SHERIFFDOM OF GRAMPIAN, HIGHLAND AND ISLANDS AT BANFF

[2026] FAI 10

BAN-B18-25

DETERMINATION

BY

SHERIFF ROBERT MCDONALD

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

into the death of

ALEXANDER ALEXANDER

Banff 9 March 2026

The sheriff having considered the information presented at the Inquiry, determines in terms of Section 26 of the Act as follows:

1. In terms of Section 26(2)(a) that the late Alexander Alexander, date of birth 29 July 1954, (hereinafter referred to as Mr Alexander), who resided in Fraserburgh died in the North Sea at the coastal area near to Melrose Point, between the towns of Macduff and Gardenstown, Aberdeenshire between 1100 hours and 1215 hours on 21 September 2023. Life was formally pronounced extinct at 1215 hours on the same date.

2. In terms of Section 26(2)(b) that the accident resulting in the death of the late Mr Alexander occurred in the North Sea at the coastal area near to Melrose Point,

between the towns of Macduff and Gardenstown, Aberdeenshire between 1100 hours and 1215 hours on 21 September 2023.

3. In terms of Section 26(2)(c) the cause of the death of the late Mr Alexander was a head injury and drowning as a consequence of his fishing vessel, the Lexi Rose grounding and capsizing. The proximate cause of death was due to drowning. The nature of the head injuries sustained would have rendered Mr Alexander helpless to keep his airways clear of water.

4. In terms of Section 26(2)(d) the accident which resulted in Mr Alexander's death was the grounding and capsize of his fishing vessel, the Lexi Rose. Due to the grounding and capsize of that vessel Mr Alexander ended up in the sea where he struck his head on a hard object, either part of the boat or a rock. As a result of this he was rendered unconscious. On balance of probabilities, the grounding and capsize of the Lexi Rose occurred due to the shearing of the outboard engine's lower assembly unit on rocks, leaving the vessel with no propulsion and at the mercy of the sea conditions. It is likely that the motion and force of the swell of the sea contributed to the shearing of the engine, both by disguising the proximity of rock promontories and by the force of pulling the vessel down and onto said rocks. On the balance of probabilities, following the loss of propulsion, the motion and force of the swell of the sea caused the Lexi Rose to be pushed towards the shore, ground on rocks there and capsize.

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

a) For Mr Alexander to have been wearing a personal floatation device when working on the deck of his vessel around the coastal inlets at Melrose Point on 21 September 2023;

b) For Mr Alexander to have avoided the inlets at Melrose Point on 21 September 2023 owing to the prevailing conditions at that particular area on that date.

6. In terms of Section 26(2)(f) there were the following defects in a system of working which contributed to the death or the accident resulting in the death:

a) That Mr Alexander, particularly when working alone, ought to have worn a personal floatation device at appropriate times, and particularly when working on the deck of the Lexi Rose.

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

a) Mr Alan West did his best to save Mr Alexander, by his immediate attempt to provide him with assistance, by summoning the emergency services, and by searching for him in the sea. He is to be commended for his efforts, in challenging conditions, and ought to be reassured that he did all he reasonably could in the circumstances.

b) The emergency services and their coordination, involving the Harbour Master, Mr Duncan Mackie, the Royal National Lifeboat Institution, and His Majesty's Coastguard, including winchman Mr Scott Sharman are to be commended for their efforts to rescue Mr Alexander in challenging conditions.

8. I do not consider it appropriate to make any recommendations in terms of Section 26(1)(b) as to any of the matters mentioned in Section 26(4).

NOTE

Introduction

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

[2] The Inquiry was a mandatory Inquiry under section 2(3)(a) and (b) of the Act as Mr Alexander died as a result of an accident which occurred in Scotland in the course of his occupation as a self-employed fisherman.

[3] The circumstances surrounding Mr Alexander's death were investigated by the Marine Accident Investigation Branch ("MAIB").

[4] The first notice in the Inquiry was lodged by the Crown on 17 June 2025.

[5] There was a preliminary hearing on 8 August 2025 and the hearing of the evidence in the Inquiry took place on 16 October 2025. A hearing on submissions on the evidence took place on 13 November 2025.

[6] The deceased's son, also called Alexander Alexander was present at the preliminary hearing on 8 August 2025. He indicated that while he wished to view proceedings, he did not wish to be a participant in the Inquiry. Accordingly, from that date the procurator fiscal was the sole participant in the Inquiry and was represented by Alan Morrison, principal procurator fiscal depute.

The evidence

[7] On 25 July 2025 the Crown lodged certain productions including the post-mortem and toxicology reports, the MAIB report and the MAIB Safety Flyer relative to this accident.

[8] On 3 October 2025 the Crown lodged Affidavits from those witnesses who were not expected to be required to give evidence in person.

[9] On 3 October 2025 the Crown also lodged a Notice to Admit Information in terms of Rule 4.12 of the Act of Sederunt (Fatal Accident Inquiry Rules) 2017 which contained evidence that I was satisfied was uncontroversial. There was no objection to this, and I accepted the facts set out in the Notice to Admit.

[10] The hearing of the Inquiry on 16 October 2025 was conducted by means of a Webex video conference. The Crown led parole evidence from two witnesses, namely Mr Alan West and Dr Will Tutton of the MAIB.

[11] On 11 November 2025 a Note of Written Submissions on behalf of the procurator fiscal was lodged in court and at the hearing on 13 November 2025 Mr Morrison narrated these submissions into the record. I then made avizandum.

The statutory framework

[12] The Inquiry is held under section 1 of the Fatal Accidents and Sudden Deaths etc. (Scotland) Act 2016 ("the Act") and is governed by the Act of Sederunt (Fatal Accident

Inquiry Rules) 2017 ("the 2017 rules"). The purpose of such an Inquiry is set out in section 1(3) of the 2016 Act and is to:

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

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

> "(1) As soon as possible after the conclusion of the evidence and submissions in an Inquiry, the sheriff must make a determination setting out –
> (a) in relation to the death to which the Inquiry relates, the sheriff's findings as to the circumstances mentioned in subsection, and
> (b) such recommendations (if any) as to any of the matters mentioned in subsection (4) as the sheriff considers as appropriate.
>
> (2) The circumstances referred to in subsection 1(a) are –
> a) when and where the death occurred;
> b) when and where any accident resulting on the death occurred;
> c) the cause or causes of the death;
> d) the cause or causes of any accident resulting in the death;
> e) any precautions which –
> (i) could reasonably have been taken, and
> (ii) had they been taken might realistically have resulted in the death or any accident resulting in the death, being avoided;
> f) any deficits in any system of working which contributed to the death or any accident resulting in the death;
> g) any other facts, which are relevant to the circumstances of the death.
>
> (3) For the purposes of subsection 2(e) and (f) it does not matter whether it was foreseeable before the death or accident that the death or accident might occur –
> (a) if the precautions were not taken, or;
> (b) as the case may be, as a result of the defects.
>
> (4) The matters referred to in subsection 1(b) are –
> (a) the taking of reasonable precautions
> (b) the making of improvements to any system of working;
> (c) the introduction of a system of working
> (d) the taking of any other steps which might realistically prevent other deaths in similar circumstances."

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

Issues for the Inquiry

[15] In the Notice of the Inquiry lodged by the procurator fiscal on 17 June 2025 the Crown indicated that it was anticipated that the sheriff would be invited to make findings in respect of the death under section 26(1)(a), as to the circumstances mentioned in section 26(2)(a), (b), (c), (d), (e), (f) and (g) of the 2016 Act. The Crown also indicated that the procurator fiscal may also, on consideration of the totality of the evidence adduced at the Inquiry, invite the sheriff to make recommendations under section 26(1)(b) as to the matters mentioned in section 26(4). In respect of the foregoing the Crown anticipated that consideration may be given to the following areas of evidence:

a. The findings and analysis contained within the report of the Marine Accident Investigation Branch (MAIB) following an investigation into the circumstances of the incident involving the Lexi Rose; and in particular:

b. The conditions and hazards around the inshore fishing areas at Melrose Point, East of Macduff, Aberdeenshire, on 21 September 2023;

c. The impact said conditions and hazards may have had on the vessel Lexi Rose and the likely cause or causes of any accident that led to the capsize.

d. The use, or otherwise, of personal safety devices and emergency procedures by Mr Alexander.

e. Fishing industry regulations and guidance as to safety measures and, in particular, such measures as to single-handed fishing operations.

Summary of Facts

I found the following facts admitted or proved;

Introduction

[16] Mr Alexander Alexander, known as "Sandy ", Alexander ("Mr Alexander"), was born in Banff, Aberdeenshire, on 29 July 1954. He lived in Fraserburgh, Aberdeenshire. He died on 21 September 2023, aged 69.

[17] Mr Alexander lived in the North East of Scotland all of his life and worked in the fishing industry all of his working life. Mr Alexander had one son, also called Alexander Alexander, and one daughter called Caroline Alexander. Mr Alexander was formerly married to Margaret Alexander, the mother of his children.

[18] At the time of his death, Mr Alexander was a self-employed fisherman and was the skipper of the creel fishing vessel Lexi Rose. Mr Alexander and his ex-wife, Margaret Alexander, co-owned the business Sanmar Fishing Company Limited. The vessel Lexi Rose and its fishing business was operated via that company. Mr Alexander and his family also owned and operated a larger commercial fishing vessel, the Lillyana,

which was operated via a separate limited company and skippered by the family's son, Mr Alexander (junior).

[19] Mr Alexander was an experienced fisherman and had completed all of the required training and certification to operate on a UK-registered fishing vessel. Mr Alexander's family report that he could not swim, and that he rarely wore a lifejacket or personal floatation device.

[20] Mr Alexander was in good health at the time of his death, and was not prescribed any medication.

The Lexi Rose

[21] The Lexi Rose was a 7.3 metre aluminium single-hulled fishing vessel which had been built in 1990. It had been purchased by Mr Alexander in 2016. It had an aluminium working deck and an aluminium platform at the stern where an automatic life raft was stowed. A hydraulic pot hauler was mounted forward on the starboard side next to a small wheelhouse. An anchor was stored in the port stern locker.

[22] The Lexi Rose was powered by a centrally mounted 50 horsepower outboard engine that was controlled from the wheelhouse. There was no secondary propulsion. The deepest point of the vessel was the outboard engine's lower assembly unit which projected approximately 150 millimetres below the keel.

[23] Three personal floatation devices ("PFDs") and an unregistered personal locator beacon ("PLB") were normally stored within the wheelhouse. The vessel was equipped

with a Very High Frequency ("VHF") digital selective calling radio, and an electronic chart plotter for navigation purposes.

[24] As of 21 September 2023, the Lexi Rose complied with all regulatory requirements. The Maritime and Coastguard Agency had issued the Lexi Rose with a Small Fishing Vessel Certificate which was valid until 07 July 2026. The vessel was also appropriately insured. The Lexi Rose was UK registered and bore the boat registration marker BF 370.

[25] Mr Alexander berthed the Lexi Rose at Banff Harbour, and would usually operate single-handed, fishing within three nautical miles of Banff Harbour.

[26] The vessel was used mainly for lobster fishing along the coast, with Mr Alexander utilising individual fishing creels attached to long ropes with marker buoys.

Circumstances of Mr Alexander's Death

[27] In the morning of 21 September 2023, Mr Alexander travelled from his home address in Fraserburgh to Banff Harbour. At around 0837 hours, same date, Mr Alexander left Banff Harbour aboard the Lexi Rose alone. He had been in communication via text with his son, Mr Alexander (junior), early that morning with the conversation focused on fishing plans for that day.

[28] Mr Alexander travelled East from Banff Harbour along the coast towards Macduff and Gardenstown. These were areas he was very familiar with and regularly used for lobster fishing along the coastal inlets.

[29] Mr Alan West is the owner of the creel fishing vessel, *Chance*, which is berthed at Macduff Harbour. Mr West had seen Mr Alexander aboard the Lexi Rose heading East on the morning of 21 September 2023. Later that morning, Mr West left Macduff Harbour aboard the *Chance* alone and headed East in the same direction that he had seen Mr Alexander travel.

[30] Mr West and Mr Alexander were well known to each other and spoke via mobile phone at around 1050 hours that morning. Mr Alexander advised he was at Melrose Point, an area on the coast between Macduff and Gardenstown. They discussed the weather and conditions and Mr Alexander stated that he thought the conditions were workable with care which echoed Mr West's opinion on those matters. Following that call, Mr West began to travel towards Mr Alexander's location.

[31] A few minutes after that phone call, Mr West heard a call on the Very High Frequency (VHF) radio channel 12 from Mr Alexander. That radio channel is the harbour working channel for the local area and not the usual channel for distress calls. Mr Alexander was panicked and calling for assistance from a lifeboat.

[32] Mr West immediately began to make his way at full speed towards Mr Alexander and contacted the lifeboat and the area harbour master to summon emergency assistance.

[33] Mr West arrived at the location of Mr Alexander at around 1110 hours. The Lexi Rose had capsized, with the upturned hull visible within a small cove at Melrose Point. Mr West was unable to safely enter the cove but began a search of the area in case Mr Alexander had been swept out to sea.

[34] At around 1112 hours a member of the public contacted His Majesty's Coastguard to report sighting a capsized vessel at Melrose Point.

[35] A Royal National Lifeboat Institution (RNLI) lifeboat was launched from Macduff. The lifeboat arrived at the cove at around 1137 hours but was unable to enter the cove due to the sea and swell. Despite their efforts, the lifeboat crew could not locate Mr Alexander.

[36] At around 1200 hours a rescue helicopter from His Majesty's Coastguard arrived on scene and quickly located Mr Alexander floating within a small cove. He was not wearing a personal floatation device and was found near to rocks around 5 metres to the West of the upturned Lexi Rose.

[37] Mr Scott Sharman, a winchman paramedic, lowered and retrieved Mr Alexander.

[38] Mr Alexander's life was pronounced extinct aboard the rescue helicopter at 1215 hours on 21 September 2023.

[39] Mr Alexander's body was transported to Raigmore Hospital, Inverness. Mr Alexander was positively identified at Raigmore Hospital by his ex-partner, Margaret Alexander, and his son, Mr Alexander (junior).

[40] The Police Service of Scotland reported Mr Alexander's death to the Scottish Fatalities Investigation Unit of the Crown Office and Procurator Fiscal Service. Due to the nature of his death, a postmortem examination was instructed.

[41] On 27 September 2023 at Raigmore Hospital, Inverness, Dr Mark Ashton, Consultant Pathologist, conducted a postmortem examination on the body of Mr Alexander. Samples were sent for toxicological analyses.

[42] Toxicological analyses of samples of Mr Alexander's blood concluded that no intoxicating or impairing substances were detected. The cause of Mr Alexander's death was certified by Dr Mark Ashton as 1a Head injury and drowning, due to Fishing vessel grounding and capsize.

[43] Due to the nature of Mr Alexander's death, the Marine Accident Investigation Branch (MAIB) initiated an investigation into the circumstances of the capsize of the Lexi Rose and Mr Alexander's death.

[44] Due to adverse weather, the wreck of the Lexi Rose was not recovered from Melrose Point until 27 September 2023. Following recovery, the wreck of the vessel was examined by officers of the Marine Accident Investigation Branch (MAIB) as part of their investigation.

[45] The post-recovery inspection of the wreck of Lexi Rose found that the outboard engine's lower assembly unit was missing. The aluminium hull was intact, with no signs of any breaches or impact damage.

[46] The MAIB investigation contracted independent assessments of the outboard engine fracture surfaces, internal components and central processing unit (CPU). Analysis of the fracture surfaces of the lower assembly unit indicated a break consistent with a single impact on the port side. Assessment of the engine components and the CPU determined that the engine lost propulsion 4 minutes before it stopped.

[47] On the morning of 21 September 2023, the conditions in the area to the east of Macduff were a south-south-westerly Beaufort force 5 wind, slight seas and a long northerly swell of approximately 1.1m. The wind direction was favourable for fishing at

Melrose point as vessels would be in the lee of the shore. The favourable effect of the wind was counteracted by a forceful northerly swell pushing vessels on to the coast. The combination of the wind and swell created a complex environment presenting a hazard when working close to the shore.

[48] Lexi Rose grounded on the rocks because the vessel was swept into the cove having lost propulsion while transiting between creel locations. The skipper usually transited between individually placed creels at a speed of 3 to 5 knots, and it is likely that the loss of propulsion was caused as the vessel struck an underwater obstacle or rock promontory, which sheared the lower assembly unit away from the outboard engine's upper casing. The shearing force was likely caused by the combination of the weight of Lexi Rose and the 1m to 1.5m swell, rather than the speed of the vessel alone.

[49] Following the loss of propulsion the Lexi Rose grounded on rocks and capsized causing Mr Alexander to enter the water. During the capsize Mr Alexander struck his head either on the vessel or the rocks and sustained an injury that caused him to become unconscious and drown.

Submissions

[50] The principal procurator fiscal depute made submissions inviting me to make findings under Section 26(2) (a) to (g) of the Act. I had no difficulty in accepting those submissions and my determination largely reflects those proposed by the principal procurator fiscal depute in his submissions.

[51] In his submissions the principal procurator fiscal depute set out the position of the Crown as to whether I should make any recommendations in terms of Section 26(1)(b) in respect of any of the matters mentioned in Section 26(4) of the Act. These matters are the taking of reasonable precautions, the making of improvements to, or the introduction of, a system of working or the taking of steps that might realistically prevent future deaths in similar circumstances. The Explanatory Notes to the Act state that there must be "a real or likely possibility that the matters recommended may prevent deaths in similar circumstances, rather than a remote chance that a similar death in the future might be prevented".

[52] It was submitted that Crown had considered the evidence carefully and that consideration had been given to inviting the court to make a recommendation as to the use of personal floatation devices. However, it was clear from the evidence before the Inquiry that such guidance is already in existence. The conclusion of the Marine Accident Investigation Branch report produced by the Crown stated the following under the heading "Recommendations": "Given the existing industry guidance on the risks of single-handed fishing operations, no recommendations for single-handed fishing are made in this report." It was submitted on behalf of the Crown that the evidence before the Inquiry supported the conclusion that Mr Alexander himself was aware of the need to have personal floatation devices onboard the Lexi Rose – that being a prerequisite for the issuing of a Small Vessel Fishing Certificate, which was in place for the Lexi Rose. For unknown reasons, Mr Alexander had exercised personal choice not to wear one. It was submitted that any recommendation of this court as to personal floatation devices

would simply be a mirror of existing guidance and codes of practice. In that respect, the Crown's submission was that such a recommendation would be unnecessary.

[53] Reference was also made to the Marine Accident Investigation Branch safety flyer which had been lodged as a production by the Crown. This safety flyer, which was posted on the MAIB website summarised the findings of the MAIB in respect of the circumstances leading to Mr Alexander's death and set out the safety lessons which the MAIB considered should be taken from this accident. The Crown suggested that the publication of the safety flyer by the MAIB and any publicity surrounding this Inquiry might serve as a reminder to those in the fishing industry of the importance of such life saving devices.

[54] I agreed with the submissions put forward by the Crown in this respect and for those reasons I did not consider it appropriate to make any recommendations in terms of Section 26(1)(b) as to any of the matters mentioned in Section 26(4).

Discussion

[55] The procurator fiscal was the only participant in this Inquiry and there were no matters in dispute in relation to the factual circumstances surrounding this tragic accident.

[56] In making my determinations in terms of Section 26(2)(a) and (b) as to where and when the death and the accident resulting in the death occurred, I was able to rely on the parole evidence of Mr Alan West and the affidavit evidence of Mr Scott Sharman. I was also able to rely on the Notice to Admit information.

[57] Mr Alan West gave evidence that he worked as a part-time shell fisherman and creel fisherman out of Macduff and that he was the owner of the fishing vessel *Chance.* He and Mr Alexander were well known to each other. At about 8.00am on the morning of 21 September 2023, the day of the accident, Mr West looked out to the sea from his home in Macduff and saw the Lexi Rose out at sea.

[58] Mr West himself headed out to sea at around 8.30am that morning. He said that the conditions were workable with care and that he had worked in similar conditions before. He said that care was required because the type of fishing he and Mr Alexander were involved in required them to come close to the shore and there was some swell movement at the rocks.

[59] At around 10.50am Mr West telephoned Mr Alexander who was, at that time, at Melrose Point which is located between Macduff and Gardenstown. They discussed the weather and conditions. Mr Alexander said that where he was working the conditions were workable with care. Mr West then headed towards Mr Alexander's location with the intention of fishing in that same area.

[60] Shortly after this conversation Mr West picked up a call on very high frequency (VHF) channel 12. This is the harbour area working channel and not the channel normally used for distress calls. Mr West heard Mr Alexander's voice on the call. Mr Alexander said that his boat was ashore and that he needed a lifeboat. He sounded very concerned. Mr West told him that he was on his way and headed towards Mr Alexander's location at full speed.

[61] Mr Alexander immediately called the harbourmaster as he reckoned that would be the quickest way to get a lifeboat launched. The harbourmaster didn't respond so Mr West left a message. Mr West then call the coxswain of the lifeboat but he was also unavailable. The harbour master then called back and told Mr West that the lifeboat was being launched.

[62] On arrival at Melrose Point Mr West saw the Lexi Rose upside down on the rocks but he was unable to see Mr Alexander. The sea was turbulent at that location and Mr West was unable to get to where the Lexi Rose had grounded.

[63] The lifeboat then arrived at the location, but it was also unable to get in to where the Lexi Rose had grounded. Mr West remained further out searching for Mr Alexander in the sea. A helicopter then arrived, and Mr West was advised by the lifeboat that a body had been found and had been taken away in the helicopter.

[64] Mr West gave his evidence in a straightforward manner, and I had no difficulty in accepting him as a credible and reliable witness.

[65] Mr Scott Sharman is employed as a winchman paramedic with His Majesty's Coastguard and Rescue based at Inverness Dalcross, Inverness.

[66] In his affidavit Mr Sharman gave evidence that he was on duty on the day of the accident and that at around 11.15am he and his colleagues were dispatched by helicopter to an area known as Melrose near Gamrie (Gardenstown) in response to a report of a fishing vessel in distress.

[67] On arrival at the scene Mr Sharman could see that the Lexi Rose was capsized on rocks below the cliffs. He could also see what appeared to be the body of a male in the

water nearby. He then lowered from the helicopter and collected the male from the sea. He and the male were then winched back on board the helicopter.

[68] He stated that he could see that the male had two large lacerations to his head. He could also see that the male had hypostasis and that rigor mortis had set in. At 12:15pm he pronounced the male's life extinct. He stated that Mr Alexander's body was conveyed back to Inverness Airport where they awaited the arrival of the police.

[69] In making my determination in terms of Section 26(2)(c) in relation to the cause of Mr Alexander's death I was able to rely on the Notice to Admit Information together with the post mortem report and the Affidavit of Doctor Mark Andrew Ashton produced by the Crown.

[70] Mr Alexander's death was medically certified by Doctor Mark Andrew Ashton, Consultant Pathologist, following postmortem examination of Mr Alexander's body and consideration of toxicological analyses. In his affidavit Dr Ashton added a commentary as to his findings. He stated that the injuries described in his report were indicative of blunt force trauma to the head, in keeping with striking a hard surface, probably on several occasions. In this case, the hard surface would, in his opinion, have been part of the boat's structure or a rock. It was his evidence that the force had been sufficient to produce some bleeding over the surface of the brain - a sub-arachnoid haemorrhage. In his view the force of this traumatic injury would have been sufficient to at least stun Mr Alexander and probably render him unconscious. However, he considered that the resultant injuries would not have been immediately fatal and he did not consider them sufficient to have been the direct cause of death.

[71] In his commentary Dr Ashton went on to explain that he had found features of drowning, with expanded lungs, froth in the airways and a large volume of water within the stomach which would indicate that drowning was the cause of death.

[72] In making my determination in terms of Section 26(2)(d) in relation to the cause or causes of the accident resulting in Mr Alexander's death I was able to rely on the Marine Accident Investigation report and the parole evidence of Dr Will Tutton who was the lead investigator with the MAIB in relation to this accident.

[73] Dr Tutton is an experienced Marine Accident Investigator with the Department of Transport Marine Investigation Branch. Following the accident Dr Tutton together with two of his colleagues carried out an investigation into the capsize of the Lexi Rose and the death of its skipper. They interviewed witnesses and carried out an assessment of the vessel. They looked at the electronic devices within the vessel and arranged independent assessments of the outboard engine fracture surfaces, internal components and its central processing unit (CPU). The investigation team also deployed a drone to take photographs of the location of the accident and the position in which the wreckage was found.

[74] The MAIB report which was lodged in court, sets out details of the investigation and an analysis of its findings. Mr Tutton spoke to the content of the report. He confirmed it was found that that Mr Alexander entered the water when the vessel grounded on rocks and capsized in a small cove on Melrose Point. During the capsize the skipper struck his head either on the vessel or the rocks and sustained an injury that caused him to become unconscious and drown. Once the vessel lost propulsion at the

entrance of the cove the skipper was likely to have had very little time to take emergency action. The skipper's single-handed operation of Lexi Rose significantly reduced his ability to carry out necessary survival tasks such as anchor, raise a "Mayday" distress or put on a Personal Flotation Device (PFD).

[75] Dr Tutton gave evidence in relation to environmental conditions on that day. He advised that the wind was generally from the south and was therefore favourable for fishing at Melrose Point as vessels would be in the lee of the shore. There was however a northerly swell which was at odds with the wind direction. Mr Alexander was fishing close to the shore and the waves from the swell would have had the effect of pushing his vessel on to the coast. Mr Alexander and Mr West were aware that this presented a hazard and therefore decided to work in proximity to each other.

[76] The report states that Mr Alexander was aware of the hazard that the swell presented when working close into the shore but started working creels before Mr West was near enough to provide support if required. The report states that although it is impossible to know what prompted this decision as a fisherman with intimate knowledge of the coast to the east of Macduff, he would have known the areas where grounding was possible, so it is likely that he was caught out by the fluctuating height of the waves caused by the swell.

[77] In his parole evidence Dr Tutton spoke about the inspection of the wreck of the Lexi Rose. He explained that the engine's lower assembly unit had been shorn off. He said that by looking at the at the breach patterns which were consistent with a single impact it was most likely that this had occurred as a result of that part of the engine

striking a rock. He explained that it was Mr Alexander's practice to move slowly between bays, and he thought it was likely that as the skipper did so the swell lifted the vessel up and then down on to a rock. Dr Tutton explained that the impact would not necessarily have stopped the engine right away and because the engine was quiet it was difficult to know when Mr Alexander would have become aware of the engine shearing. Mr Alexander may therefore have had a very short time in which to react.

[78] The investigation was not able to determine the exact circumstances and mechanism of the vessel capsizing. Dr Tutton expressed the view that the impact of successive waves from the swell could have pushed the vessel and tipped it over. In any event it was found that due to the damage to the engine the Lexi Rose lost propulsion and grounded within 4 minutes with Mr Alexander ending up in the water.

[79] In making my determination in terms of Section 26(2)(e) in relation to any precautions which could reasonably have been taken, and had they been taken might realistically have resulted in the death or any accident resulting in the death, being avoided I again relied on the Marine Accident Investigation report and the parole evidence of Dr Will Tutton together with the affidavit evidence of Dr Ashton.

[80] Dr Tutton highlighted the potential dangers associated with single handed fishing and this is reflected in the MAIB report where it refers to the Fishermen's Safety Guide issued by the Maritime and Coastguard Agency ("MCA")which lists several issues with single-handed operations such as no one to help to raise the alarm or assist in the recovery of a person in the water. The report also referred to the MCA guide Single Handed Fishing which stated: "…fishing solo is risky so you need to think about

what might go wrong when there's no-one around to help you if, for example: you get injured; there's a sudden vessel loss; you fall overboard."

[81] In relation to this accident the report points out that Mr Alexander's ability to react to a developing situation was limited because he was operating single-handed. Focusing on the task of hauling and shooting creels and moving to the next creel might have distracted him from noticing the changing environment around him. He would have been unable to take all possible actions to improve his chances of survival. Although there might have been time to don a PFD and/or raise a "Mayday "distress call he did neither, possibly because of the limited time available or difficulty reaching the wheelhouse. The report points out that it cannot be known if these actions would have been sufficient to ensure the skipper's survival.

[82] Mr Alexander was not wearing a PFD at the time of the accident, and the evidence suggest that he rarely did so. I agreed with the Crown submission that had Mr Alexander been wearing a PFD at the time of the accident his death might have been avoided. It is important to note the wording of this sub-section of the 2016 Act. The wording refers to reasonable precautions which, if taken, *might* have resulted in the death being avoided. Further guidance is to be found within the Explanatory Notes to the 2016 Act, where it is stated that: "A precaution might realistically have prevented a death if there is a real or likely possibility, rather than a remote chance, that it might have done so." It follows, therefore, that no certainty as to avoidance of death is required.

[83] Having considered the evidence and Crown submissions I have reached the view that Mr Alexander's death might well have been avoided had he been wearing a PFD at the time of the accident. There were three devices available to Mr Alexander at that time. These devices are designed, when worn and in water, to turn the wearer onto their backs and to provide the best chance of keeping the wearer's airways clear of water. The evidence from Dr Ashton supports the position that Mr Alexander was unconscious in the water due to the head injuries sustained as a result of the capsize and therefore unable to keep his airways clear of water. The wearing of a PFD would have would have offered the best chance at preventing drowning until the arrival of emergency assistance which had been summoned. This measure would not have guaranteed his survival but might realistically have avoided his death.

[84] The MAIB report made reference to the MCA's Fishermen's Safety Guide which stated that fishermen must wear a PFD or a safety harness if the risk of falling overboard could not be mitigated. On PFDs, the guide instructed single-handed fishermen to: "Always wear your PFD and make sure it has enough buoyancy to turn you on your back, keeping your mouth clear of the water, even if you become unconscious."

[85] Taking all of this into account I considered it appropriate to make a determination in terms of Section 26(2)(e) in respect of the use of a PFD.

[86] Dr Tutton pointed out that Mr Alexander did not send out an emergency "Mayday" call. The vessel was equipped with a VHF digital selective calling (DSC) radio. This is a digital alerting system that, on the press of a single button, can send a vessel's identity, position and the nature of its distress to all DSC-equipped vessels and

shore stations within range. Instead of operating this device Mr Alexander made a call on VHF Channel 12 which is the harbour area working channel. As indicated above this was immediately picked up by Mr West who took immediate steps to alert the emergency services resulting in the lifeboat and an emergency helicopter being deployed. I could find no evidence that the emergency services would have been able to attend and provide assistance any sooner if Mr Alexander had elected to use the DSC device.

[87] Dr Tutton also gave evidence that dropping an anchor was one course of action which might have been open to Mr Alexander. The accepted method used by lobster fishermen operating near Macduff to prevent grounding and capsize on the loss of propulsion was to drop an anchor to hold the vessel away from the shore. Although this had enabled the rescue of creel fishing vessels in the past, no evidence was found of an anchor being used during this accident. However, it was not possible to rule out the attempted use of an anchor. Whether it would have been a suitably effective method in shallower water under the action of waves is less certain and I could find no evidence that the deploying of an anchor might, realistically have avoided the Mr Alexander's death.

[88] It is clear from the report and Dr Tutton's evidence that increasing the distance between a vessel and the shore offers more time for avoiding action to be effective. Exposure to the hazards of grounding and capsize is high during inshore creel fishing, particularly when the conditions result in waves breaking onshore. In this case, as referred to above, there is evidence before the court in relation to the weather conditions

on the 21 September 2023 and that the sea swell was a particular danger. Mr West had described to the court that he and Mr Alexander had agreed that the conditions were "workable with care." However, when asked about the conditions around Melrose Point, Mr West noted that the conditions there were "turbulent." The swell and the rocks at that area were considered to be dangerous by Mr West when he arrived at that area very shortly after having heard Mr Alexander on the radio calling for help. There was also evidence that both Mr West on the *Chance* and the Royal National Lifeboat Institution lifeboat could not enter the cove there due to the conditions as there was a danger they too may have grounded.

[89] It is not possible to say exactly what Mr Alexander saw or made of the conditions when he arrived at Melrose Point, but the evidence strongly suggests that the conditions were not safe for inshore fishing. On that basis I agree with the submission put forward by the Crown that it would have been reasonable to have avoided that particular area. Clearly this would have avoided the causes of the accident and thereby the death in the circumstances that it occurred. Whilst there is evidence about the general conditions that day, there is no evidence before the court about other inlets fished by Mr Alexander that day and I agree with the Crown submission that it would be too broad to suggest that the entire day's fishing operations ought to have been abandoned. It is for these reasons I made a determination in terms of Section 26(2)(e) that a precaution which could reasonably have been taken and had it been taken, might realistically have resulted in the death or the accident resulting in the death, being avoided would have

been for Mr Alexander to have avoided the inlets at Melrose Point on 21 September 2023 owing to the prevailing conditions at that particular area on that date.

[90] I have made a determination in terms of Section 26(2)(f) that there was a defect in a system of working which contributed to the death or the accident resulting in the death namely that Mr Alexander, particularly when working alone, ought to have worn a personal floatation device at appropriate times, and particularly when working on the deck of the Lexi Rose. This determination follows on from my determination under Section 26(2)(e) that it would have been a reasonable precaution for Mr Alexander to have been wearing a PFD at the relevant time. I accepted the evidence which suggested that Mr Alexander rarely wore such a device, and this indicates that he had developed a system of working when fishing alone which was contrary to established fishing industry guidance and may have contributed to his death. I have already considered the evidence in support of this finding in more detail in my comments in relation to my determination under Section 26(2)(e).

[91] My determination under Section 26(2)(g) in respect of other facts which I considered to be relevant is largely self-explanatory. I have described above the efforts Mr West made to assist Mr Alexander by summoning the emergency services. He used his local knowledge by contacting the persons whom he knew would be responsible for getting the lifeboat launched and this was effective in bringing about the launching of the lifeboat with the least possible delay. Both Mr West and Dr Tutton gave evidence as to just how turbulent the seas were in the area where the accident occurred. In particular Dr Tutton explained that while the reference to "slight seas" under the

heading "Environmental conditions" at page 5 of the MAIB report was perhaps the correct technical term for the conditions in that area on the day of the accident it was a touch misleading. He described how the strong swell from one direction conflicted with the wind coming from the opposite direction making conditions near the shore very difficult. He reinforced this by referring to a photograph of the location contained within the MAIB report (Fig 3) which was taken a few hours after the accident and showed strong wave action and a lot of white water creating a complex environment.

[92] I did not consider it appropriate to make any recommendations in terms of Section 26(1)(b) as to any of the matters mentioned in Section 26(4). As indicated above the matters referred to in subsection 1(b) are –

> "(a) the taking of reasonable precautions
> (b) the making of improvements to any system of working;
> (c) the introduction of a system of working
> (d) the taking of any other steps which might realistically prevent other deaths in similar circumstances."

I agreed with the Crown submissions which I have set out in detail above and it is for those reasons I did not consider it appropriate to make any recommendations in terms of Section 26(1)(b)

Final remarks

[93] I am grateful to Mr Morrison, principal procurator fiscal depute for the clear and professional manner in which the Crown evidence was presented to me and for his helpful submissions on the evidence. I would wish to acknowledge the important work

done by the Marine Accident Investigation Branch in their investigation of this accident and their clear and comprehensive report.

[94] Finally, I would wish to extend my sincere condolences to the family and friends of the late Mr Alexander.