SHERIFFDOM OF GRAMPIAN, HIGHLAND AND ISLANDS AT LOCHMADDY

[2019] FAI 3

Case ref: LMD-B22-18

DETERMINATION

BY

SHERIFF CHRISTOPHER DICKSON

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

into the death of

GERARD GILLIES

Lochmaddy, 16 January 2019

Determination

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

1. **In terms of section 26(2)(a) of the 2016 Act (when and where the death occurred):**

   That the late Gerard Gillies, born 20 January 1973, died at about 16.30 hours on 4 October 2015 at Western Isles Hospital, Stornoway.

2. **In terms of section 26(2)(b) of the 2016 Act (when and where any accident resulting in death occurred):**

   That the accident resulting in death took place at about 13.20 hours on 4 October 2015 on board the fishing vessel *Annie T* at a location with the co-ordinates 56º 50′ .28 N, 007º 35′ .21 W, being between the islands of Mingulay and Pabbay, south of the Isle of Barra.

3. In terms of section 26(2)(c) of the 2016 Act (the cause or causes of death):

That the cause of death was:

I (a) Salt water immersion

due to (or as a consequence of):

(b) Fall from a fishing boat

II Ischaemic heart disease.

4. In terms of section 26(2)(d) of the 2016 Act (the cause or causes of any accident resulting in death):

That cause of the accident resulting in death was as follows:

(a) After all the creels had been shot into the water there remained a moving rope on the deck of the *Annie T*. This rope was connected to: (i) the fleet of creels that had been shot into the water; (ii) the end weight; and (iii) the end buoy. Both the end weight and the end buoy remained on the deck near to the wheelhouse.

(b) Mr Gillies attempted to move from the starboard side of the vessel, past the moving rope, in order to collect the end weight and take it to the transom opening at the stern of the vessel.

(c) When Mr Gillies was in approximately the middle of the deck, near to the moving rope, his foot became caught in a loop in said rope (known as a bight) and he fell. The moving rope then pulled Mr Gillies out of the transom opening at the stern of the vessel and into the water.

5. In terms of section 26(2)(e) of the 2016 Act (any precautions which (i) could reasonably have been taken, and (ii) had they been taken, might realistically have resulted in death, or any accident resulting in death, being avoided):

That the precaution which could reasonably have been taken that might realistically have resulted in the death being avoided, was:

(a) The wearing of a lifejacket or personal flotation device (hereinafter referred to as "PFD") by Mr Gillies.

That the precaution which could reasonably have been taken that might realistically have resulted in the accident resulting in death being avoided, was:

(b) A system of work that avoided the need for Mr Gillies to manually handle the end weight along the deck of the *Annie T* to the transom opening at the stern of the vessel and thereby avoid the risk of coming into contact with a moving rope on the deck of the vessel.

6. In terms of section 26(2)(f) of the 2016 Act (any defects in any system of working which contributed to the death or the accident resulting in death):

That the defect in the system of shooting creels on the *Annie T* which contributed to the accident resulting in death was:

(a) The need for Mr Gillies to manually handle the end weight along the deck of the *Annie T* to the transom opening at the stern of the vessel and thereby run the risk of coming into contact with a moving rope on the deck of the vessel.

7. In terms of section 26(2)(g) of the 2016 Act (any other facts which are relevant to the circumstances of the death):

That the other facts relevant to the circumstances of death are:

(a) A Casualty Review Panel led by the Marine and Coastguard Agency (hereinafter referred to as "MCA") carried out a study on marine fatality data from 2007 to 2013. The Panel concluded that, during that period, 148 lives, including 29

commercial fishermen, could have been saved had lifejackets or other buoyancy aids been used.

(b) Since 2013, the National Federation of Fishermen's Organisation, the Scottish Fishermen's Federation, the Fishermen's Mission and the Sea Fish Industry Authority have been distributing heavily subsidised or free constant wear lifejackets to fishermen in the UK.

(c) Between January 2013 and November 2016 the Marine Accident Investigation Branch (hereinafter referred to as the "MAIB") started 35 investigations into accidents involving commercial fishing vessels. The MAIB found that: (i) there were 22 cases where the wearing of a constant wear PFD was relevant to the outcome of the accident (with constant wear PFDs being available on board in 17 cases and worn in 3 cases); (ii) that 14 lives could have been saved had the casualty been wearing a constant wear PFD (with constant wear PFDs being available on board in 9 of those cases); and (iii) in some cases, the subsidised / free PFDs supplied to fishermen had never been removed from their packaging (and in one case had been left at home).

(d) The MAIB have made several recommendations for the wearing of a lifejacket or PFD to be mandatory.

(e) Despite significant efforts to encourage fisherman to wear a lifejacket or PFD, many fishermen still do not routinely wear a lifejacket or PFD.

(f) In order to effect culture change amongst fishermen and reduce the loss of further lives, it is necessary for the wearing of a lifejacket or PFD to be mandatory.

(g) The MCA issued Marine Guidance Note 588 (F) – *Compulsory provision and wearing of personal flotation devices on fishing vessels*, in November 2018. Para 6.1 of MGN 588 (F) provides that:

> "…the MCA requires, unless measures are in place which eliminate the risk of fishermen falling overboard, all fishermen must be provided and wear PFDs or safety harnesses. The measures preventing Man Overboard must be documented in a risk assessment."

MGN 588 (F) makes clear that a failure to follow the above requirements, following the publication of MGN 588 (F), will be considered by the MCA to be a breach of current health and safety legislation.

(h) Fishermen, particularly those who have never previously experienced a man-overboard (hereinafter referred to as "MOB") situation, may not fully appreciate: (i) the human body's typical reaction to immersion in cold water; and (ii) how difficult it can be to recover a casualty from the water.

(i) Monthly MOB drills (which have, since the accident, become mandatory) should, in order to be effective and avoid becoming a box ticking exercise: (i) be as realistic as possible; and (ii) be used to assess what MOB equipment is required by the particular vessel to conduct an effective MOB rescue.

(j) Some fisherman: (i) find it difficult to access and understand the relevant legislation, guidance and codes of practice applicable to their working environment (collectively referred to as "relevant information"); (ii) do not become aware of safety flyers and other significant changes to the relevant information; (iii) do not fully read relevant information; and (iv) would welcome simplified, user friendly and consolidated guidance capable of being accessed from a single source in relation to the particular vessel type that they operate.

(k) The MCA may, with a view to assisting fishermen to access and understand relevant information regarding the particular vessel type that they operate, wish to consider: (i) whether any improvements could be made in the way relevant information is presented, and, in particular, whether it would be possible and practical to provide simplified, user friendly and consolidated guidance; and (ii) whether any improvements could be made in relation to the communication methods for alerting fishermen to significant changes / updates to working practices.

Recommendations

1. **In terms of section 26(1)(b) of the 2016 Act (recommendations (if any) as to (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):**

   That the court recommends that all creel fishermen:

   (a) read the Industry Advisory Note on potting safety, published in January 2001 by Seafish, the MCA's Fishermen's Safety Guide, published in May 2014, the MAIB Potting Safety Message, published in February 2014, and MGN 571 (F) - *Fishing Vessels: Prevention of Man Overboard*;

   (b) review their system of working in light of the above information; and

   (c) devise a system of working which avoids the risk of crew coming into contact with moving fishing gear.

NOTE

Introduction

[1] This inquiry was held into the death of Gerard Gillies. Mr Gillies died on 4 October 2015 after falling into the water from the deck of the fishing vessel *Annie T*. The death of Mr Gillies was reported to the Procurator Fiscal (hereinafter referred to as "PF") on 4 October 2015. A preliminary hearing was held on 2 November 2018. The inquiry took place over two consecutive days, namely 21 and 22 November 2018. Mr Main, PF Depute, represented the Crown. Mr MacLean represented Mr Alistair MacNeil, who was the owner and skipper of the fishing vessel *Annie T* at the time of the accident.

[2] The representatives had conscientiously agreed a significant amount of evidence in a joint minute of agreement which ran to 27 paragraphs. That resulted in the need for oral evidence to be significantly reduced. I heard oral evidence from the following witnesses:

1. Alistair MacNeil, owner and skipper of the *Annie T* at the time of the accident;
2. Donald John Macintyre, former crew member of the *Annie T*;
3. Gopinath Chandroth, MAIB Inspector of Marine Accidents.

Mr Chandroth had prepared a detailed MAIB accident report and he referred to that report during his evidence. I found all three witnesses to be credible and reliable and considered that they were all doing their best to assist the inquiry. Findings in fact 1 to 7, 11 to 21 and 23 to 29 are based on the agreed evidence / undisputed evidence. Findings in fact 8 to 10 and 22 are made on the basis of the oral evidence and the other information before me (see para 4 below) that I accepted.

The Legal Framework

[3] This inquiry was held in terms of section 1 of the 2016 Act. Mr Gillies died in the course of his employment or occupation, and, therefore, the inquiry was a mandatory inquiry held in terms of section 2 of the 2016 Act. The inquiry was governed by the Act of Sederunt (Fatal Accident Inquiry Rules) 2017 (hereinafter "the 2017 Rules") and was an inquisitorial process. The Crown, in the form of the PF, represented the public interest.

[4] The purpose of the inquiry was, in terms of section 1(3) of the 2016 Act, to establish the circumstances of the death of Mr Gillies and to consider what steps (if any) might be taken to prevent other deaths in similar circumstances. It was not the purpose of the inquiry to establish civil or criminal liability (see section 1(4) of the 2016 Act). The manner in which evidence is presented to an inquiry is not restricted. Information may be presented to an inquiry in any manner and the court is entitled to reach conclusions based on that information (see Rule 4.1 of the 2017 Rules).

[5] Section 26 of the 2016 Act sets out what must be determined by the inquiry. Section 26 of the 2016 Act is in the following terms:

> "**26 The sheriff's determination**
>
> (1) As soon as possible after the conclusion of the evidence and submissions in an inquiry, the sheriff must make a determination setting out—
>
> > (a) in relation to the death to which the inquiry relates, the sheriff's findings as to the circumstances mentioned in subsection (2), and
> > (b) such recommendations (if any) as to any of the matters mentioned in subsection (4) as the sheriff considers appropriate.
>
> (2) The circumstances referred to in subsection (1)(a) are—
>
> > (a) when and where the death occurred,
> > (b) when and where any accident resulting in the death occurred,
> > (c) the cause or causes of the death,
> > (d) the cause or causes of any accident resulting in the death,
> > (e) any precautions which—

(i) could reasonably have been taken, and
(ii) had they been taken, might realistically have resulted in the death, or any accident resulting in the death, being avoided,

(f) any defects in any system of working which contributed to the death or any accident resulting in the death,
(g) any other facts which are relevant to the circumstances of the death.

(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.

(5) A recommendation under subsection (1)(b) may (but need not) be addressed to—

(a) a participant in the inquiry,
(b) a body or office-holder appearing to the sheriff to have an interest in the prevention of deaths in similar circumstances.

(6) A determination is not admissible in evidence, and may not be founded on, in any judicial proceedings of any nature."

[6] In this Note I propose, first, to set out the summary of the facts that I have found proved, second, to set out a brief summary of the submissions made by the parties and, third, consider the circumstances identified in section 26(2)(a) to (f) and explain the conclusions and recommendation I have reached.

Summary

[7] I found the following facts admitted or proved:

1. That Gerard Gillies was born on 20 January 1973 and resided on the Isle of Barra.
2. That Mr Gillies worked as a self-employed share fisherman and, at the time of his death, worked as a crew member on the fishing vessel *Annie T*. Mr Gillies could not swim but never wore a lifejacket or PFD whilst fishing.
3. That Mr Gillies had completed all four mandatory Sea Fish Industry Authority (hereinafter referred to as "Seafish") safety training courses to allow him to work as a fisherman.
4. That Alistair MacNeil was the owner and skipper of the *Annie T* on 4 October 2015.
5. That Mr MacNeil held an unrestricted under 16.5m skipper's certificate issued by Seafish. He too had completed all four mandatory safety training courses to allow him to work as a fisherman.
6. That the *Annie T* had a registered length of 8.60m. She possessed a UK Small Fishing Vessel Inspection Certificate valid until 7 June 2016.
7. That a MCA surveyor inspected the *Annie T*, after the accident, on 22 October 2015. No deficiencies were found with the vessel.
8. That on 4 October 2015 Mr MacNeil and Mr Gillies were on board the *Annie T* fishing for crabs and lobsters. At that time there were three foam lifejackets and three constant wear lifejackets on board the vessel. They had worked several fleets of creels to the West of Pabbay island and then made their way to the east of the sound of Mingulay where they hauled and re-shot a further two fleet of creels. As the creels were hauled in, the catch was emptied into containers stored at the starboard aft end of the vessel and on the cat-catcher. The creels were then rebaited and stored on the port side ready to be shot.

9. That the deck of the *Annie T* contained a sorting table and an area to haul creels at the starboard side. The stern contained a transom opening which allowed the shooting of creels out of the stern of the vessel. The process for shooting creels was as follows: (i) the crew member would stand on the deck aft of the sorting table on the starboard side of the deck behind a board which separated him from the transom opening; (ii) said crew member would throw the first buoy through the transom opening into the water; (iii) the first buoy was connected by a rope to the first weight, 25 creels spaced approximately 28m apart, an end weight and an end buoy; (iv) the skipper would steam *Annie T* at around 3.5kts and the tension on the rope, which was flaked out on the deck, would then pull the first weight and then successive creels through the transom opening and into the water; (v) the said connecting rope would be constantly moving and dragging creels into the water during this process but the crew member would remain on the starboard side of the vessel, clear of moving gear, until all the creels had been shot; (vi) the said crew member, after the last creel had entered the water, would then walk from the starboard side of the vessel, past the moving rope and collect the end weight which would be located on the deck towards the wheelhouse of the vessel; (vii) the said crew member would then, to avoid the end weight rattling down the deck of the vessel and risk causing damage to the deck, carry / move the end weight (which weighed 36kg) to the transom opening at the stern of the vessel and cause that to enter the water; and (viii) the end weight would then cause the end buoy to be pulled into the water.

10. That at about 13.20 hours on 4 October 2015, said Mr MacNeil and Mr Gillies were on board the *Annie T* at the east of the Sound of Mingulay between the islands of Mingulay and Pabbay south of the Isle of Barra. At this time they were at the end of

the process of shooting a fleet of creels. Neither Mr MacNeil nor Mr Gillies were wearing a lifejacket or PFD. Mr MacNeil was in the wheelhouse and Mr Gillies was on the deck of the vessel. After all the creels had been shot into the water there remained a moving rope on the deck of the *Annie T*. This rope was connected to: (i) the fleet of creels that had been shot into the water; (ii) the end weight; and (iii) the end buoy. Both the end weight and the end buoy remained on the deck near to the wheelhouse. Mr Gillies attempted to move from the starboard side of the vessel, past the moving rope, in order to collect the end weight and take it to the transom opening at the stern of the vessel. When Mr Gillies was in approximately the middle of the deck, near to the moving rope, his foot became caught in a loop in said rope (known as a bight) and he fell. The moving rope then pulled Mr Gillies out of the transom opening at the stern of the vessel and into the water.

11. That, at this time, Mr MacNeil was in command of *Annie T* from within the wheelhouse. Mr MacNeil took the boat out of gear, came out of the wheelhouse and ran to the back of the boat and spoke to Mr Gillies who was in the water. Having established that Mr Gillies was clear of the rope, Mr MacNeil thereafter cut the rope that was keeping the creels attached to the boat.

12. That Mr MacNeil used the dual controls on the deck on the starboard side to manoeuvre the vessel so that Mr Gillies was on the starboard side of the vessel adjacent to the controls and the hauler. Mr MacNeil then, whilst speaking continually with Mr Gillies, who was conscious and responsive, threw Mr Gillies a rope and a life ring. Mr Gillies could not get a proper hold of the life ring but took hold of the rope. Mr MacNeil pulled Mr Gillies into the starboard side of the vessel and secured the rope on the vessel.

13. That Mr MacNeil then took another piece of rope, put a loop into it, put it in the water, and told Mr Gillies to place his foot in it and he would haul him up using the hauler. Mr Gillies responded and placed his right foot into the loop and took hold of the rope using both hands. Mr MacNeil began to use the hauler to haul him up slowly. When Mr Gillies' upper body was out of the water, he let go of the rope, fell into the water and was lost to sight.

14. That at this time Mr MacNeil immediately re-entered the wheelhouse and made a mayday call to the Coastguard. He gave the boat's position as 56º 50' .28 N, 007º 35'.21 W, which was a location between the islands of Mingulay and Pabbay, south of the Isle of Barra. As he did so, he saw Mr Gillies appear in the water at the starboard bow face down, about ten feet from the vessel. He slowly manoeuvred the vessel forward so that Mr Gillies was amidships on the starboard side. He used a grappling hook, with rope attached, and positioned it within Mr Gillies' boiler suit and jumper. Mr MacNeil then took the rope to the hauler and used it to lift Mr Gillies out of the water and onto the deck.

15. That at approximately 13.25 hours that day Roderick Michael MacLean, Lifeboat Operations Manager of Barra Lifeboat was notified of an emergency by his lifeboat pager going off. At about 13.30 hours that day, Donald William Macleod, Coxswain of Barra lifeboat, received notification of a mayday call from the Coastguard. He immediately attended at Castlebay Pier and he and other crew members departed the pier on the Barra lifeboat.

16. That after getting Mr Gillies on deck, Mr MacNeil noted there was a very faint pulse from his neck. He was unconscious and not breathing. He immediately began CPR, using both compressions and breaths. On commencing CPR, food and a quantity of

water exited his mouth. Mr MacNeil continued CPR and placed Mr Gillies in the recovery position. Mr MacNeil radioed the Coastguard to update them. He was advised to make his way to Castlebay. Mr MacNeil thereafter placed the vessel on autopilot and recommenced CPR. Mr Gillies was unresponsive.

17. That at about 13.55 hours, Mr Macleod and the lifeboat crew arrived at the *Annie T*. Due to the winds, it was decided not to transfer Mr Gillies to the lifeboat immediately. Initially, two members of the lifeboat crew boarded the *Annie T* and took over the CPR. During this time, both vessels proceeded into a position of shelter, using a nearby island.

18. That on successful positioning of the vessels, Mr Gillies was placed on a stretcher and taken onto the lifeboat, where the crew continued CPR. This continued all the way to Castlebay, where the lifeboat arrived at 14.25 hours. On arrival, ambulance paramedics, Raymond Robertson and Neil Davidson, continued CPR. Mr Gillies remained unresponsive. The Coastguard Helicopter, which was requested to attend from Stornoway, arrived at 14.30 hours. The crew from the helicopter boarded the lifeboat at the same time and took over CPR for a brief time prior to taking Mr Gillies onto the helicopter. The helicopter departed shortly thereafter and conveyed Mr Gillies to Western Isles Hospital, Stornoway and, whilst enroute, advanced life support was conducted.

19. That at about 15.09 hours, the helicopter landed at Western Isles Hospital. CPR was continued on Mr Gillies. His temperature was about 32ºC on arrival and he was given warm fluid to try to heat him up. He remained unresponsive to all treatment given. At about 16.30 hours that day, Dr Gordon Stewart pronounced life extinct.

20. On 6 October 2015, Dr Natasha Inglis FRCPath, Consultant Pathologist, undertook a post mortem examination of said Gerard Gillies and prepared a post mortem report. Dr Inglis' conclusion of said examination was that Mr Gillies died:

> "as a result of salt water immersion following a fall from a fishing boat into the sea. Whilst there are no definitive signs of drowning found at post mortem, there was a degree of pulmonary oedema and on admission to hospital there was evidence of a prolonged APTT and hypothermia. The prolonged APTT could be the cause of the bloodstained fluid present within the abdomen as no other source has been found. It is also possible that, given the history of hypertension and the presence of coronary artery atheroma, that death had been caused by a cardiac dysrhythmia secondary to the stress of the situation."
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> The medical certificate of cause of death was completed as follows:
>
> "I (a) Salt water immersion
>
> due to (or as a consequence of)
>
> (b) Fall from fishing boat
>
> II Ischaemic heart disease"

21. That 'APTT' stands for 'activated partial thromboplastin time' and is a measurement of how long blood takes to clot. If prolonged, blood will clot more slowly and this can lead to spontaneous bleeding. There are studies which have noted the presence of prolonged APTT in situations where a person has drowned and have also noted bleeding at the time of resuscitation of victims of drowning. The evidence of prolonged APTT and bleeding in Mr Gillies' case may suggest his cause of death was drowning as these have been shown to be brought on by drowning-induced asphyxia.

22. That, following the accident, Mr MacNeil made changes to the system of shooting creels on the *Annie T*. First, Mr MacNeil introduced a remote release link. This change still required the crew member to throw the first buoy through the transom

opening from the starboard side of the deck. However, only four or five metres of the rope was then deployed into water with the remaining rope, creels, end weight and end buoy remaining on deck held by the remote release link. The remote release link could only be operated from the wheelhouse. It was only when the remote release link was operated that the creels, end weight and end buoy would be shot into the water. Second, Mr MacNeil strengthened the deck and placed rubber matting on it. This change protected the deck and allowed the end weight to be pulled along the deck to the transom opening without being manually handled. The changes in the system of shooting creels meant that the only manual handling required was the throwing by the crew member of the first buoy from a safe position at the starboard side of the deck behind a board. The crew member throwing the first buoy could then either remain on the starboard side of the vessel or move to the wheelhouse before the remote release link was operated. Thereafter the operation of the remote release link allowed the creels, end weight and end buoy to be self-shot into the water without the need for the crew member to come into contact with the moving rope.

23. That the MCA issues three types of Marine Notices:

(1) Marine Guidance Notes (MGNs) contain advice and guidance on a particular piece of legislation, practice or subject;

(2) Merchant Shipping Notices (MSNs) contain the technical detail of legislation relevant to merchant ships and/or fishing vessels. This is mandatory information which must be complied with under UK legislation;

(3) Marine Information Notes (MINs) tend to give information that is valid for a short period of time or relevant to a small group of people.

The letter suffix after the M Note or Notice number indicates whether the document relates to merchant ships and/or fishing vessels:

(1) "(M)" for merchant ships;

(2) "(F)" for fishing vessels;

(3) "(M+F)" for both merchant ships and fishing vessels.

24. That the MCA published MGN 571 (F) – *Fishing Vessels: Prevention of Man Overboard*, in October 2017. This Note: (i) provides guidance on how to prevent MOB situations from occurring; (ii) discusses why cold water shock and hypothermia make it vital that MOB situations are avoided; (iii) provides guidance on how to assess the risks of going overboard and preventing it from happening; and (iv) provides guidance on the wearing of PFDs and safety lines.

25. That the MCA published MGN 570 (F) – *Fishing Vessels: Emergency Drills*, in October 2017. This Note, amongst other things, provides generic guidance on scenarios for different types of emergency drills. It states that quick rescue in MOB situations is vital due to the dangers of cold water shock and hypothermia and sets out what to consider in order to be best prepared for such a situation.

26. That MGN 570 (F) and 571 (F) have both replaced MGN 430 (F) – *Fishing Vessels: Checks on Crew Certification and Drills*, which was in place at the time of the accident.

27. That MSN 1813 (F) – *The Fishing Vessels Code of Practice for the Safety of Small Fishing Vessels* was in force at the time of the accident. It was replaced in October 2017 by MSN 1871 (F) – *The Code of Practice for the Safety of Small Fishing Vessels of less than 15m Length Overall*. MSN 1871 (F) was subsequently amended and the current version is MSN 1871 Amndt 1 (F), which was published in November 2018.

28. That the MCA published MGN 588 (F) – *Compulsory Provision and Wearing of Personal Flotation Devices on Fishing Vessels*, in November 2018. Para 6.1 of MGN 588 (F) provides that:

> "…the MCA requires, unless measures are in place which eliminate the risk of fishermen falling overboard, all fishermen must be provided and wear PFDs or safety harnesses. The measures preventing Man Overboard must be documented in a risk assessment."

MGN 588 (F) makes clear that a failure to follow the above requirements, following the publication of MGN 588 (F), will be considered by the MCA to be a breach of current health and safety legislation.

29. That MGNs and MSNs are published on the www.gov.uk website.

Submissions

[8] Both parties were in agreement as regards the findings that should be made in terms of section 26(2)(a) to (d) of the 2016 Act.

[9] As regards section 26(2)(e) of the 2016 Act, the crown submitted that had Mr Gillies been wearing a lifejacket or PFD his death might have been avoided. The solicitor for Mr MacNeil submitted that, given the medical evidence, it could not be concluded that the wearing of a lifejacket or PFD would have resulted in Mr Gillies' death being avoided. It was simply unknown what the outcome would have been had a lifejacket or PFD been worn. The solicitor for Mr MacNeil did, however, accept that a system of work that avoided the need for Mr Gillies to manually handle the end weight along the deck of the *Annie T* (and thereby avoid the risk of coming into contact with a moving rope on the deck of the vessel) was a precaution that might have resulted in the accident resulting in death being avoided.

[10] As regards section 26(2)(f) of the 2016 Act, the crown submitted that the need for Mr Gillies to manually handle the end weight along the deck was a defect in the system of working which contributed to the accident resulting in death. The solicitor for Mr MacNeil submitted that this was the same point as he had conceded under section 26(2)(e) of the 2016 Act and it was therefore unnecessary to make a finding under this head as well.

[11] As regards section 26(2)(g) of the 2016 Act, the crown submitted that a finding should be made to the effect: (i) that fishermen may not fully appreciate how difficult it is to recover a casualty from the water, particularly when affected by cold water shook; and (ii) that effective monthly MOB drills should be conducted to ensure that, first, all crew are properly trained in MOB recovery and, second, to identify MOB rescue equipment suitable for the particular vessel in question. The solicitor for Mr MacNeil did not seek any findings to be made under this head.

[12] As regards the making of recommendations, the crown sought the recommendation set out at para 37. The solicitor for Mr MacNeil was in agreement with the crown's submission in this regard. He submitted that no recommendations should be addressed to Mr MacNeil specifically.

Discussion and Conclusions

Section 26(2)(a) of the 2016 Act (when and where the death occurred)

[13] In this inquiry there was no dispute as regards when and where the death occurred. Therefore I had no difficulty in determining from the undisputed evidence:

> That the late Gerard Gillies, born 20 January 1973, died at about 16.30 hours on 4 October 2015 at Western Isles Hospital, Stornoway.

Section 26(2)(b) of the 2016 Act (when and where any accident resulting in death occurred)

[14] There was no dispute as regards when and where the accident resulting in death occurred. Therefore I had no difficulty in determining from the undisputed evidence:

> That the accident resulting in death took place at about 13.20 hours on 4 October 2015 on board the fishing vessel *Annie T* at a location with the co-ordinates 56º 50′.28 N, 007º 35′ .21 W, being between the islands of Mingulay and Pabbay, south of the Isle of Barra.

Section 26(2)(c) of the 2016 Act (the cause or causes of death)

[15] There was no dispute as regards the cause or causes of death. On 6 October 2015, Dr Natasha Inglis FRCPath, Consultant Pathologist, undertook a post mortem examination of Mr Gillies and subsequently prepared a post mortem report. The parties had agreed the evidence of Dr Inglis and she did not require to give oral evidence at the inquiry. Dr Inglis noted in her report that Mr Gillies had a history of essential hypertension for which he was prescribed medication. Dr Inglis, following her examination of Mr Gillies, concluded that he had died:

> "as a result of salt water immersion following a fall from a fishing boat into the sea. Whilst there are no definitive signs of drowning found at post mortem, there was a degree of pulmonary oedema and on admission to hospital there was evidence of a prolonged APTT and hypothermia. The prolonged APTT could be the cause of the bloodstained fluid present within the abdomen as no other source has been found. It is also possible that, given the history of hypertension and the presence of coronary artery atheroma, that death had been caused by a cardiac dysrhythmia secondary to the stress of the situation."

[16] Dr Inglis noted that 'APTT' stood for 'activated partial thromboplastin time' and was a measurement of how long blood takes to clot. If prolonged, blood will clot more slowly and this can lead to spontaneous bleeding. Dr Inglis explained that there were studies in the literature which have noted the presence of prolonged APTT in situations where a person

has drowned and have also noted bleeding at the time of resuscitation of victims of drowning. Accordingly, in relation to Mr Gillies, the evidence of prolonged APTT and bleeding possibly suggested his cause of death was drowning as these symptoms had previously been shown to be brought on by drowning-induced asphyxia. However, although Dr Inglis was able to confirm that the cause of death was due to immersion in water, whether that had led to drowning or a cardiac event was difficult for her to state with any certainty. In the circumstances the medical certificate of cause of death was completed as follows:

"I (a) Salt water immersion

due to (or as a consequence of)

(b) Fall from fishing boat

II Ischaemic heart disease"

[17] In the circumstances I did not consider that I could make a finding that the cause of death was as a result of drowning and I determined that the cause of death was as set out in the medical certificate.

Section 26(2)(d) of the 2016 Act (the cause or causes of any accident resulting in death)

[18] There was no dispute about the cause of accident resulting in death. The cause of the accident was not part of the agreed evidence but was explained by Mr MacNeil who witnessed the accident occurring. Mr MacNeil explained the process of shooting creels and, in particular, that the collection of the end weight by the crew member was to stop it rattling down the deck of the vessel and avoid the risk of it causing damage to the deck.

Mr MacNeil described how the accident had occurred. He explained that he was in the wheelhouse and the last creel had been shot. He saw Mr Gillies move from the starboard side of the vessel towards the end weight which was located on the deck near to the

wheelhouse. As Mr Gillies reached the middle of the deck, near to where the moving rope would have been, he saw Mr Gillies fall. Mr MacNeil then saw Mr Gillies being pulled towards and through the transom opening at the stern of the vessel into the water. Mr MacNeil did not see what had caused Mr Gillies to fall but was, in the circumstances, in complete agreement with the conclusion reached by Mr Chandroth, following the MAIB investigation, that the fall would have been caused by Mr Gillies' foot getting caught in a loop of the moving rope (known as a bight) which had then pulled Mr Gillies out of the transom opening at the stern of the vessel and into the water. Findings in fact 8 to 10 are based on the evidence of Mr MacNeil taken together with the conclusions reached by Mr Chandroth. As a result of those findings in fact I determined that the cause of the accident resulting in death was as follows:

(a) After all the creels had been shot into the water there remained a moving rope on the deck of the *Annie T*. This rope was connected to: (i) the fleet of creels that had been shot into the water; (ii) the end weight; and (iii) the end buoy. Both the end weight and the end buoy remained on the deck near to the wheelhouse.

(b) Mr Gillies attempted to move from the starboard side of the vessel, past the moving rope, in order to collect the end weight and take it to the transom opening at the stern of the vessel.

(c) When Mr Gillies was in approximately the middle of the deck, near to the moving rope, his foot became caught in a loop in said rope (known as a bight) and he fell. The moving rope then pulled Mr Gillies out of the transom opening at the stern of the vessel and into the water.

Section 26(2)(e) of the 2016 Act (any precautions which (i) could reasonably have been taken, and (ii) had they been taken, might realistically have resulted in death, or any accident resulting in death, being avoided)

[19] Mr MacNeil explained that Mr Gillies, despite being a non-swimmer, never wore a lifejacket or PFD. Neither Mr MacNeil nor Mr Gillies had worn a lifejacket or PFD on 4 October 2015, despite lifejackets being available on board the vessel. Mr Chandroth's report detailed the human body's typical reaction to immersion in cold water (under 15ºC) at para 1.6, which stated:

> "The human body's typical reaction to immersion in cold water (under 15ºC) is normally considered in four stages:
>
> 1. Cold water shock
> Cold water shock takes place within the first 30s to 2 minutes and is generally associated with a gasp reflex as the body comes into contact with the cold water, along with hyperventilation and a dramatic increase in heart rate and blood pressure. If the head goes underwater during this stage, the inability to hold one's breath will often lead to water entering the lungs in sufficient quantities to cause death. The increased heart rate and blood pressure can result in cardiac arrest, especially if the casualty has an existing cardiovascular condition. Panic can cause the hyperventilation to continue even after the initial physiological effects have subsided.
>
> 2. Cold incapacitation
> Cold incapacitation usually occurs within 2-15 minutes of entering the water. The blood vessels are constricted as the body tries to preserve heat and protect vital organs. This results in the blood flow to the extremities being restricted, causing cooling and consequent deterioration in the functioning of muscles and nerve ends. Useful movement is lost in the hands and feet, progressively leading to the incapacitation of arms and legs. Unless a lifejacket is worn, death by drowning occurs as a result of impaired swimming.
>
> 3. Hypothermia
> Hypothermia occurs when the human body's core temperature drops below 35ºC (it is normally about 37ºC). Depending on circumstances, this can occur after 30 minutes. The body's core temperature can continue to drop even after the casualty has been recovered from the water if the re-warming efforts are not effective.

4. Circum-rescue collapse
Circum-rescue collapse can occur just before, during or after rescue due to a variety of mechanisms that result in unconsciousness or death. Collapse just before rescue may occur when a casualty relaxes mentally resulting, among other things, in a sudden drop of stress hormones, possibly leading to [*a*] drop in blood pressure."

The parties did not take issue with the above four stages and I accepted they set out the human body's typical reaction to immersion into cold water under 15ºC.

[20] Mr Chandroth referred to an expert opinion from Professor Mike Tipton, Professor of Human and Applied Physiology, which had previously been commissioned by the MAIB in relation to the advantages of wearing a lifejacket. Professor Tipton's summary of the main advantages of wearing a lifejacket was as follows:

(1) Keeping the airway and face clear of the water;

(2) Decreasing cooling due to additional insulation against the cold, reduced need to exercise and fewer periods of head immersion;

(3) Decreasing cardiac workload due to reduced need to exert oneself; and

(4) Increasing detection and enabling more effective means of recovery from the water.

[21] The parties were in dispute as regards whether the wearing of a lifejacket or PFD was a precaution that might realistically have resulted in death being avoided (see para 9 above). In my view the agreed evidence set out at findings in fact 11 to 14 made clear that Mr Gillies, after entering the water, managed to speak to Mr MacNeil and was able to take hold of a rope thrown to him. Unfortunately, Mr Gillies ultimately let go of the rope, fell back into the water and was lost to sight for a period. Mr MacNeil, after making a mayday call, next saw Mr MacNeil face down in the water but was able to recover him from the water using a grappling hook with a rope attached and utilising the hauler on the vessel. It

is not known what effect Mr Gillies' immersion in the cold water had on him, nor is it known why he let go of the rope that he managed to get hold of. However, when the circumstances of the accident are viewed against the background of: (i) the fact that Mr Gillies was a non-swimmer; (ii) the human body's typical reaction to immersion in cold water; and (iii) Professor Tipton's summary of the advantages of wearing a lifejacket or PFD, I consider that the wearing of a lifejacket or PFD may have had the benefits set out in points 1 to 3 of Professor Tipton's summary in respect of his initial fall into the water and may have had the benefits set out in points 1 to 4 of Professor Tipton's summary when Mr Gillies was first lost to sight. In particular the wearing of a lifejacket or PFD may: (i) have resulted in Mr Gillies being in a better physical condition when he took hold of the rope and therefore able to sustain his hold on the rope and participate in his own rescue; (ii) have avoided Mr Gillies being lost to sight; and (iii) have avoided Mr Gillies being in a face down position.

[22] In the circumstances, whilst I cannot say that Mr Gillies' death *would* have been avoided if he had worn a lifejacket or PFD, I determine that the wearing of a lifejacket or PFD was a precaution that could reasonably have been taken and that, had it been taken it *might* realistically have resulted in Mr Gillies' death being avoided.

[23] I have already commented on the cause of the accident resulting in death at para 18. Mr Chandroth's report highlighted guidance which had been issued as regards safe systems of work. The Industry Advisory Note on potting safety, published in January 2001 by Seafish and the MCA's Fishermen's Safety Guide, published in May 2014, specifically warned of the danger to crew members who are not separated from the running gear when shooting creels. The Seafish Advisory Note identified the main hazards encountered in creel fishing. It recommended several methods to reduce or eliminate the risks of being carried overboard by fishing gear, including:

(1) Rope pounds or divisions to physically separate the crew member from the back rope;

(2) Detachable creels using a loop and toggle system, allowing the crew to work the gear in a controlled fashion while being separated by a barrier from the gear; and

(3) Self-shooting systems, which do not require manual intervention.

The Fisherman's Safety Guide includes a section on potting that discusses the layout of working decks and warns that familiarity and repeated tasks can cause lapses in concentration, which can result in serious accidents. In February 2014 the MAIB published a Potting Safety Message which warned that crew should ensure they are standing in a safe area during shooting to avoid the chance of being taken overboard by running gear.

[24] At finding in fact 22 I have set out the relatively simple precautions that were put in place by Mr MacNeil to avoid the need for the crew to manually handle the end weight along the deck of the *Annie T* to the transom opening at the stern of the vessel and thereby avoid the risk of the crew member coming into contact with a moving rope on the deck of the vessel. The precautions put in place resulted in the system effectively becoming a self-shooting system with the only manual handling being the throwing of the first buoy from a safe position. I consider these precautions (or other precautions, highlighted by the available guidance, which avoided the need for the crew to come into contact with moving gear on the deck) could reasonably have been taken prior to the accident.

[25] In the circumstances I determine that the precaution that could reasonably have been taken which might realistically have resulted in the accident resulting in death being avoided was a system of work that avoided the need for Mr Gillies to manually handle the end weight along the deck of the *Annie T* to the transom opening at the stern of the vessel

and thereby avoid the risk of coming into contact with a moving rope on the deck of the vessel.

Section 26(2)(f) of the 2016 Act (any defects in any system of working which contributed to the death or the accident resulting in death)

[26] At finding in fact 9 I have set out the system of shooting creels. At paras 23 to 25 I have set out the defect that was present in that system. In the circumstances I determine that the defect in the system of shooting creels on the *Annie T* which contributed to the accident resulting in death was the need for Mr Gillies to manually handle the end weight along the deck of the *Annie T* to the transom opening at the stern of the vessel and thereby run the risk of coming into contact with a moving rope on the deck of the vessel.

Section 26(2)(g) of the 2016 Act (any other facts which are relevant to the circumstances of the death)

[27] Section 26(2)(g) of the 2016 Act does not require there to be any causal connection with the death. I consider that this paragraph gives the court wide scope, in the public interest, to make findings under this paragraph. The inquiry was limited in scope and heard limited evidence. It did not review the available guidance at any length and the MCA were not represented. However, the inquiry did have the benefit of the evidence and report from Mr Chandroth and did hear from two fishermen, including Mr MacNeil who had over 25 years fishing experience.

Lifejacket/PFDs

[28] Mr Chandroth made clear that there was a significant problem with fishermen refusing to wear a lifejacket or PFD. Mr Chandroth explained: (i) under reference to a study led by the MCA, that there had been numerous deaths which could potentially have been

saved if the fisherman in question had been wearing a lifejacket or PFD; (ii) that various organisations had issued heavily subsidised or free constant wear lifejackets in the UK; (iii) that even when a lifejacket or PFD has been provided free of charge and was available on board, they were seldom worn; (iv) that fishermen complain that lifejackets or PFDs: (a) are uncomfortable and too bulky to work in; (b) risk becoming snagged on the fishing gear; and (c) that there was a risk of inadvertent activation of the auto-inflation mechanism; (v) that light and comfortable PFDs, suitable for use by fishermen, are now available and have been successfully trialled in the USA and by the RNLI; (vi) that crew on workboats serving the offshore oil and windfarm sectors have an excellent record of wearing PFDs whilst carrying out onerous tasks which involve the danger of becoming snagged in the working gear; (vii) that a MCA and RNLI sponsored report concluded that the main reasons why fishermen do not habitually wear a lifejacket or PFD are that they do not appreciate how difficult it can be to rescue a casualty from the water and do not understand just how debilitating cold water shock can be; (viii) that the MAIB have made several recommendations for the MCA to introduce legislation that will require the wearing of a lifejacket or PFD to be mandatory and had again made that recommendation in this case.

[29] Mr MacNeil, despite having witnessed Mr Gillies' death, advised the inquiry that he still did not wear a lifejacket or PFD. He explained that, in his experience, it was the norm, both before and after Mr Gillies' accident, for fishermen not to wear a lifejacket. The reason for this was because the solid lifejackets were too restrictive and there was a concern that the self-inflated style lifejacket could have been inadvertently pierced without the fishermen knowing and then not worked when they were needed. Mr Macintyre explained that he did not routinely wear a lifejacket or PFD.

[30] I considered the evidence and report of Mr Chandroth taken together with the evidence of Mr MacNeil and Mr Macintyre demonstrated that despite significant efforts to encourage fisherman to wear a lifejacket or PFD, many fishermen still do not routinely wear a lifejacket or PFD. In the circumstances I considered that, in order to effect culture change amongst fishermen and reduce the loss of further lives, the wearing of a lifejacket or PFD ought to be made mandatory. It was a matter of agreement that steps were finally being taken to make the wearing of a lifejacket or PFD mandatory. The MCA published MGN 588 (F) – *Compulsory Provision and Wearing of Personal Flotation Devices on Fishing Vessels*, in November 2018. Para 6.1 of MGN 588 (F) provides that:

> "…the MCA requires, unless measures are in place which eliminate the risk of fishermen falling overboard, all fishermen must be provided and wear PFDs or safety harnesses. The measures preventing Man Overboard must be documented in a risk assessment."

MGN 588 (F) refers to Regulations 4 and 21 of the Merchant Shipping and Fishing Vessels (Health and Safety at Work) Regulations 1997 and Regulation 4 of the Merchant Shipping (Work in Fishing Convention) Regulations 2018 and makes clear that a failure to follow the above requirements, following the publication of MGN 588 (F), will be considered by the MCA to be a breach of current health and safety legislation. Had it not been for the above steps being taken I would have made a formal recommendation that the wearing of a lifejacket or PFD be made mandatory, however, in the circumstances such a recommendation is unnecessary.

MOB rescue equipment

[31] Mr Chandroth advised that there is no mandatory requirement for vessels under 15 metres length overall (hereinafter referred to as "LOA") to carry MOB recovery equipment.

The MCA's publication, *Fishermen's Safety Guide: A guide to safe working practices and emergency procedures for fishermen*, does, however state at p 42:

> "Deploy a scrambling net or ladder if possible. Have a heaving line ready to throw to the person in the water in case it is difficult to manoeuvre alongside them. A boat hook can assist in getting the person back alongside."

Mr MacNeil conceded that he did not appreciate how difficult it would be to recover a MOB. Mr Chandroth also considered it likely that Mr MacNeil had not considered how Mr Gillies, a non-swimmer, would cope in the water, nor had he considered the effects that sudden immersion in cold water would have on him.

[32] Mr Chandroth explained that Mr MacNeil's efforts to rescue Mr Gillies were hampered by the fact that there was no MOB equipment available. Mr Chandroth considered that had a ladder, scramble net or some other dedicated MOB equipment been available, it could have changed the outcome of the accident.

[33] Mr Chandroth did, however, accept that Mr MacNeil had done his best to rescue Mr Gillies with the equipment he had available. He had used the hauler and a line with a bowline in it but Mr Gillies was, unfortunately, unable to keep hold of the line that Mr MacNeil had thrown to him.

[34] Mr Chandroth explained that in his report he had made a recommendation for the MCA to issue guidelines regarding MOB recovery equipment for fishing vessels under 15 metres LOA. The MCA's response was to issue: (i) MSN 1871 (F) – *The Code of Practice for the Safety of Small Fishing Vessels of less than 15m Length Overall*; (ii) MSN 570 (F) – *Fishing Vessels: Emergency Drills*; and (iii) MGN 571 (F) – *Fishing Vessels: Prevention of man over board.* Para 3.19 of MGN 1871 (F) provides:

> "3.19 The skipper and crew shall ensure that they are familiar in the use of all lifesaving and fire appliances and equipment with which the vessel is provided and shall ensure that all members of the crew know where the equipment is stowed.

> Related training shall be carried out in drills, including flooding drills, held in port or at sea, at intervals of not more than one month. Further information is contained in MGN 570 (F) Fishing Vessels: Emergency Drills or any superseding document. Information on how to prevent Man Overboard situations occurring is contained in MGN 571 (F) Fishing Vessels: Prevention of Man Overboard."

Para 3.21 of MSN 1871 (F) goes on to state that the time, dates and particulars of drills should be recorded and available for inspection. Mr Macintyre explained that he was aware of the requirement to do monthly drills but explained that the drills he had been involved in simply consisted of hooking a buoy out of the water and recording that a MOB drill had been done. Mr Macintyre conceded that such a drill bore little resemblance to rescuing a MOB. Mr Chandroth advised that, in his experience, these drills were often little more than a box ticking exercise. He went on to explain that it would be problematic to make the carrying of MOB equipment mandatory on vessels under 15 metre LOA because there are a vast number of vessels with different configurations and capacities to store MOB equipment. Mr Chandroth advised that the MCA approach to that difficulty was the measures set out in MSN 1871 (F), MSN 570 (F), and MGN 571 (F), which included a pro-active inspection regime. Mr Chandroth advised that, in the circumstances, the MAIB were content with the MCA's approach, but stressed the need for MOB drills to be as realistic as possible.

[35] It is clear at the time of the accident that there was no need for the *Annie T* to have MOB rescue equipment on board. When Mr Gillies went overboard Mr MacNeil, in my view, acted swiftly, made good use of the equipment that he did have available and did all he could to rescue Mr Gillies. Given the varying storage capacities of vessels under 15 metres LOA I consider the MCA's approach to be a pragmatic one but I do consider that monthly MOB drills should, in order to be effective and avoid becoming a box ticking exercise: (i) be as realistic as possible; and (ii) be used to assess what MOB equipment is required by the particular vessel to conduct an effective MOB rescue.

Accessing and understanding of relevant information

[36] Mr MacNeil accepted that, as a skipper, he required to follow the relevant legislation and guidance but explained that there was lots of information in a variety of documents and it was, at times, difficult to access and understand the legislation and guidance. There were also some documents which had limited relevance to his length of vessel and it was disheartening to have read through such documents to try and find what was relevant to his type of vessel. He explained he would only become aware of new developments if his local fishing association made him aware but noted that not all fishermen were members of an association. Mr MacNeil also was unclear where he could obtain relevant information, although he was now aware that information could be found on the MCA website. He considered that fishermen would obtain a better understanding of the relevant legislation and guidance if it was simplified, consolidated and capable of being accessed from a single source in relation to the particular vessel type that they operated. Mr Chandroth considered that the MCA guidance was complicated and difficult for fishermen to read. He explained that the MAIB issued short and simple safety flyers after an accident via social media with the hope being that their simple format would result in them more likely to be read by fishermen.

[37] Both the crown and the solicitor for Mr MacNeil submitted that the various MGNs and MSNs were likely to be difficult for fishermen to comprehend and that it may be possible to simplify guidance to make it easier for fisherman to understand and follow. The crown considered that it may be possible to make improvements about the way in which information and new developments were communicated and invited me to make a recommendation that: "the MCA be asked to consider the methods by which it makes fishermen and all other relevant stakeholders aware of relevant legislation and guidance,

including any significant changes or updates, with a view to determining whether any other methods may ensure important information is provided and clearly understood".

[38] Whilst the various MGNs and MSNs contain sound advice I did consider that they were fairly complicated documents with multiple cross references to other MGNs / MSNs. For example, as we have seen, para 3.19 of MSN 1871 (F) cross refers and requires the reading of both MSN 570 (F), and MGN 571 (F). In addition, during the course of the inquiry an amendment was issued to MSN 1871 (F) (known as" MSN 1871 Amndt 1 (F)") however, MSN 1871 Amndt 1 (F) does not identify what amendments have in fact been made and requires a comparison between MSN 1871 (F) and MSN 1871 Amndt 1 (F) to work out what has actually been amended.

[39] I did consider from the limited evidence heard that some fishermen: (i) find it difficult to access and understand the relevant legislation, guidance and codes of practice applicable to their working environment (collectively referred to as "relevant information"); (ii) do not become aware of safety flyers and other significant changes to the relevant information; (iii) do not fully read relevant information; and (iv) would welcome simplified, user friendly and consolidated guidance capable of being accessed from a single source in relation to the particular vessel type that they operate.

[40] The way that relevant information was presented and disseminated was not considered at any length and the MCA were not represented at the inquiry. In the circumstances I do not consider that it is appropriate to make any formal recommendation. However, in light of the above, the MCA may, with a view to assisting fishermen to access and understand relevant information regarding the particular vessel type that they operate, wish to consider: (i) whether any improvements could be made in the way relevant information is presented, and, in particular, whether it would be possible and practical to

provide simplified, user friendly and consolidated guidance; and (ii) whether any improvements could be made in relation to the communication methods for alerting fishermen to significant changes / updates to working practices.

[41] In all the circumstances I determine that the other facts relevant to the circumstances of death are:

(a) A Casualty Review Panel led by the MCA carried out a study on marine fatality data from 2007 to 2013. The Panel concluded that, during that period, 148 lives, including 29 commercial fishermen, could have been saved had lifejackets or other buoyancy aids been used.

(b) Since 2013, the National Federation of Fishermen's Organisation, the Scottish Fishermen's Federation, the Fishermen's Mission and the Sea Fish Industry Authority have been distributing heavily subsidised or free constant wear lifejackets to fishermen in the UK.

(c) Between January 2013 and November 2016 the MAIB started 35 investigations into accidents involving commercial fishing vessels. The MAIB found that: (i) there were 22 cases where the wearing of a constant wear PFD was relevant to the outcome of the accident (with constant wear PFDs being available on board in 17 cases and worn in 3 cases); (ii) that 14 lives could have been saved had the casualty been wearing a constant wear PFD (with constant wear PFDs being available on board in 9 of those cases); and (iii) in some cases, the subsidised / free PFDs supplied to fishermen had never been removed from their packaging (and in one case had been left at home).

(d) The MAIB have made several recommendations for the wearing of a lifejacket or PFD to be mandatory.

(e) Despite significant efforts to encourage fisherman to wear a lifejacket or PFD, many fishermen still do not routinely wear a lifejacket or PFD.

(f) In order to effect culture change amongst fishermen and reduce the loss of further lives, it is necessary for the wearing of a lifejacket or PFD to be mandatory.

(g) The MCA issued Marine Guidance Note 588 (F) – *Compulsory provision and wearing of personal flotation devices on fishing vessels*, in November 2018. Para 6.1 of MGN 588 (F) provides that:

> "…the MCA requires, unless measures are in place which eliminate the risk of fishermen falling overboard, all fishermen must be provided and wear PFDs or safety harnesses. The measures preventing Man Overboard must be documented in a risk assessment."

MGN 588 (F) makes clear that a failure to follow the above requirements, following the publication of MGN 588 (F), will be considered by the MCA to be a breach of current health and safety legislation.

(h) Fishermen, particularly, those who have never previously experienced a MOB situation may not fully appreciate: (i) the human body's typical reaction to immersion in cold water; and (ii) how difficult it can be to recover a casualty from the water.

(i) Monthly MOB drills (which have, since the accident, become mandatory) should, in order to be effective and avoid becoming a box ticking exercise: (i) be as realistic as possible; and (ii) be used to assess what MOB equipment is required by the particular vessel to conduct an effective MOB rescue.

(j) Some fishermen: (i) find it difficult to access and understand the relevant legislation, guidance and codes of practice applicable to their working

environment (collectively referred to as "relevant information"); (ii) do not become aware of safety flyers and other significant changes to the relevant information; (iii) do not fully read relevant information; and (iv) would welcome simplified, user friendly and consolidated guidance capable of being accessed from a single source in relation to the particular vessel type that they operate.

(k) The MCA may, with a view to assisting fishermen to access and understand relevant information regarding the particular vessel type that they operate, wish to consider: (i) whether any improvements could be made in the way relevant information is presented, and, in particular, whether it would be possible and practical to provide simplified, user friendly and consolidated guidance; and (ii) whether any improvements could be made in relation to the communication methods for alerting fishermen to significant changes / updates to working practices.

Recommendations

Section 26(1)(b) of the 2016 Act (recommendations (if any) as to (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

[42] I have set out at finding in fact 22 the changes Mr MacNeil made to the system of working on the *Annie T*. Those changes avoided the need for the crew to manually handle the end weight along the deck and therefore avoided the risk of the crew member coming into contact with a moving rope on the deck of the vessel. In the circumstances I do not consider it necessary to make any recommendations as regards the system of work on the *Annie T*.

[43] I would have made a recommendation that the wearing of lifejackets or PFDs be made mandatory but, for reasons set out in para 30, such a recommendation is now not necessary.

[44] I do, however, consider that the following recommendation will result in the making of improvements to the systems of working by creel fishermen which might realistically prevent other deaths in similar circumstances.

[45] The court recommends that all creel fishermen:

(a) read the Industry Advisory Note on potting safety, published in January 2001 by Seafish; the MCA's Fishermen's Safety Guide, published in May 2014; the MAIB Potting Safety Message, published in February 2014; and MGN 571 (F) – *Fishing Vessels: Prevention of Man Overboard*;

(b) review their system of working in light of the above information; and

(c) devise a system of working which avoids the risk of crew coming into contact with moving fishing gear.

[46] I have set out the terms of section 26 of the 2016 Act at para 5 above. Section 26(5) of the 2016 Act makes clear that a recommendation may (but need not) be addressed to a participant to the inquiry or a body or office holder appearing to have an interest in the prevention of deaths in similar circumstances. Section 27(1) of the 2016 Act provides:

"(1) The Scottish Courts and Tribunals Service ("the SCTS") must-

(a) publish, in such manner as it considers appropriate, each determination made under section 26(1),
(b) give a copy of each such determination to-

(i) the Lord Advocate,
(ii) each participant in the inquiry,
(iii) each person to whom a recommendation made in the determination is addressed, and
(iv) any other person who the sheriff considers has an interest in a recommendation made in the determination."

I do not consider that section 26 of the 2016 precludes the making of a recommendation of a general nature. The recommendation I have made is general in nature and is not addressed to a participant in the inquiry or to a body or office holder described in section 26(5) of the 2016 Act. In my view section 27(1)(b)(iii) of the 2016 Act requires the SCTS to give a copy of the determination to a specific named person or persons to whom a recommendation is addressed. I do not consider that it applies to a recommendation of a general nature addressed to a group of people whose particular identities are not known. In the circumstances I consider: (i) that the SCTS must give a copy of this determination to the Lord Advocate and the participants to the inquiry; (ii) that the MCA and the MAIB have an interest in the recommendation made and ought to be given a copy of the determination.

Postscript

[47] At the outset of the inquiry I extended my condolences to Mr Gillies' family. I was joined in those condolences by all parties. I wish to formally repeat my condolences to Mr Gillies' family in this determination.