SHERIFFDOM OF NORTH STRATHCLYDE AT OBAN

[2020] FAI 15

OBN-B92-19

DETERMINATION

BY

SHERIFF PATRICK HUGHES

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

into the death of

HUGO VAJK

Oban, 12 March 2020

Determination

The Sheriff, having considered all of the evidence, determines:

(1) in terms of section 26(2)(a) of the Inquiries into Fatal Accidents and Sudden Deaths etc. (Scotland) Act 2016 ("the Act"), that Hugo Vajk died in Loch Creran at approximately 16:00 hours on 7 January 2018;

(2) in terms of Section 26(2)(c) of the Act, that the cause of death was drowning.

Thereafter makes no findings in terms of section 26(2)(b), (d), (e), (f) and (g) of the Act, and makes no recommendations in terms of section 26(1)(b) of the Act.

NOTE:

Introduction

[1] This was an inquiry held under the Fatal Accidents and Sudden Deaths etc (Scotland) Act 2016 ("the Act") into the death of Hugo Vajk. His death was reported to the Crown Office & Procurator Fiscal Service on 8 January 2018. A notice of an inquiry was given by the procurator fiscal under section 15(1) of the Act on 7 November 2019. I pronounced a first order on 8 November 2019, dispensing with a preliminary hearing and assigning 27 January 2020 as the date for the hearing of the inquiry. On that date no oral evidence was heard but a joint minute of agreed facts was lodged together with documentary productions, and the court adjourned to issue a written decision.

[2] In these proceedings the Crown was represented by Mr Stuart Fauré, procurator fiscal depute. Mr Vajk's family were represented by Mr Gordon McNab, solicitor.

The Legal Framework

[3] This inquiry was held under section 1 of the Act. Its purpose is to establish the circumstances of Mr Vajk's death, and to consider what steps, if any, might be taken to prevent other deaths in similar circumstances. The holding of an inquiry is governed by the Act of Sederunt (Fatal Accident Inquiry Rules) 2017. It is an inquisitorial process, not an exercise in establishing criminal or civil liability. The public interest is represented by the Crown. In terms of section 26(1)(a) and section 26(2) of the Act, the sheriff's determination must set out findings made on:

(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.

[4] In terms of section 26(1)(b) and section 26(4) of the Act the sheriff must make such recommendations, if any, as are considered appropriate regarding any of the following matters which might realistically prevent other deaths in similar circumstances;

(a) the taking of reasonable precautions,

(b) the making of improvements to any system of working,

(c) the introduction of a system of working, and

(d) the taking of any other steps.

[5] In terms of section 2(3) of the Act, the holding of this inquiry was mandatory, because Mr Vajk's death resulted from an accident which took place in Scotland and which occurred while he was acting in the course of his occupation as an oyster farmer.

Summary

[6] Mr Vajk was born on 15 June 1955 in Canada. Prior to his death he lived in Oban with his wife Judith. Mr Vajk had previous experience of farming oysters in France and the Channel Islands. In 1995 he and his wife established an oyster farming business, the Caledonian Oyster Company. This company operated an oyster farm in Loch Creran, approximately 1 mile north of Benderloch.

[7] Loch Creran is a sea loch approximately 10 kilometres long, forming part of the larger Loch Linnhe. The company's oyster farm consists of numerous metal trestle tables which sit submerged within the water with bags attached to their frames. Immature oysters are placed within the bags where they begin to grow, drawing sustenance from the incoming tides. The oysters require constant attention; the growing bags have to be regularly turned, and the oysters checked for disease, graded and transferred into other growing bags with oysters of a similar size.

[8] On average oysters take three years to become mature enough to be harvested. They are harvested at low tide. To assist in harvesting, a floating platform is used to store the harvested oysters. It is secured by rope to a trestle table while the oysters are harvested from the attached bags, allowing the harvesters to use both hands when harvesting.

[9] At around 16:00 hours on 7 January 2018 Mr Vajk and his employee Marcin Sapinski were working at the north-western point of the farm, harvesting oysters at low tide. It was the last day of harvesting in this particular harvesting cycle. The depth of the water was waist high and both men were wearing waders. Mr Vajk was

approximately 200 yards beyond Mr Sapinski. He was not wearing a life jacket or any other form of buoyancy aid.

[10] The two men were using a floating platform made from plastic measuring three metres by two metres on which the harvested oysters were stored. The platform slipped its tether and floated out into deeper water. Mr Vajk swam after it in an attempt to retrieve it. Mr Sapinski then noticed that Mr Vajk had stopped swimming although he was still visible in the water. Mr Sapinski tried to swim towards Mr Vajk but the water was too cold. He had difficulty breathing and his waders were filling up with water. He stopped and shouted at Mr Vajk who was still some way off in the water. Mr Vajk did not respond and Mr Sapinski returned to the shore, where he telephoned the emergency services.

[11] At approximately 16:15 hours the Stornoway coastguard deployed the Oban lifeboat, the coastguard helicopter and an ambulance to attend at the scene. The lifeboat left its berth at 16:35 hours and arrived at the scene at 17:00 hours. On arrival, the boat's coxswain Mr Richard Johnston spoke with Mr Sapinski who directed him and his crew to where he had last seen Mr Vajk.

[12] Mr Vajk was recovered from the waters of Loch Creran about five metres from the edge of the oyster farm, which was about 200 metres from the shoreline. The coastguard helicopter arrived at the scene at 17:02 hours; Mr Vajk was winched into the helicopter and then flown to the Lorn & Islands District Hospital in Oban. He was not breathing and was unresponsive. Adrenaline and cardiopulmonary resuscitation ("CPR") was administered to him inside the helicopter.

[13] Mr Vajk arrived at the hospital at approximately 17:30 hours where he was attended to by consultant physician Hasan Fattah and consultant surgeon John Abraham, who continued CPR until 19:20 hours. No signs of life were noted by either physician. Life was pronounced extinct at 19:20 hours by Mr Fattah within the resuscitation room at the accident & emergency department of the hospital.

[14] On 7 January 2018 at the Queen Elizabeth II University Hospital in Glasgow a post-mortem examination was carried out by forensic pathologist Dr John Williams. The cause of death was recorded as being consistent with drowning. The report noted a history of asthma.

[15] Ms Eve Macready Jones of the Health and Safety Executive (HSE) investigated the incident and concluded that no action by HSE was required. The report notes that it is not common practice to wear buoyancy aids in oyster farming, due to workers normally working at a depth of water that rarely exceeds one metre, the bulky nature of such aids and the risk of snagging.

Discussion and Conclusions

[17] The representatives of both the Crown and Mr Vajk's family sought only formal findings. I agree that no further findings are necessary. It is clear that Mr Vajk drowned after becoming incapacitated whilst swimming after the raft. The most likely explanation for this is that he experienced the same breathing difficulties caused by the cold water that were described by Mr Sapinski; in Mr Vajk's case these problems may

have been exacerbated by his asthma. Swimming would also have been made more difficult by his clothing becoming waterlogged.

[18] At the hearing on 27 January 2020 I expressed my condolences to those members of Mr Vajk's family who were present in court. I do so again now, and hope that this determination may offer them some degree of closure.