SHERIFFDOM OF GRAMPIAN, HIGHLAND AND ISLANDS AT DORNOCH

UNDER THE FATAL ACCIDENTS AND SUDDEN DEATHS INQUIRY (SCOTLAND) ACT 1976

Case Ref: B10/09

DETERMINATION

by

Sheriff David Oman Sutherland

Sheriff of Grampian, Highland and Islands at Dornoch

In

FATAL ACCIDENT INQUIRY

into the death of

JOSE MARIA MARTOS FERNANDEZ

Dornoch, 12 May 2009

An inquiry under the Fatal Accident and Sudden Deaths Inquiry (Scotland) Act 1976 into the death of Jose Maria Martos Fernandez was held before me at Dornoch Sheriff Court on 23rd February 2009.

The Crown was represented by Mr Alistair MacDonald, Procurator Fiscal and Lagun Talde SA was represented by Mr Donald MacKenzie, solicitor, Inverness.

I made the following findings:-

(1) Jose Maria Martos Fernandez died at Lochinver shortly after 3.30am on 6th May 2006.

(2) Mr Fernandez died from chest injuries including transection of the aorta due to blunt trauma from a falling pallet on MSV Kirrixki fishing vessel at Lochinver harbour. The said vessel was owned by Lagun Talde SA, Egidazu Kaia 12, 48700 Ondarroa, Bizkaia, Spain, employers of the deceased.

(3) The accident was caused by a pallet falling on to the deceased due to the parting of the wire rope of the boat's crane. The failure of the rope was due to the effects of fatigue and corrosion.

(4) The accident and death of Seńor Fernandez might have been avoided if steps had been taken to regularly inspect the wire rope of the crane. There should have been a visual inspection of the extended wire by a crew member every week at sea using a gloved hand and a fuller inspection by the owners of the vessel when the boat returned to its home port every three months.

Sheriff

Note

[1] I heard evidence from various witnesses both orally and via written statement.

[2] I heard first from Mrs Fiona Gudgeon, Operations Manager for Inverpesh Limited which acted as an agent for fishing vessels in Lochinver harbour and in particular acted as an agent for the vessel known as the Kirrixki. She described how lorries would be loaded up with boxes of fish which had been removed from the vessels' hold on wooden pallets and slung and hoisted up and over to the waiting lorries by means of a crane on the vessel concerned.

[3] She first heard from the vessel's skipper of the accident and she made immediate calls to the emergency services, including calling ambulance control requesting a helicopter. She described how the emergency services had arrived very quickly and how the doctor had confirmed that the casualty had died at the scene of the accident.

[4] Mrs Gudgeon also described how the Kirrixki had been coming to Lochinver harbour since 2000 and how their pattern of work meant that they would come for approximately three months at a time and would land weekly during that three month period.

[5] I also heard from Police Constable Graeme Erskine and Detective Sergeant Andrew Logan who both spoke to investigating the accident, including the taking of photographs, interviewing crew members and recovering productions, including wire rope from the Kirrixki.

[6] The various statements of the crew described how a line of fishermen would hand the boxes of fish to each other with the boxes being iced and the deceased standing on the pallet. When the pallet was being lifted the deceased was underneath the lift and was putting another pallet on hurrying to get the next one loaded. It was at this stage that the pallet fell on top of the deceased causing the crush injury.

[7] I heard from Mr Iain MacDonald of I. A. M. Engineering Services, Rigging and Crane specialists. Mr MacDonald, a qualified mechanical engineer, inspected the crane on the Kirrixki on 14th May 2006 and made various recommendations which he felt should be attended to prior to use of the crane. *Inter alia* he recommended that the crane should be fully overhauled because as he described it was fairly old and was not in the best of conditions. He felt that the overhaul should take place within a period of six months and stated that lubrication of the rope was not being carried out. He recommended that this should be done as part of a weekly service schedule. He also recommended that there should be a regular inspection of the crane and the winch on a monthly basis by a member of the crew who was sufficiently competent to do it.

[8] I heard finally from Mr Keith Burkitt, a Chartered Engineer employed by the Health and Safety Executive at their laboratory at Harperhill, Buxton in Derbyshire. Mr Burkitt examined the wire rope recovered by the police officers from the fishing vessel and produced a report on his findings. Mr Burkitt's conclusion was that the accident was caused by the parting of the rope due to the effects of fatigue and corrosion. It was Mr Burkitt's evidence that the rope had not been lubricated and that it had not, in his view, been properly maintained. He felt that the wire rope should

have been examined not less than monthly. It was his view that this clearly had not been done and examination could be done by simply conducting a visual and gloved hand examination of the extended rope which would have revealed any deficiency.

[9] I also had before me the report of Dr Rosslyn Rankin, Consultant Pathologist, Raigmore Hospital, Inverness, whose report showed that the cause of death was chest injuries, including transection of the aorta, due to blunt trauma from a falling pallet on a fishing vessel.

[10] Clearly this accident was distressing for all Seńor Fernandez's colleagues who were working with him at the time. It is clear from their statements that Seńor Fernandez, or Papaito as he was affectionately known by his colleagues, was a very hard working and popular member of the crew and the court can only extend its sympathies to the relatives of the deceased, assuring them that the description of their loved one given at the inquest by his colleagues was of someone of whom they should be very proud.

[11] Clearly this accident was not foreseen by anyone and the description given in the statements of the crew of a modern vessel with a crew who got on very well together only goes to remind us of dangers which face even the most diligent and hard working crews in our fishing industry.

[12] It is clear, however, that this accident could have been avoided. The rope did not have to break and all the evidence points to the inescapable fact that the crane and the wire rope was not well maintained. Indeed even a weekly visual examination using a gloved hand would have alerted the crew to a potential difficulty and certainly a more rigorous examination when the boat went back to its home port in Spain every three months should have been carried out and might well have prevented this tragedy.