

SHERIFFDOM OF GRAMPIAN, HIGHLAND AND ISLANDS AT BANFF

[2016] FAI 13

B110/16

DETERMINATION

By

SHERIFF GORDON FLEETWOOD

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

Into the death of

GARY DANIEL FORBES

Inverness 24th August 2016

The Sheriff, having resumed consideration of the Fatal Accident Inquiry into the death of Gary Daniel Forbes determines in terms of section 6 of *The Fatal Accidents and Sudden Deaths (Scotland) Act 1976* as follows:-

In terms of section 6(1)(a)

Gary Daniel Forbes, born 8th June 1977, residing in Aultbea, died while creel fishing west of Tanera Beg, Summer Isles, at or about 10.30 hours on 13th May 2014 as a result of accidentally entering the sea from the fishing boat Barnacle 111.

In terms of section 6(1)(b)

Mr Forbes died as a result of 1(a) drowning and (b) fall from a fishing boat as a result of an accident in which he entered the sea from the stern of the fishing boat Barnacle 111.

The cause of the accident was probably Mr Forbes' right leg becoming caught in an end buoy rope then paying out from the stern of said fishing boat. The accident happened shortly after he had walked an end weight towards the stern of said fishing boat.

In terms of section 6(1)(c)

Mr Forbes' death may have been avoided if he had taken the reasonable precaution of wearing a personal flotation device, or lifejacket. The accident which resulted in

Mr Forbes' death may have been avoided by the reasonable precaution of storing the end buoy rope in which he became caught in a bucket whilst it was on deck.

In terms of section 6(1)(d)

I have no recommendation to make under this section.

In terms of section 6(1)(e)

- (i) That the Maritime and Coastguard Agency give consideration to amending *The Merchant Shipping and Fishing Vessels (Health and Safety at Work) Regulations 1997* so that they apply to share fishermen, thereby requiring all persons on board

fishing vessels to wear personal flotation devices or lifejackets when working on deck.

- (ii) That the Maritime and Coastguard Agency give consideration to amending *The Merchant Shipping and Fishing Vessels (Health and Safety at Work) Regulations 1997* so that the present mandatory risk assessment required for vessels of the class of Barnacle 111 is recorded in writing and stored appropriately.

NOTE

[1] This was a mandatory Inquiry because Mr Forbes died during the course of his employment. It was heard by me on 17th and 18th August 2016. The Crown were represented by Mr Aitken, PFD and Mr and Mrs Grant, owners of the Barnacle 111 by their solicitor, Mr MacLean. I am grateful to both for the careful and considerate way they dealt with the evidence and submissions in this Inquiry. Parties prepared and lodged a substantial Joint Minute which is attached to this determination and should be read as incorporated into it. Two witnesses gave oral evidence, Mr Roderick Grant, skipper and part owner of Barnacle 111 and Mr Wheal, a principal investigator with the Marine Accident Investigation Branch (MAIB).

EVIDENCE

- (1) The first witness to give evidence was Roderick Grant. He is 57 years old and a fishing boat skipper. He commands a boat called Barnacle 111, an 11 metre creel fisher operating from Loch Ewe. He and his wife are the owners of this boat. He

has considerable experience and all necessary qualifications. In May 2014 his crew consisted of the now deceased, Gary Forbes. Mr Forbes had been doing this job for about 15 years when he died and had all necessary qualifications. The Barnacle 111 was inspected by the Maritime and Coastguard Agency before and after 13th May 2014 and found to be free of defects.

- (2) Mr Forbes was what is called a share fisherman. This means that although he had no interest in ownership of the boat his earnings were determined as a percentage of the catch. The significance of this is that he was not regarded as an employee so far as certain Regulations I will refer to later are concerned, and in turn the witness was not an employer of Mr Forbes.
- (3) Barnacle 111 is concerned in catching crabs and prawns by using creels. Each species requires a different type of creel. Creels are set by leaving a number of creels (fifty in all, known together as a "fleet") on the seabed for a time. They are baited to attract the target species. The fleet is connected together by ropes and at the beginning and end of the fleet is a rope connected to a weight, which in turn is connected to a buoy by a further rope. The first buoy is sent overboard followed by the first weight, then the creels then the second weight and finally the second buoy. The weights serve to hold the fleet in place on the seabed and the buoys mark its location.
- (4) When a single fleet is being retrieved to be emptied and reset the end rope, between the weight and the buoy, is stored in a bucket kept on deck for that purpose. When two fleets are on board the end rope from the first fleet recovered

(and second to be shot) is coiled on the port side of the boat, under the creels.

When a single fleet is on board for moving to a different location the creels are stacked two high on the deck. If two fleets are on board they require to be stacked four high.

- (5) On 13th May 2014 Barnacle 111 left Aultbea in the early morning and headed to sea. The witness and Mr Forbes were on board. Two fleets were recovered from the seabed and stacked on the deck of the boat. This is an operation the boat carried out two or three times annually when the witness wanted to move two fleets to a different location. On arriving south of Tanera Beg the rear of the two fleets on board was shot without incident. The boat then moved to a location to the west of Tanera Beg and started to shoot the second fleet.
- (6) The witness was at the wheelhouse of the boat, steering as the creels were shot. Mr Forbes was on deck as they left the boat. After all the creels had left the boat Mr Forbes required to move the end weight astern from its place behind the wheel house. As he was about to do this the witness was distracted by an emergency call being received on the boat from another boat. This was an automated signal via a system known as DSC. He entered the wheelhouse and his attention was on this for a short while until he realised it was a false alarm and he turned his attention back to the deck. Mr Forbes was lost to view. The weight was overboard and the end rope between the weight and the marker buoy was paying out. This end rope is about 80 metres long (the witness gave its length as 30 fathoms) and takes about three minutes to leave the boat entirely.

- (7) The witness immediately turned the boat and headed back towards the area where he had been. The buoy was in the water and as he approached it to retrieve it, with a view to hauling the rope a wellington boot came to the surface near the buoy followed shortly thereafter by the inert and unresponsive body of Mr Forbes. He was face down in the water. The witness pulled Mr Forbes on board and attempted to resuscitate him without success. He then sent a Mayday call to Stornoway Coastguard. Other vessels attended to assist along with a helicopter which transported Mr Forbes to Stornoway, where life was pronounced extinct later that day.
- (8) At the time of the accident neither the witness nor Mr Forbes had been wearing a Personal Flotation Device (PFD). PFDs were available on the boat. The witness explained that he found such devices to be uncomfortable and restrictive. The attached straps constituted a potential hazard because there was a danger of getting them caught as one moved about the boat. He understood that Mr Forbes had had a penknife in his pocket at the time of the accident. A sharp knife was now kept on deck of the boat, near the creel door at the stern of the boat. He no longer stored two fleets of creels on deck. He had carried out a risk assessment on his vessel prior to the accident but it was not in writing; it did not require to be in writing.
- (9) The witness further advised that he now wore a PFD, as did his crew, a suitable device had been identified and was now being used. The device now in use was

- built in or incorporated into oilskin outer clothing worn on the boat. It did not have the drawback of straps which could catch on other articles on deck.
- (10) Next to give evidence was David Anthony Wheal, a principal Investigator with the MAIB. The MAIB is an independent body tasked with investigating marine accidents and advising on changes which could reduce the chances of similar accidents. The witness is very experienced in this field, his expertise was not questioned.
- (11) The witness was the principal investigator involved in the enquiry by the MAIB into this accident and had assisted in preparing the Report which is now Crown Production (CP) 5. Much of his evidence was his speaking to the Report. The conclusion of the MAIB Report was that Mr Forbes' right leg probably became entangled in the buoy rope as he was walking the weight to the stern of the boat or shortly thereafter and the weight then pulled him overboard through the creel door.
- (12) He drew the court's attention to Regulation 5 of *The Merchant Shipping and Fishing Vessels (Health and Safety at Work) Regulations 1997* which places a general duty on an employer to "ensure the health and safety of workers and other persons so far as is reasonably practicable" He explained that this Regulation did not cover share fishermen. The reason for this was that a skipper on a share fishing boat was not regarded as the employer of the crew on the boat because of the nature of the relationship between them regarding payment. The MAIB had been trying to have this altered for some time but this had not happened. He understood the

effect of the Regulation to be that the employer of seamen was expected to provide and ensure the use of PFDs by his or her employees.

- (13) The witness confirmed that a health and safety risk assessment was required for the boat's normal shooting arrangement but that it did not have to be in writing. He understood that such a risk assessment had been carried out by Mr Grant in this case. The Report recommended consideration be given to requiring this risk assessment to be reduced to writing. Regarding the use of PFDs the witness confirmed they had been on the boat but that their use was not compulsory. The voluntary code of practice covering such boats recommends their use. He agreed that there were situations where their use would not prevent accidents or death but was of the view that any disadvantages were outweighed by the advantages. He accepted that certain types of PFD could be uncomfortable or restricting and straps could get caught. There were types available now, he understood, which he did not consider to have these disadvantages. Taken as a whole the witness's opinion was that the advantages of a PFD in assisting to preserve life outweighed any perceived disadvantages. He accepted that in the particular circumstance of this accident, with Mr Forbes being pulled downwards by the weight attached to the fleet of creels he could not say that a PFD would have prevented the fatality, he was of the view that it might have prevented it. He reached this view on the basis that had Mr Forbes become free of the rope, as he did, the PFD would have returned him to the surface with his head above water.

- (14) The conclusion of the Report was that the method of shooting creels did not adequately control the risk of a crew member becoming entangled in ropes. Further that had a more formal process of risk assessment been carried out a safer system may have been developed. Had the *Merchant Shipping and Fishing Vessels (Health and Safety at Work) Regulations 1997* applied to the vessel and been adhered to a safer system of work would probably have resulted. Having a knife immediately available may have given Mr Forbes an opportunity to free himself from the rope. Neither Mr Grant nor Mr Forbes had properly considered the risk of falling overboard and decided to wear PFDs. Such a device could have reduced the time Mr Forbes was underwater and turned him into an upright position on the surface. He accepted Mr Grant had complied with the relevant Regulations as presently framed.
- (15) The Report recommended to the Maritime and Coastguard Agency that steps be taken to encourage the voluntary wearing of PFDs, failing which to introduce regulations making such use compulsory on the decks of fishing vessels. They also recommended that Regulation 5 of *The Merchant Shipping and Fishing Vessels (Health and Safety at Work) Regulations 1997* be amended so that it applies to all persons on fishing vessels, regardless of their employment status.

SUBMISSSIONS

[2] Written submissions were prepared by parties and lodged with the court. They are attached to this determination and should be considered part of it. In brief the

Crown moved me to accept the findings of the MAIB report, in making determinations under sections 6(1) (c), (d) and (e). Mr Aitken submitted that the evidence showed that the accident could have been avoided if the buoy rope which caught Mr Forbes' leg had been stored in a bucket and that the death might have been avoided if Mr Forbes had been wearing a PFD. Mr MacLean submitted that his client, Mr Roderick Grant, had adhered to his statutory obligations and nothing in the evidence showed an unsafe system of work. Mr Forbes had had a PFD available to him but had chosen not to wear it.

DISCUSSION

[3] I begin by restating what was stressed in court by Mr Aitken for the Crown. The purpose of a Fatal Accident Inquiry is not to establish fault or blame but to carry out a dispassionate examination of the facts surrounding a fatal accident, so far as that is possible, and thereafter to see what if any lessons can be learned and steps taken to prevent or reduce the chances of similar accidents in the future. It is a truism to say that fishing in the open sea from relatively small boats is an inherently dangerous undertaking. That is recognised by those who undertake it. That an activity is inherently dangerous in and of itself however does not mean that the risks cannot be foreseen and mitigated. In this case the evidence was in relatively short compass and largely uncontroversial but in my opinion three important issues were raised and should be addressed. Before turning to these issues I must record that I found the two witnesses who gave oral testimony to be truthful and reliable. Mr Grant clearly found reliving the

events of 13th May 2014 to be a strain but answered questions put to him openly and frankly. Mr Wheal struck me as a thoughtful and careful witness who was prepared to consider propositions put to him and to accept that not all the conclusions of the MAIB Report were of relevance to the present Inquiry although they were of relevance to the MAIB's wider agenda.

[4] There was no dispute about the cause and nature of Mr Forbes' death. Those matters are covered fully in the Joint Minute. While working on Barnacle 111, doing a task he had no doubt done many times before, his right leg became caught in the buoy rope then paying out from the stern of the boat. This pulled him into the water and the weight falling to the seabed pulled him below the surface. Mr Grant's response in promptly turning the boat, recovering Mr Forbes, attempting resuscitation and making a Mayday call to the Coastguard was, in the circumstances, entirely appropriate.

Mr Wheal was initially critical of the sequence of events, being initially of the view that a Mayday call should have been made first but as I understood him softened that approach in cross-examination and agreed that Mr Grant's response was reasonable and appropriate.

[5] The first matter raised and on which I have made a section 6(1) (c) determination concerns the stowing of ropes on board the Barnacle 111. The evidence revealed that when one fleet was on board the rear buoy line was stored in coils in a large bucket on deck. Mr Wheal's evidence was that such a method of stowing reduced the likelihood of a bight or loop of rope making its way across the deck as the rope paid out. When two fleets were on board the rear buoy rope from the second fleet to leave the boat was

stowed in a heap below the creels. It was this rope which appears to have caught Mr Forbes' leg. A simple precaution would have been to have had two buckets. Mr Grant now appears to have done just that, looking at the MAIB Report, and in addition gave evidence that he now no longer transports two fleets at a time. The MAIB Report raised other matters concerning the storage of ropes on board while creels were being shot. Nothing in the evidence suggested there was any force in these criticisms and this arrangement appears to have played no part in the accident. I do not consider any finding to be appropriate on this aspect of the case.

[6] The second matter on which I have made a determination concerns both section 6(1) (c) and (e), the recurring question of the use of PFDs by skippers and crew when working on the decks of fishing boats. I must stress that PFDs were available on the Barnacle 111 and the decision not to wear one was Mr Forbes'. That said I am not the first sheriff to comment on the apparent reluctance of fishermen to use these eminently sensible devices. There is now available on the market, I was told, by Mr Grant and Mr Wheal, PFDs which largely overcome the previous view that they were bulky, uncomfortable and liable to snag. Mr MacLean submitted I would have to specify the type, I disagree; I consider that is for others to do. For my part I am content to accept the evidence of Mr Wheal that the wearing of a PFD might have prevented the death in this case and determine accordingly. *The Merchant Shipping and Fishing Vessels (Health and Safety at Work) Regulations 1997* requires employers to "ensure the health and safety of workers and other persons so far as reasonably practicable". Mr Wheal explained that the relationship between skipper and crew in a share fishing situation meant that this

regulation did not apply. There appears to be no reason why the Regulation cannot be amended to cover share fishermen. Were that to happen the terms of the Regulation, in my opinion, would require skippers to ensure the wearing of PFDs on deck on fishing vessels.

[7] The final matter on which I have made a determination is under section 6(1)(e).

The Merchant Shipping and Fishing Vessels (Health and Safety at Work) Regulations 1997

presently requires that a risk assessment be carried out for a boat's normal shooting arrangements. There is no requirement that this be reduced to writing. The lack of any written risk assessment makes it difficult for the MAIB or any other investigative agency to ascertain whether risks have been properly assessed and whether any requirements for safe operation have been adhered to. I can see no reason for this and none was advanced in either evidence or submissions. I would suggest that requiring the risk assessment to be written would help to ensure compliance therewith. In the particular circumstances of this case I should say that the only fault in the shooting arrangements either Mr Wheal in his evidence or Mr Aitken in submissions could identify was the method of storing the rear buoy rope, dealt with in this determination.

[8] Other matters concerning accessibility of a knife during shooting operations and the use of the DSC alarm system were canvassed during the inquiry. In the event I am of the view that nothing turned on these matters so far as Mr Forbes' untimely and unfortunate death was concerned and I make no comment or findings.

[9] Finally, I am aware that Ms Sutherland, Mr Forbes' fiancée, attended the Inquiry. I take this opportunity to repeat the court's condolences on her sad loss.

JOINT MINUTE OF AGREEMENT

In the Fatal Accident Inquiry into the circumstances surrounding the death of Gary Daniel Forbes, Aitken, Procurator Fiscal Depute for the Crown and MacLean, Solicitor for Mr and Mrs Grant, owners of the creel fishing vessel Barnacle III, hereby concur in stating to the court that the following facts are agreed and should be admitted in evidence:

1. On the morning of 13 May 2014 Gary Daniel Forbes (now deceased) born 8 June 1977 of [...] Aultbea [...] was working as a share fisherman on board the Aultbea based creel fishing vessel Barnacle III (the vessel) west of Tanera Beg when at approximately 10:27 hours he unexpectedly entered the sea.
2. All the shares in the vessel had been owned by the witness Roderick MacLennan Grant and his wife for 22 years.
3. The vessel had a registered length of 11 metres.
4. The vessel was inspected under the procedure for inspection of Small Commercial Vessels and Small Fishing Vessels by a Maritime & Coastguard Agency surveyor at Aultbea on 28 November 2013 and on 29 May 2014 and found to have no defects.

5. Mr Grant held an unrestricted under 16.5m skipper's certificate issued by Seafish, the Sea Fish Industry Authority, and had completed all four mandatory safety training courses for commercial fishermen.
6. Said Gary Daniel Forbes had completed all four mandatory safety training courses for commercial fishermen. He had been the crew member of Barnacle III for 15 years.
7. Said Gary Daniel Forbes was quickly recovered on board the said vessel by Mr Grant.
8. Said Gary Daniel Forbes was unresponsive and not breathing.
9. A Mayday message was transmitted by Mr Grant at 10:36 hours.
10. The skipper commenced CPR and shortly afterwards a number of local fishing vessels arrived alongside and assisted.
11. At 11:01 hours a search and rescue helicopter arrived. Said Gary Daniel Forbes was winched on board and taken to hospital in Stornoway where despite extensive attempted resuscitating measures life was pronounced extinct at 12:25 hours.

12. The cause of his death was later certified by Mark A Ashton FRCPATH Consultant Pathologist at Raigmore Hospital Inverness who dissected the body as (a) Drowning (b) Fall from Fishing Boat. Tests on samples taken post mortem proved negative for drugs and alcohol.
13. Crown Production No 3 Album of Photographs contains photographs taken at the Accident and Emergency Department at the Western Isles Hospital Stornoway on 13th May 2014 and depict
 - 1) Photograph of hospital trolley with Mr Forbes covered
 - 2) Photograph of hospital trolley with Mr Forbes covered
 - 3) Photograph of Mr Forbes' face and head
 - 4) Photograph of Mr Forbes uncovered
 - 5) Photograph of Mr Forbes' chest area
 - 6) Photograph of Mr Forbes
 - 7) Photograph of Mr Forbes showing slight abrasion to upper thigh left
 - 8) Photograph of navy t-shirt
 - 9) Photograph of black hooded top
 - 10) Photograph of denim jeans
 - 11) Photograph of denim jeans
 - 12) Photograph of black belt
 - 13) Photograph of blue coloured shirt

- 14) Photograph of lighter
- 15) Photograph of wrist band
- 16) Photograph of pen knife
- 17) Photograph of black hooded top
- 18) Photograph of blue oilskins
- 19) Photograph of damaged oilskins
- 20) Photograph of damaged oilskins
- 21) Photograph of blue waterproof gloves
- 22) Pair of socks
- 23) Photograph of black boxer shorts
- 24) Photograph of blue denim jeans

14. Crown Production No 4 - Photographic Album contains photographs of the said vessel "Barnacle III" taken on 13 May 2014 and depict

- 1) Photograph of a general view showing the 'Barnacle III'.
- 2) Photograph of a further general view showing the 'Barnacle III'.
- 3) Photograph of a general view showing the rear deck area.
- 4) Photograph of a view showing the mast, boom and lines including the automatic release.
- 5) Photograph of a further general view showing the rear deck area.
- 6) Photograph of a further general view showing the rear deck area.

- 7) Photograph of a view showing the shooting door, creels and boxes on the starboard side of the rear deck.
- 8) Photograph of a further view showing creels and boxes on the starboard side of the rear deck.
- 9) Photograph of a view showing a boat hook and a wellington boot.
- 10) Photograph of a further view showing boom and lines.
- 11) Photograph of a view showing lines stowed to the port side of the wheelhouse.
- 12) Photograph of a general view showing the interior of the wheelhouse.
- 13) Photograph of a view showing the galley area in the wheelhouse.
- 14) Photograph of a further general view showing the interior of the wheelhouse.
- 15) Photograph of a further general view showing the interior of the wheelhouse and the electronic equipment.
- 16) Photograph of a further general view showing the interior of the wheelhouse.

Various items of electronic equipment can be seen including the VHF radio in the upper right foreground portion of the view.

- 17) Photograph of a further view showing the VHF radio referred to in Photograph 16.
- 18) Photograph of a further view showing the VHF radio in greater detail.
- 19) Photograph of a further view showing the VHF radio in greater detail.
- 20) Photograph of a view showing the autopilot.
- 21) Photograph of a view showing the MOB Guardian alarm system.

- 22) Photograph of a further view showing the MOB Guardian alarm system in greater detail.
- 23) Photograph of a general view showing the interior of the wheelhouse looking to starboard.
- 24) Photograph of a further general view showing the rear interior of the wheelhouse.
- 25) Photograph of a general view showing the sleeping quarters in the fo'csle below the wheelhouse.
- 26) Photograph of a further general view showing the sleeping quarters in the fo'csle below the wheelhouse.

PROCURATOR FISCAL DEPUTE

SOLICITOR FOR MR AND MRS GRANT

CROWN SUBMISSIONS

Firstly I wish to pass my condolences to Mr Forbes' fiancé, Caroline Sutherland, and to pay tribute to her for her fortitude in sitting through what must have been very difficult evidence. I hope that the Inquiry has been of some assistance to her.

The significance of an Inquiry should not be measured by the length or the number of witnesses. Much of the evidence in this Inquiry is not in dispute and has been presented in the form of a Joint Minute and associated documentary productions. Nevertheless, there are still important issues to be considered in relation to Mr Forbes' death.

Of course, a Fatal Accident Inquiry is not an exercise in finding fault or blame. The purpose is to establish the facts of the case in the hope that lessons can be learned to prevent a similar tragedy occurring in the future.

To that end, in addition to the evidence contained in the Joint Minute of Agreement the Inquiry has heard from Mr Grant, the skipper of the vessel who was present at the time and was able to describe, so far as he was able, what happened at the time and the reasons for some of the decisions taken by Mr Forbes and himself and from Mr Wheal, from the Marine Accident Investigation Branch (MAIB), who spoke to Production 5 – the MAIB report into the circumstances surrounding Mr Forbes' death.

In my submission, as highlighted yesterday, the precaution that might have made most difference in the particular circumstances of this incident is for the end buoy line of the second fleet of creels to be stored in a bucket. However, issues of wider concern in relation to the wearing of personal floatation devices and access to knives have also been canvassed and I think it is to be welcomed that technology has moved on sufficiently that personal floatation devices are available which fishermen feel can be worn without compromising, in their view, their freedom to carry out their duties. The evidence has also touched on the unusual legal position of share fishermen. The focus should perhaps be the other way round. It follows that if Mr Forbes was not an employee, Mr Grant was not an employer and as such was not bound by the requirements of the Health and Safety regulatory framework. Hence the reason that I was able to provide him with the assurance I did at the beginning of his evidence.

Sadly, Fatal Accident Inquiries have been held before in relation to very similar deaths. There are a number of Determinations in relation to similar cases available on the Scottish Court Service website, for instance the Determination by Sheriff Gregor Murray dated 26 November 2014 in relation to the death of Raymond Hector Davidson, Forfar Sheriff Court, 3 and 4 November 2014. It is to be hoped that the combined lessons from these Inquiries are now taken to heart by the fishing industry.

That brings me to the findings the Court is required to make in terms of the 1976 Act. My submissions in relation to Section 6(1)(c), (d) and (e) are, of course, made with the considerable benefit of hindsight. I submit the following:-

Section 6(1)

(a) Gary Daniel Forbes died while creel fishing west of Tanera Beg, Summer Isles at approximately 10:27 hours on 13 May 2014 as a result of accidentally entering the sea there from the creel fishing vessel *Barnacle III*.

(b) Mr Forbes died as a result of 1(a) Drowning and 1(b) Fall from fishing boat; as a result of an accident in which he entered the sea there from the creel fishing vessel *Barnacle III*. The cause of said accident was probably Mr Forbes' right leg becoming caught in a buoy line shortly after he had walked an end weight towards the stern of said fishing vessel.

(c) Mr Forbes' death might have been avoided if he had taken the reasonable precautions of wearing a personal floatation device or lifejacket and having ready access to a suitable knife. The accident resulting in Mr Forbes' death might have been avoided by the reasonable precautions of placing the end buoy line of the second fleet of creels in a bucket while on deck.

(d) The system to work used when shooting two fleets of creels did not provide sufficient separation between Mr Forbes and the running gear after the final weight was carried towards the stern of the vessel prior to being shot overboard.

(e) That the Maritime and Coastguard Agency should take steps to ensure that The Merchant Shipping and Fishing Vessels (Health and Safety at work) Regulations 1997 can be applied to all fishermen on board vessels, including share fishermen and that the Maritime and Coastguard Agency should consider taking steps to make the wearing of personal floatation devices mandatory on fishing boats.

SUBMISSIONS ON BEHALF OF MR AND MRS GRANT

1 Introduction

1.1 My Lord, I begin by extending condolences to Mr Forbes' fiancé Ms Sutherland, and by recording formally on behalf of both Mr and Mrs Grant their great regret and sorrow at the tragic loss of the life of Gary Forbes who was a longstanding and valued crew member on their vessel.

2 Submissions on the evidence

2.1 It is, in my submission, apparent from the evidence that the circumstances which led to Mr Forbes' death occurred in a matter of seconds on a well-run vessel, and at the very time when the vigilant Mr Grant was distracted from his observation of Mr Forbes on deck by a distress alarm being triggered by another vessel in the area with which he required to deal. It is also established on the evidence that the response by Mr Grant and the emergency services was appropriate and timely, although sadly it did not influence the outcome.

2.2 The evidence is that Mr Forbes and Mr Grant were appropriately qualified and very experienced fisherman. MCA inspections of the vessel less than six months before and then less than two weeks after the accident found her to be free from defects. Mr Wheal commented favourably about the arrangement of the gear on the vessel.

2.3 Although the court has heard evidence of two sets of creels being lifted and shot, it is clear from the evidence of Mr Grant, which was accepted by Mr Wheal, that the accident occurred at the end of shooting of the second fleet of creels. Accordingly, the accident can be considered in the context of the moving of the end weight and the marker buoy as part of the normal process of shooting the gear. To that extent the evidence did not support, as Mr Wheal accepted, the idea in the MAIB report that the accident had anything to do with Mr Forbes stepping across the back rope, or not being clear of the running gear when the creels were being shot.

2.4 The shooting process was similar, although the buoy rope was stored on the deck underneath the second fleet rather than in a bucket. Whether there were one or two fleets on board, the weight had to be moved down the deck towards the end of the shooting process so that it could go out the shooting door, the buoy had to be lifted from that safe position on which it was stowed at the back of the wheelhouse, and the buoy line had to pay out down the deck. The buoy rope was not paying out fast or under strain or tension. That a change has been made to the stowage and shooting of creels when two fleets are being moved does not mean that there was a defect in the earlier system. It is an understandable response to this accident.

2.5 Mr Grant did not see what happened, but it is clear that the last creels had been shot. Mr Forbes had moved the weight down the centre of the vessel towards the shooting door to allow it to go over the stern. He had not yet moved the buoy, which was all that

remained to go, from its hanging position so it could run out free on its 30 fathoms of rope. It is not clear from the evidence that Mr Forbes would have had to step across the buoy line to release the buoy, but it does appear that the buoy line is what he somehow became caught in. The precise mechanism of him going overboard cannot be determined as it was not witnessed by any person. This was a tragic accident resulting in Mr Forbes' death.

2.6 Mr Grant had completed a risk assessment. It did not require to be in writing - The Merchant Shipping and Fishing Vessels (Health and Safety at Work) Regulations 1997 do not require that, and in any event they are only engaged if the person is an employer, which Mr Grant was not. It is, in my submission, clear from Mr Grant's evidence that he was a careful and thoughtful fisherman.

In a situation where he and Mr Forbes had worked together on the same vessel for 15 years, there is nothing to suggest that a written risk assessment would have made any difference to the tragic outcome on 13 May 2014.

2.7 A PFD was available to Mr Forbes but he chose not to wear it. I respectfully submit that it cannot be concluded from the evidence at this Inquiry that if Mr Forbes was wearing a life jacket, we would not be here today. We simply do not know. If the court is minded to make a recommendation in this regard it should be no more than that consideration is given by those charged with these matters as to whether it is appropriate to make the wearing of PFDs (which term would have to be defined)

mandatory at all times. We heard evidence that the wearing of life jackets brings with it hazards in connection with moving gear and equipment so the matter can only be properly dealt with after full consideration and balancing of these risks. The extant 2013 MAIB recommendation to MCA relates to culture and behaviour rather than just the supply of equipment and in my submission all that could appropriately be said on the evidence is that this matter remains outstanding.

2.8 There is my submission no evidence that if Mr Forbes had been carrying a knife on his body he would have had an opportunity to use it and that the outcome would have been any different.

3 Determination

3.1 I invite the court to make the following determination under reference to the statutory heads.

a. Where and when the death and any accident resulting in the death took place

At about 10.30 am on 13 May 2014 Mr Forbes unexpectedly entered the water west of Tanera Beag in the Summer Isles, having gone overboard from the fishing vessel *Barnacle III*, as a result of which Mr Forbes was pronounced dead at the Western Isles Hospital, Stornoway at 12.25pm that day.

b. The cause or causes of such death and any accident resulting in the death

The cause of Mr Forbes death was drowning after a fall from the vessel. The cause of the accident was Mr Forbes becoming caught in a line, the precise circumstances being unknown, at the end of the process of shooting a fleet of creels.

c. The reasonable precautions, if any, whereby the death and any accident resulting in the death might have been avoided

The evidence does not establish that there was any different system of shooting the gear which might have avoided the accident.

The weight had to be moved at some point and the marker buoy released from its secure position. It is clear that the system of shooting was well thought through and that the system and method of working was well known to Mr Grant and Mr Forbes who had formed a close knit crew for a period of 15 years. The system of working was considered and understood by both of them and mitigated against relevant risks. Even if the buoy line was stored in a bucket on deck it would still have to come out of that bucket to go down the deck and out over the stern of the vessel.

d. The defects, if any, in any system of working which contributed to the death or any accident resulting in the death

There were no defects in relation to the system of working which was contributed to Mr Forbes death.

The self-shooting system had been devised so that the requirement to handle the gear was minimised. During the limited handling of gear which was necessary, the crew member was well positioned, and looked out for his own safety. Very close attention was paid by Mr Grant to the crew on deck while shooting. The fishing gear could not be fully deployed into the water without some minimal handling. There was no evidence of a system that would have avoided the need for any handling at all.

e. Any other facts which are relevant to the circumstances of the death.

I have no further submissions in this regard.

A Duncan MacLean

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