

SHERIFFDOM OF GRAMPIAN, HIGHLAND AND ISLANDS AT LERWICK

2012 FAI 25

DETERMINATION
of
Philip Mann
Sheriff of Grampian, Highland
And Islands at Lerwick
in respect of
Fatal Accident Inquiry
relating to the Death of
Neil Smith

Lerwick April 2012.

The Sheriff, having heard evidence on 16 April 2012 and now having resumed consideration of the matter Finds and Determines as follows:-

- (a) In terms of Section 6(1)(a) of the Fatal Accident and Sudden Deaths Inquiry (Scotland) Act 1976, Neil Smith, aged 54 years (date of birth 2 June 1956), who resided at Bluehamar, Gord, Cunningsburgh, Shetland died in the course of his self-employment as a single handed creel fisherman at approximately 11:00 hours on 20 January 2011 in the sea at a point approximately 5.5 miles due east of Score Head, Bressay, Shetland. His death was the result of an accident on board the fishing vessel Breadwinner (“the vessel”) at that location at about that time.
- (b) In terms of Section 6(1)(b) of the said Act, Mr Smith’s death was caused by salt water drowning as a result of his being dragged from the vessel into the sea following an accident in which his right leg became caught in a leader

Fatal Accident Inquiry re Neil Smith

rope attached to a series of creels which had already been shot from the vessel into the sea.

- (c) In terms of Section 6(1)(c) of the said Act, I determine that if Mr Smith had exercised, or had been able to exercise, the reasonable precaution of remaining in the wheelhouse of the vessel during the shooting of the creels from the vessel the accident which resulted in his being dragged into the sea and being drowned would not have occurred.
- (d) In terms of Section 6(1)(d) of the said Act I cannot identify any defect in any system of working which contributed to Mr Smith's death.
- (e) There is nothing to add in terms of Section 6(1)(e) of the said Act but I make reference to my note appended hereto.

Sheriff Philip Mann

Note/

Note

1. Representation

- 1.1 The Procurator Fiscal was represented by Mr MacKenzie, Procurator Fiscal Depute. No other party was represented but members of Mr Smith's family were present and displayed great dignity throughout the inquiry.

2. The Witnesses

- 2.1 I heard evidence from the following witnesses:

- Rodney Smith, Wyndroyd, Scousbrough, Drumrossness, Shetland. He is the deceased's brother.
- Edwin Graham, Police Inspector, Northern Constabulary, Police Station, Lerwick, Shetland
- Dr James Henderson Kerr Grieve, Forensic Medicine Unit, University Medical Buildings, Foresterhill, Aberdeen
- William Andrew West, Marine Accident Investigation Branch ("MAIB"), Mountbatten House, Grosvenor Square, Southampton.

I found all of these witnesses to be credible and reliable and I record my gratitude to them for answering the call to give evidence in these proceedings. I especially record my gratitude to Rodney Smith who gave his evidence in a measured and most dignified manner.

3. Documentary and other productions

- 3.1 Dr Grieve referred to his written report which was lodged as a production.

- 3.2 Mr West referred to a comprehensive report written by him under the auspices of MAIB dated November 2011. It was lodged as a production. The report was obviously prepared with great care and attention to detail. I found it to be most helpful and I would commend it as essential reading for anyone involved in single handed creel fishing. It can be found on the internet at the address noted below¹.
- 3.3 There was also lodged as a production a video produced by MAIB demonstrating the safe operation of a system of shooting and recovering creels by a single handed fisherman. This was played during the evidence of Rodney Smith.

4. The Background

- 4.1 Neil Smith was the skipper and owner of the vessel. He was a very experienced fisherman and, in particular, he was very experienced in single handed creel fishing. He was held in high regard as a fisherman and was a very well respected member of the Shetland community.
- 4.2 Mr Smith purchased the vessel in October 2006 and went to some expense and trouble in adapting it for safe single man operation. At the time of the accident the vessel was in good and safe condition.
- 4.3 Mr Smith was known to be, and was, a very careful and measured man in the way he approached his work as a fisherman. He was very safety-conscious.
- 4.4 It seems to me to be unnecessary for me to attempt to describe creel fishing operations and the dangers associated with them. These matters are admirably covered in the MAIB report. Suffice to say that it is very dangerous for any person to be on the deck of a vessel in the vicinity of the ropes attached to the

¹ http://www.maib.gov.uk/cms_resources.cfm?file=/Dual_Report_DISC_BW.pdf

creels at any time during the operation of shooting the creels into the sea. It is especially dangerous to attempt to rectify a situation where the creels and ropes have become fouled during the shooting, as can and does happen. Mr Smith was very well aware of these dangers. His attitude to fouled creels, which was well known to his peers, was to let the fouled creels shoot off the boat and “sort the mess out later”. It was understood that his invariable practice was to remain in the wheelhouse of the vessel during the entire shooting operation.

- 4.5 The system of work adopted by Mr Smith in shooting his creels was safe. However, as with any system of work, safety is compromised if the system is not adhered to.

5. The Accident

- 5.1 The accident whereby Mr Smith became entangled in the ropes attached to the creels and was dragged into the sea can only have happened because Mr Smith did not adhere to his system of work and left the safety of the wheelhouse during the shooting operation.

6. Why did Mr Smith leave the wheelhouse?

- 6.1 No one will ever know for certain why Mr Smith put himself in danger by leaving the safety of the wheelhouse during the shooting operation. Two possibilities were canvassed during the inquiry. The first was that the creels and ropes had become fouled and he left the wheelhouse to sort out the situation. This would have been against his oft stated attitude to fouled creels. The second possibility, which arises out of Dr Grieve’s evidence, is that Mr Smith became unwell and left the wheelhouse to get fresh air. Dr Grieve explained that Mr Smith’s heart was found to be somewhat enlarged by virtue of concentric left ventricular hypertrophy, the commonest, recognisable, documented cause of which is raised blood pressure. He explained that people with heart failure will very often try to

get into an open space to get fresh air or may feel sick and want the same thing. He could not rule out heart failure and its effects as a possible explanation for Mr Smith leaving the wheelhouse. I prefer to think on the evidence that this latter is the more likely explanation but as it is not necessary for me to do so in order to make the formal determinations required by the 1976 Act I express no concluded view on the matter.

7. Reasonable Precautions

- 7.1 The MAIB report refers to three areas of Mr Smith's operation where safety might have been improved and the risk of accident and death reduced. These were (a) separation of crew from gear; (b) stacking of creels; and (c) survival and accident mitigation considerations, including the availability of a knife to cut the rope pulling Mr Smith overboard, the wearing of a personal flotation device ("PFD") and personal locator beacon ("PLB") and the fitting of the vessel with a remote engine cut-out device. I have come to the conclusion on the evidence that the only reasonable precaution which might have prevented the accident and the death of Mr Smith would have been for him to have remained in the wheelhouse until all the creels, fouled or otherwise, had been shot from the vessel. A PFD, a PLB and a remote engine cut-out device would only have been of any use in the event that Mr Smith had been able to use a knife to cut the rope. The evidence was that the period of time between Mr Smith becoming entangled in the rope and his landing in the sea would have been about 3 seconds. Even if he had had a knife on his person, which appears not to be the case, and again on the evidence, it is highly improbable that Mr Smith would have been able to evaluate the situation and gain the presence of mind to use the knife to free himself before entering the sea. Mr West was able to cite only one incident in which a fisherman had survived after being dragged into the sea in similar circumstances. However in that incident there had been three persons on the vessel and there were thus two persons available to assist immediately in the rescue. Even so, in that incident it

had been necessary for the rescuers to perform resuscitation techniques for a long period in order to save the man's life.

8. Final remarks

- 8.1 I have nothing further to add but I take the opportunity, once again, to express the sympathy of the court to Mr Smith's relatives for the loss of such a well respected and beloved man who is obviously sorely missed. I also wish to pay tribute to the relentless efforts of members of Mr Smith's family, including his brother Rodney, which resulted in Mr Smith's body being recovered from the sea some eight days after the accident.
- 8.2 I also wish to record my gratitude to Mr MacKenzie for his skilful presentation of the evidence and for his well considered and helpful submissions.