continued to attempt to resuscitate Mr Robertson before he was pronounced dead at 20.35 hours.

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

(i) That had Mr Robertson been wearing his personal flotation device at the time he fell into the water his chances of survival would have been greater. In addition, had the remaining crew been familiar with the location and use of the boat's emergency man overboard recovery equipment his chances of survival would have most likely improved.

(ii) That had such precautions been taken as set out above Mr Robertson's chances of survival would have been greater.

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

   (i) That had the nets which had been winched on board been secured to the deck then the resultant accident involving both the senior deckhand and Mr Robertson might not have occurred.

   (ii) That the crew's unfamiliarity with the use of the Lazelus Lifelink emergency equipment stored at the bough of the boat together with their failure to practise "man overboard" recovery drills may have contributed to Mr Robertson being in the water and therefore exposed to the obvious danger for longer than might otherwise have been the case.

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

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

Note

[1] This inquiry was held into the death of Lachlan Robertson on 11 October 2024 at Fort William Sheriff Court. Miss Mairi Graham, Procurator Fiscal Depute, represented the Crown. Mr Robertson's family were not legally represented but a number of them were present in court throughout the proceedings.

[2] At the time of the accident Lachlan Robertson was the skipper of the fishing boat, *Reul A' Chuain*, which he had owned since 1999. It was registered in Oban but based in Mallaig where Mr Robertson resided.

[3] The boat was originally used to catch scallops but in 2007 had been refitted with a trawl arrangement which also allowed it to also catch prawns.

[4] The boat's fishing nets were towed from the stern by wires which ran from a forward winch through blocks towards the stern. All nets were to be stowed in a container at the stern. The Marine Coastguard Agency (MCA) conducted a 5 yearly survey and statutory roll tests in 2013 with a further full survey in 2018 as well as an intermediate inspection in March 2011. No major concerns were raised in these inspections and the boat was assessed as seaworthy.

[5] As stated, Lachlan Robertson was owner and skipper of the boat. The two other crew members were AF, the senior deckhand and AM, the junior deckhand. AF is a Romanian national, aged 34 years at the time, who had worked on merchant ships after leaving school. In 2015 he started work in the fishing industry in Mallaig and had worked on the boat for a year prior to the incident. AM, who was 21 years at the time, had worked on the boat since February 2021, a period of 4 months before the incident. All three had completed their mandatory Sea Fish Industry Authority safety courses. Mr Robertson and AF had also completed the safety awareness and risk assessment course as required of crew members with at least 2 years' experience at sea.

[6] The incident occurred in the sea waters known as the Sound of Rum which lie between the Isles of Rum to the north and Eigg to the south. The fishing port of Mallaig lies approximately 20 miles to the east.

[7] On the morning of 23 June 2021 the boat, skippered by Mr Robertson with AF and AM on board, left Mallaig and headed towards the fishing grounds west of the Isles of Rum and Muck. The following day, 24 June 2021, the boat was trawling for prawns, which was done by use of the winch shooting nets from the rear of the boat and then hauling them back in later in the day. Mr Robertson steered the boat and AF operated the winch manually to lower and lift the nets out of the water. When being lifted back onto the boat AM assisted by pulling the nets on board and then sorting the catch once it was released.

[8] At about 16.50 hours on 24 June 2021 the final catch was pulled on board and AF and AM began to sort it for sale. Mr Robertson left the wheelhouse to assist in the task. Mr Robertson and AF were wearing oil skins and rubber boots. AM was wearing oil skin trousers, a hooded top and rubber boots. No one was wearing a Personal Flotation Device. Whilst there was a swell on the water it was not severe.

[9] Following this task, and as the vessel started to travel back to Mallaig, the weather conditions worsened causing the boat to roll in the waves. At or about 18.50 hours one of the fishing nets slipped back overboard and into the sea swell. Mr Robertson left the wheelhouse and assisted AM in attaching the winch's hook to a retrieval line which was then attached to the net that was overboard. AF attempted to use the winch to haul the net back onto the boat but, in doing so, the hook slipped from

the netting causing it (the winch) to shoot up into the air without the netting attached. As result, approximately 5 metres of the net remained in the sea being dragged by the boat.

[10] Mr Robertson, together with AF and AM, attempted to pull the net back in by hand but the boat continued to roll causing the net to be pulled further from the boat. AF then stood on top of the net which was on the deck to try and prevent more from slipping into the sea. As he did so, the boat rolled again causing AF to slip overboard together with more of the net he was holding onto. AF managed to swim away from the net but was unable to pull himself back onto the boat.

[11] Mr Robertson and AM both tried to assist AF to get back on board but were unable to do so. As Mr Robertson leant over the bulwark to reach down and help pull AF back onto the boat, it rolled again causing Mr Robertson himself to be thrown into the water.

[12] AM retrieved two lifebuoys from the front of the boat and threw them towards AF and Mr Robertson. AF was able to help place one of the lifebuoys around Mr Robertson before doing the same for himself.

[13] At 19.06 hours AM made a high frequency distress call which was immediately picked by the Coastguard. At 19.11 hours the Coastguard alerted the lifeboats at Mallaig and Tobermory, on the Isle of Mull, along with a search and rescue helicopter at Stornoway, on the Isle of Lewis. A "Mayday" call was also broadcast resulting in three nearby ships responding and proceeding towards the boat's location.

[14] AM attempted to use the lifebuoy line to pull Mr Robertson back on board where he (Mr Robertson) managed to grab onto one of the boat's side tyre fenders. As he attempted to climb onto the boat from the lifebuoy it rolled again causing him to fall back into the water with his legs or part of his lower body within the lifebuoy's ring. In doing so, the buoyancy of the ring caused Mr Robertson's knees to be pushed upwards which simultaneously caused his upper body and head to be tipped upside down into the water. AF, who was still in the water, managed to pull Mr Robertson upright with his head out of the water. AM used the winch to drop a rope to AF which he wrapped around Mr Robertson's chest. AM was then able to winch Mr Robertson from the water. AM then repeated the exercise for AF who was also pulled on board. It was estimated that Mr Robertson was in the water for approximately 20 minutes.

[15] At 19.25 hours AM advised the Coastguard that both Mr Robertson and AF were on board but Mr Robertson appeared unconscious and unresponsive. The Coastguard advised AM and AF to carry out cardiopulmonary resuscitation (CPR) on Mr Robertson until further help arrived.

[16] The first vessels to reach the locus at 19.50 hours were the *Ronja Harvester* closely followed by a RNLI all-weather lifeboat from Mallaig. Conditions were poor with a northernly offshore wind 7 Near Gale force (28-33 knots) and swells of 3 metres. The *Ronja Harvester* was able to transfer oxygen and a defibrillator onto the boat as well as provide shelter for the RNLI lifeboat to come onside and allow its crew to transfer on board.

[17] Once on board the RNLI crew continued CPR on Mr Robertson. The Coastguard search and rescue helicopter arrived shortly thereafter and a paramedic was able to be winched on board to examine Mr Robertson and assist with CPR. The paramedic assessed that it was unsafe to attempt to move him off the boat and regrettably at 20.35 hours the decision was made to cease CPR. Mr Robertson was pronounced dead at the scene. The RNLI lifeboat thereafter escorted the boat back to Mallaig with Mr Robertson, now deceased. It arrived in harbour at 23.50 hours.

[18] A post-mortem examination was carried out on 28 June 2021. The report concluded that Mr Robertson died from the effects of "immersion in water". Macroscopic signs of drowning were not identified. Hypothermia was not present. In addition, there was no evidence of significant natural disease, injury or intoxication from drugs or alcohol. In response to a follow-up inquiry the consultant pathologist explained there were no overt signs of drowning. Whilst there was a likelihood of drowning the conclusion was that "immersion in water" more appropriately described the cause of Mr Robertson's death, given the length of time he was in the water and the likely deterioration in his bodily system caused by exposure to the cold and stormy waters.

[19] An initial inspection of the boat was carried out by the Maritime Coastguard Agency (MCA) on 25 June 2021. Some damage had been caused to the starboard side due to physical contact with the *Ronja Harvester* when it had come alongside the boat.

[20] An accident investigation was carried out by the Marine Accident Investigation Branch (MAIB) which published its report in December 2022 following consultation

with Mr Robertson's family. Lifejackets and Personal Flotation Devices (PFDs) were found to be available to each crew member. The PFDs had been manufactured in 2013 and were in good condition with little sign of significant use but the service records for them had not been completed. Safety belts or harnesses with lifelines (restraint arrangements) were not found on board. All other statutory safety equipment was found to be in date. The boat was also equipped with a Lalizas Lifelink recovery system which was stowed in the forward bough. The report concluded, *inter alia,* the following:

(i) The net falling overboard resulted in an emergency situation developing in which the crew became task focussed and so did not assess the risks involved to themselves.

(ii) The size and volume of the trawl nets at the stern of the boat meant they were above the height of the boat's bulwark and were not secured. As a result, when the boat rolled in the heavy sea some of the net fell back into the water. The failure of the winch's net hook to work as it should have led to AF exposing himself to danger by standing on the netting and attempting to haul the net back in by hand.

(iii) When AF climbed on to the nets that were still on deck he was not wearing a restraint arrangement harness nor his PFD. When the boat rolled again AF slipped or was pulled by the nets causing him to fall overboard.

(iv) Mr Robertson fell overboard whilst the boat was rolling and as he leant over the bulwark to try to assist AF to reboard. Mr Robertson was not wearing a restraint harness or his PFD.

(v) Mr Robertson's chances of survival would have been greater had he been wearing his PFD.

(vi) The crew had not practised "man overboard" recovery procedures and were unfamiliar with the boat's recovery equipment. As a result, their reaction to AF initially going overboard was ineffective.

(vii) The boat's low bulwark increased the risk of a crew member falling overboard. However, it had been granted an exemption from the relevant health and safety regulations due its age and the type of fishing operations in which it engaged.

(viii) Restraint arrangements were not found on board during the MAIB inspection.

(ix) Poor storage of equipment, which was not properly secured, created a potential hazard on the boat.

(x) AM, the junior deckhand, acted with commendable fortitude in his actions by assisting both AF and Mr Robertson back on board, alerting the Coastguard and performing CPR as he did.

(xi) The MCA Fishermen's Safety Guide provided guidance on health and safety best practice and procedures. It emphasised that training drills, including man overboard recovery situations, should be completed monthly. In the event of a man falling overboard the guide stated: "Ensure the crew are wearing PFDs even if you think the risk of going overboard has been eliminated…"

[21] In response to certain follow-up queries by the Crown the MAIB explained that lifebuoys, which are fitted to every ship, are specifically designed for emergency situations such as in the present case. A PFD performs the same function in a more immediate manner as it is fitted around the body of the wearer whereas a lifebuoy relies on its ring being fitted under the arms of the person in the water in order to assist that person in staying afloat.

[22] Following a further request from the Crown in September 2024, the MAIB advised that the International Maritime Organisation (IMO) proposed a standard for crew members on fishing vessels of at least 24 metres in length to undergo mandatory refresher training in restraint and recovery procedures. In addition, the National Federation of Fishermen's Organisations (NFFO) advised that they were involved in ongoing discussions with several stakeholders in the fishing industry (including the Scottish Fishermen's Federation) to enhance workforce skills to further reduce the risks of such accidents at sea.

[23] In December 2022 the MAIB published a safety flyer to the fishing industry highlighting the accident and Mr Robertson's death. In particular it drew attention to the failings identified in the report and highlighted the importance of the wearing PFDs and/or safety harnesses in adverse weather conditions as well as the requirement to carry out regular emergency drills.

[24] In addition, the following productions were referred to in the Crown's Notice to Admit which in chronological order were:

CP1 – statement by Mr Robertson's family

CP2 – redacted copy of Intimation of Death to Procurator Fiscal dated 29 June 2021

CP3 – redacted copy of Final Post-Mortem Examination Report dated 24 July 2021

CP4 – redacted copy of Toxicology Report dated 7 July 2021

CP5 – book of photographs taken 25 June 2021

CP6 – redacted copy of Initial Fact-Finding Form by the Principal Consultant Surveyor for MCA dated 24 June 2021

CP7 – redacted copy of witness statement of Principal Consultant Surveyor

CP8 – 18 – copies of photographs of boat *Reul A' Chuain* referred to in CP7

CP19 – copy of MCA Survey Report dated 26 June 2021

CP20 – copy of MCA Inspection Report dated 25 June 2021

CP21 – copy of MCA Prohibition Notice dated 25 June 2021 (paper copy)

CP22 – electronic copy of MCA Prohibition Notice dated 25 June 2021

CP23 – copy of MCA Fishermen's Safety Guide dated May 2020

CP24 – copy of MCA Marine Guidance Note 570 (F) – emergency drills on fishing vessels (in force until 10 June 2022)

CP25 – copy of MCA Marine Guidance Note 570 (F) dated 10 June 2022 (replacing CP24)

CP26 – copy of MCA Marine Guidance Note 571 (F) – assessing the risk of "Man Overboard" situations and preventative measures - dated 23 October 2017

CP27 – copy of MCA Marine Guidance Note 588 (F) no. 2 – compulsory provision and wearing of PFDs – dated 30 April 2024

CP28 – copy of MAIB Final Investigation Report published December 2022

CP29 – copy of MAIB Safety Flyer to Fishing Industry published December 2022

CP30 – redacted copy of RNLI Incident Report 24 June 2021

CP31 – redacted copy of HM Coastguard Operation Log re distress call received 24 June 2021

CP32 – CP34 – photographs by RNLI taken from Tobermory Lifeboat 24 June 2021

CP35 – redacted copy of the Search & Rescue paramedic dated 5 September 2023

CP36 – statement the coxswain for RNLI Mallaig Lifeboat dated 3 February 2023

[25] All productions were part of the Crown's Notice to Admit and are true and accurate in their terms.

Legal framework

[26] This is a mandatory inquiry in terms of section 2 of the 2016 Act (*supra*) concerning the death of Mr Robertson whilst in the course of his occupation as a fisherman.

[27] The purpose of the inquiry, with reference to section 1(3) of the Act, is to establish the circumstances surrounding Mr Robertson's death and to consider what steps, if any, might be taken to prevent other deaths in similar circumstances. It is not the purpose of the inquiry to establish either civil or criminal liability. The manner in

which evidence and other information is presented is unrestricted and it is for the inquiry to reach its conclusions based on such evidence and other information (Rule 4.1, Fatal Accident Inquiry Rules 2017). Throughout the proceedings the Crown acts in the public interest.

[28] Section 26(1) and (2) of the Act sets out the requirements for the Sheriff's written determination following the inquiry:

> "(1) As soon as possible after the conclusion of the evidence and submissions in an inquiry, the sheriff must make a determination setting out —
> (a) in relation to the death to which the inquiry relates, the sheriff's findings as to the circumstances mentioned in subsection (2), and
> (b) such recommendations (if any) as to any of the matters mentioned in subsection (4) as the sheriff considers appropriate.
> (2) The circumstances referred to in subsection (1)(a) are —
> (a) when and where the death occurred,
> (b) when and where any accident resulting in the death occurred,
> (c) the cause or causes of the death,
> (d) the cause or causes of any accident resulting in the death,
> (e) any precautions which—(i), could reasonably have been taken, and (ii), had they been taken, might realistically have resulted in the death, or any accident resulting in the death, being avoided;
> (f) any defects in any system of working which contributed to the death or any accident resulting in the death;
> (g) any other facts which are relevant to the circumstances of the death."

[29] Accordingly, I will set out the facts I have found to be admitted and proved and then explain why I consider it appropriate to make findings as I have in terms of section 26 of the Act (*supra*).

Summary

[30] I found the following facts to be admitted/proved:

1. That Lachlan Robertson was the skipper of the boat, *Reul A′ Chuain*, which he had owned since 1999.

2. That on 23 June 2021 the boat had left Mallaig harbour to fish for prawns in the Sound of Rum, between the Isles of Rum and Eigg. Present on board were the deceased, Mr Robertson, accompanied by the two crew members, AF and AM, the respective senior and junior deckhands.

3. That on the 24 June at about 16.50 hours the boat had completed its fishing for the day and the crew were in the process of hauling the nets on board by means of a manual winch. Mr Robertson, as skipper, was steering the boat whilst AF operated the winch.

4. That in the process of hauling the nets on board in the manner described, an unsecured net slipped from the deck and back into the sea whereby it started to drag behind the boat.

5. That the weather and sea conditions began to deteriorate as the crew worked together to retrieve the net by continuing to operate the winch. However, in doing so, the winch's hook detached from the netting causing more of the net to slip into the sea.

6. That in an effort to prevent more of the net slipping into the water and to help haul it back on board, AF stood on the netting which was on deck and used his hands to try to pull the net from the water.

7. That as the boat rolled heavily in the sea AF lost his footing and fell overboard.

8. That Mr Robertson and AM immediately went to help rescue AF by attempting to pull him back on board by hand.

9. That as the boat rolled again Mr Robertson, who was leaning over the boat's low bulwark, attempting to get hold of AF, also fell overboard.

10. That at 19.06 hours AM contacted the Coastguard and sent a "Mayday" distress call to alert other vessels within proximity of the incident.

11. That AM threw two lifebuoys into the water to assist AF and Mr Robertson, neither of whom were wearing a PFD. AF helped Mr Robertson into one of the buoys before putting the other around himself.

12. That AM used the lifebuoy line to help pull Mr Robertson alongside the boat. As he (Mr Robertson) attempted to climb from the lifebuoy onto the boat he lost his footing and fell backwards into the sea with the lifebuoy around his legs and lower body. As a result, his legs and knees were forced by the ring's buoyancy into the air which caused his head and upper body to be turned upside down and under the water. AF managed to grab hold of Mr Robertson and hold him upright while AM used the winch to drop a rope to AF which he then secured around Mr Robertson's waist. Thereafter, AM was able to winch Mr Robertson on board. Having done so AM repeated the same manoeuvre for AF. Mr Robertson was, at that point,

unconscious and unresponsive having been exposed to the cold and stormy water for a period of approximately 20 minutes.

13. That AM and AF immediately commenced CPR on Mr Robertson in an attempt to resuscitate him and so save his life.

14. That at 19.50 hours the ship, *Ronja Harvester*, reached the boat closely followed by the RNLI all-weather lifeboat from Mallaig.

15. That conditions were rough with a northernly offshore wind measured at 7 Near Gale force with a speed of 28 to 33 knots and a sea swell of up to 3 metres.

16. That the *Ronja Harvester* was able to pass oxygen and a defibrillator onto the boat and provided shelter to the lifeboat to allow its crew to board.

17. That shortly thereafter, the Coastguard helicopter arrived at the locus and the Search & Rescue paramedic was winched onto the boat.

18. That the RNLI crew and the paramedic continued to perform CPR on Mr Robertson but, at or about 20.35 hours, the paramedic determined, with no electrical output showing on the defibrillator, that efforts to resuscitate should cease.

19. That at or about 20.35 hours Mr Robertson was pronounced dead at the scene, namely on board the boat, the *Reul A' Chuain*.

20. That a post-mortem examination of Mr Robertson was carried out on 28 June 2021. It was concluded that he died from the effects of "immersion in water". In such a situation death can occur within a matter of minutes

from cold shock, an inability to perform bodily movements and so stay afloat during or soon after rescue as a result of rapidly decreasing blood pressure causing the body system to effectively shut down.

21. That a toxicology report was carried out on 29 June 2021. Samples tested showed no signs of alcohol, prescriptive or recreational drugs within Mr Robertson's blood system.

22. That the MAIB subsequently investigated the circumstances surrounding the accident and produced its Accident Report in December 2022.

23. That the report found that lifejackets and Personal Flotation Devices (PFDs) were available for each crew member and were in good condition at the time of the accident.

24. That, in addition, the report concluded that the volume of trawl nets at the stern of the boat were such that they were above the height of the bulwark and not secured to the boat. As result, when the boat rolled in the heavy seas some of the netting slipped overboard.

25. That neither AF nor Mr Robertson was wearing a fall prevention harness or a PFD when each fell from the boat and into the water.

26. That the crew had not practised the "man overboard recovery" procedure and were also unfamiliar with the boat's "man overboard recovery" equipment (Lazelus Lifelink) which was stored at the front of the boat.

27. That in December 2022 the MAIB issued a safety communication by way of a flyer to the entire fishing industry highlighting the accident and its main findings.

Submissions

[31] Miss Graham, on behalf of the Crown, accepted that Mr Robertson died at the locus in the circumstances as described above. As a result of this and as set out in their detailed written submissions, the Crown merely sought formal findings in respect of section 26(2) (a), (b), (c) and (d) of the Act. They did not seek findings in respect of the remaining parts of the sub-section.

Decision

[32] It is a matter of fact (see para [30] 20. above) that Mr Robertson died from the effects of immersion in water on 23 June 2021 in heavy seas at the locus in the Sound of Rum.

[33] Mr Robertson was skipper of the boat which he had owned since 1999. He was regarded as a highly experienced and competent seaman with extensive knowledge of the sea waters from the boat's base at Mallaig into the Sound of Rum and the surrounding waters.

[34] Whilst the two crew members, AF and AM, had worked on the boat for relatively short periods of time both had demonstrated competence in their respective roles as senior and junior deckhand. In the case of AF he had been working at sea since

leaving school and in the local fishing industry at Mallaig since 2015. In the case of AM, whilst he had only been employed by Mr Robertson for 4 months prior to the accident, it is evident from his actions on the date in question he displayed admirable common-sense and courage in dealing with an emergency of the highest degree by helping to rescue both AF and Mr Robertson after they had fallen overboard into very heavy and dangerous sea waters.

[35] In addition, AM is to be commended for his actions in immediately contacting the Coastguard and other shipping in the area by way of a Mayday distress call.

[36] Similarly AF is to be commended for keeping Mr Robertson afloat, securing a rope around his waist and helping to get him back on board. He and AM thereafter did all they could to try to keep Mr Robertson alive prior to the arrival of the RNLI crew members and TJ.

[37] Equally, it is obvious that the RNLI crew and the search and rescue paramedic did all they could to save Mr Robertson's life by their extensive CPR efforts when they took over from AM and AF.

[38] From the findings of the MCA and MAIB reports it is apparent that neither Mr Robertson nor AF were wearing PFDs at the time of the accident. In the case of Mr Robertson, it was concluded that his chances of survival would have been improved had he been wearing a PFD. No safety belts or harnesses with life restraint arrangements were found on board which whilst not normally worn were not available to either at the time of the incident developing. The boat was, however, fitted with a "man overboard" recovery system and equipment but, regrettably, these were not

utilised by the crew who were unaware of its storage and unfamiliar with the procedures that would be involved in its use. As stated in the MAIB report a combination of these failures together with infrequent emergency drills led to this tragic event unfolding as it did.

[39] In stating the above it must also be recognised that what happened on the date of the accident was extremely unexpected. As a result, Mr Robertson and the crew were caught completely off guard. They had finished a normal working day fishing for prawns and having hauled the nets back on board were in the process of heading back to harbour when the weather conditions changed resulting in the boat starting to roll in the sea swell. As a result, part of the nets, which had been hauled on board but were not secured, slipped back into the sea. The crew immediately took steps to try to haul those nets back in by firstly the use of the boat’s winch. Unfortunately, the hook on the winch detached from the net’s mesh causing more of the nets to slip into the sea. It was at this point that AF stood on the nets which were on deck to try to haul the rest back on board by hand. In doing so he slipped overboard as the ship rolled. Mr Robertson, who had left his position in the wheelhouse, attempted to assist AF back onto the boat by leaning over the bulwark to grab hold his hand. As the boat rolled again, Mr Robertson also fell overboard. Without a PFD he struggled to stay afloat in what was a very cold and stormy sea. As a result, he quickly started to suffer from the effects of such cold water immersion which affected his ability to swim and stay afloat. AM had the presence of mind to contact the Coastguard, throw lifebuoys and a rope to AF and Mr Robertson

and then winch each of them on board. He and AF immediately commenced CPR on Mr Robertson.

[40] All of this happened within a relatively short period of time in a very heavy and rolling sea. As stated in the MAIB accident report the crew were focussed on, firstly, retrieving the nets that had slipped from the deck and, secondly, attempting to rescue AF and Mr Robertson when they each had fallen overboard. In this very challenging and fast-moving situation it is perhaps understandable why matters deteriorated as they did. However, it is apparent that the crew were not familiar with the location of the emergency equipment that was on board nor up to date in its use. Matters would also have been improved if the nets had been properly secured or lashed to the deck which might well have prevented AF from falling into the water as when he did.

[41] It must be stated that had Mr Robertson been wearing his PFD his chances of survival would almost certainly have been greater. As the boat's skipper the responsibility for this lay with Mr Robertson. It is telling that Mr Robertson instructed AM to put on his PFD but neither he (Mr Robertson) or AF did so. As highlighted in the conclusion of the MAIB report statistics clearly show that survival in such a situation is more likely if a PFD or lifejacket is being worn.

[42] Account must also be taken of the comments in the summary of the MAIB report which states:

> "Given the existing extensive safety guidance to fishing vessel owners and skippers, specifically on mitigating the risks of falling overboard, and the requirement for fishermen to wear a personal flotation device or to have measures in place to prevent falling overboard, no recommendations are made…"

[43] In addition, when Mr Robertson attempted to climb back on board he fell back into the sea with his legs still in the lifebuoy. As a result, the lifebuoy lifted his knees up which, in turn, pushed his head and upper body down into the water. At this point his ability to cope with being immersed in the stormy waters rapidly deteriorated. AF was able to grab hold of and then right Mr Robertson before securing a rope around him which allowed AM to winch him out of the water.

[44] It is also necessary to take into account the steps taken since the accident to improve safety at sea particularly for those directly involved in the fishing industry. Firstly, the MAIB has emphasised that a lifebuoy or life ring is a very simple piece of lifesaving equipment which is fitted to every ship as well at harbours and many beaches and lakesides. They are designed to help support any person in difficulty, who has fallen into water but, with the caveat that such a person is able to properly secure the lifebuoy/ring around him/herself. In this case Mr Robertson was unable to right himself in the lifebuoy/ring when he fell back into the water. The MAIB have confirmed that there is no intention to change any of the guidance which is in place for the use of lifebuoys because of the importance of the simplicity of both the design and instructions for use in an emergency situation.

[45] Secondly, the MAIB has advised that a PFD or lifejacket carries out a very similar function to that as a lifebuoy/ring but is worn around the body and so allows the wearer to remain buoyant in water. In this case Mr Robertson had ensured that AM was wearing his PFD but neither he nor AF had put on their own, which was against the

specific advice and guidance given to all vessel owners and skippers as referred to in the MAIB summary *(supra).*

[46] Thirdly, the International Maritime Association has proposed a standard for all fishermen to undertake mandatory refresher training for vessels over 24 metres in length although this is still to be implemented. The *Reul A' Chuain* being 18 metres in length fell outwith this category.

[47] Finally, the Seafish Industry Authority (SIA) chairs the Fishing Industry Safety Group (FISG) which represents various groups of the UK's fishing industry including the Scottish Fishermen's Association. Its main purpose is to encourage collaboration between members and regulators to promote safe working in the fishing industry. Sustained efforts have been made to ensure there is mandatory refresher training for new industry entrants as well as to highlight and encourage voluntary workforce skills. As a result, it is reported that many thousands of courses and skippers' tickets for boats under 16.5 metres have been undertaken and obtained.

[48] So far as the productions are concerned it is important to draw attention to the following parts of the documents highlighted below which are very relevant to the present case:

CP23 – MCA Fishermen's Safety Guide dated May 2020 – the responsibility on board a vessel rests with skipper to, *inter alia*, provide supervision for fishermen to work safely at all times and to arrange regular on-board occupational safety and health awareness training;

CP24 – MCA Marine Guidance Note 570 (F) Emergency Drills (in force to June 2022 and now superseded by CP25) – to review drills with crew; to practise use of equipment; to have a plan for recovering a man overboard and to ensure crew wear PFDs when there is such a risk of falling overboard;

CP26 – MCA Marine Guidance Note MGN 571 (F) Prevention of Man Overboard dated October 2017 – if it is necessary for fishermen to climb on rails etc while fishing or performing work on nets, precautions should be taken; safety harnesses or lines must be worn;

CP27 – MCA Marine Guidance Note MGN 588 (F) Compulsory Provision & Wearing of PFDs dated April 2024 – unless measures are in place to eliminate the risk of falling overboard all fishers must be provided with and wear PFDs or safety harnesses;

[49] Because of these directions and for the reasons given above, the Crown seek findings without any further recommendation being made. Having considered all of the above, I am satisfied that it is not appropriate to make any other recommendations and that the industry's various regulatory and representative organisations, and in particular the MCA and MAIB, are best placed to understand, monitor and, if needs be, update or change the safety procedures that currently exist to protect all fishermen. I am therefore satisfied that the current measures in place, including the steps taken since this accident, adequately address the concerns that have been identified in the investigation and subsequently raised in this inquiry.

[50] I therefore consider that what occurred on the date was a tragic accident where no blame can be attached to AM or AF, the other crew members. Indeed, they are to be commended for the admirable courage and wherewithal they displayed in the most challenging of circumstances. It is obvious that they were visibly shaken and distressed by what had happened to the skipper of their boat with whom it appears they had a very good relationship.

[51] I consider that it was a combination of factors that resulted in the accident occurring as it did. This included the unexpected and rapidly deteriorating weather conditions, the unsecured net slipping overboard, the failure of both Mr Robertson and AF to wear their PFDs, together with the crew's unfamiliarity with the boat's emergency equipment and man overboard procedures.

[52] In stating this it is acknowledged that Mr Robertson was regarded as a highly experienced fisherman with an extensive knowledge of the waters in which he fished. He was popular with his colleagues and kind to all who knew him, including his much-loved family.

[53] I am satisfied that Mr Robertson's death was due solely to the circumstances as described above and as recorded in the autopsy report and death certificate. I therefore consider that the appropriate findings are formal ones in terms of section 26(2)(a), (b), (c), (d) of the Act together with my findings in terms of section 26(2)(e) and (f), as reflected at the start of this determination and in para [30] (*supra*).

[54] I will finish by thanking Miss Graham, on behalf of the Crown, for her very comprehensive report and to also extend my sincere condolences to Mr Robertson's

family, friends and colleagues for their very sad loss in these most tragic of circumstances. In addition, I would like to record my thanks to Mr Robertson's family for their participation in this inquiry and the very dignified manner in which they conducted themselves throughout the proceedings.