SHERIFFDOM OF GRAMPIAN, HIGHLAND AND ISLANDS AT LOCHMADDY

[2021] FAI 10

LMD-B12-20

DETERMINATION

by

SHERIFF GARY AITKEN

UNDER THE INQUIRIES INTO FATAL ACCIDENTS AND SUDDEN DEATHS ETC.

(SCOTLAND) ACT 2016

into the death of

MICHAEL MONK

Lochmaddy, 5 February 2021

Determination

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

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

The late Michael Monk, born 29 April 1962, died between 12.00 and 12.30 hours on 24 July 2019 in the water off Benbecula between Loch Carnan and Peters Port whilst fishing for crabs in the course of his employment.

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

The accident resulting in death took place between 12.00 and 12.30 hours on 24 July 2019 on the water off Benbecula between Loch Carnan and Peters Port.

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

The cause of the death of said Michael Monk was 1 (a) drowning.

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

The cause of the accident resulting in the death of said Michael Monk, was a man overboard event. The precise circumstances of the accident are unknown because Mr Monk was working alone and no one witnessed how he came to fall in the water.

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)

Had Michael Monk been wearing a personal flotation device it might realistically have resulted in his death being avoided. Given that the precise mechanism of the accident which resulted in Mr Monk falling overboard are unknown it cannot be determined whether there are precautions which might realistically have resulted in that accident being avoided.

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)

Michael Monk was engaged in fishing operations while not wearing a personal flotation device, and to that extent the system of work was defective.

In terms of section 26(2)(g) (any other facts which are relevant to the circumstances of the death)

Michael Monk was not wearing a personal locator beacon at the time of his death. Given that the gap between the last time he was seen alive by the crew of the *Sparkling Star* and their discovery of him face down in the water was only around thirty minutes I am not

satisfied that it is possible to say whether he would have been found any earlier, or with any different outcome had he been wearing a personal locator beacon. However, in other circumstances the wearing of such a device could be critical. Compliance with the now mandatory use of such devices is strongly encouraged.

Recommendations

In terms of sections 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)

There are no recommendations made.

NOTE

Legal Framework

[1] This inquiry was held in terms of section 1 of the 2016 Act and was governed by the Act of Sederunt (Fatal Accident Inquiry Rules) 2017 (hereinafter referred to as "the 2017 Rules"). This was a mandatory inquiry in terms of section 2 of the 2016 Act as Mr Monk died as a result of an accident in the course of his employment or occupation.

[2] The purpose of the inquiry is set out in section 3 of the 2016 Act as being to establish the circumstances of the death and to consider what steps, if any, might be taken to prevent other deaths in similar circumstances. It is not intended to establish liability, either criminal or civil. The inquiry is an exercise in fact finding, not fault finding. It is not open to me to

engage in speculation. The inquiry is an inquisitorial process. The Crown, in the form of the Procurator Fiscal, represents the public interest.

[3] In terms of section 26 of the 2016 Act the inquiry must determine certain matters, namely where and when the death occurred, when any accident resulting in the death occurred, the cause or causes of the death, the cause or causes of any accident resulting in the death, any precautions which could reasonably have been taken and might realistically have avoided the death or any accident resulting in the death, any defects in any system of working which contributed to the death, and any other factors relevant to the circumstances of the death. It is open to the Sheriff to make recommendations in relation to matters set out in subsection 4 of section 1 of the 2016 Act.

Introduction

[4] This inquiry was held into the death of Michael Monk. He was the owner and skipper of a creel fishing vessel, the *May C*. Mr Monk sadly died on 24 July 2019 while out fishing. About 12.30 hours that day he was found face down and unresponsive in the sea by the crew of another fishing boat. He had fallen overboard from the *May C* earlier in the day, but that had not been witnessed.

[5] A preliminary hearing was held by Webex on 1 December 2020. It was clear that much of the evidence was not in dispute and the Crown were instructed to prepare a Notice to Admit Information in terms of rule 4.12 of the 2017 Rules.

[6] The inquiry proceeded, by Webex, on 26 January 2021. Ms Whyte, Procurator Fiscal Depute, represented the Crown. No other parties were represented. The Crown lodged a

substantial Notice to Admit Information. I accepted the facts set out in the Notice to Admit Information.

[7] The Crown also lodged an inventory of productions as follows:

1. Intimation of death
2. Post Mortem Examination Report dated 14 August 2019
3. Toxicology Report dated 8August 2019
4. Marine Accident Investigation Branch Report Number 16/2020 – Fishing vessel *May C*
5. Marine Accident Investigation Branch Report Number 14/2019 – Fishing vessel *Sea Mist*
6. Marine Guidance Note MGN 588(F) – Compulsory Provision and Wearing of Personal Flotation Devices on Fishing Vessels
7. Maritime and Coastguard Agency – Enforcement of Personal Flotation devices – 9 December 2020
8. Maritime and Coastguard Agency MCA/276/2A – Single Handed fishing

[8] The Crown lodged a list of witnesses as follows:

1. William Evans, Inspector, Marine Accident Investigation Branch

Much of Mr Evans' evidence was contained in the Marine Accident Investigation Branch report, lodged as Production 4. However, I heard oral evidence from him to supplement said report. He also made reference to the Recommendations contained in the Marine Accident Investigation Branch report into a fatal accident on the fishing vessel *Sea Mist*, lodged as Production 5.

The facts

[9] Michael Monk was born on 29 April 1962. He was 57 years old at the time of his death. He lived on the Isle of Benbecula and was the owner and skipper of a creel fishing boat, the *May C*, registration number SY213.

[10] About 06.20 hours on Wednesday 24 July 2019, Mr Monk arrived at Peters Port, Benbecula, rowed out to his boat *May C* with his bait and other provisions for the day and made his way to Loch Carnan to fish for crabs.

[11] Throughout the morning the crewmen of another fishing boat, the *Sparkling Star*, saw Mr Monk periodically as they were tending to their creels in the same area. The crew of the *Sparkling Star* last saw Mr Monk around 12.00 hours.

[12] At about 12.30 hours, the crew of the *Sparkling Star* became concerned for Mr Monk as *May C* seemed to be very close to inshore rocks and they went over to investigate. As they approached *May C* they found no one was on board, the outboard engine was in the raised position, lifted out the water and not running and the independent generator which hauls the creels was still running. There were no creels in or around the boat. A search began for Mr Monk and moments later he was seen face down in the sea, off Benbecula between Loch Carnan and Peters Port, close to his boat. He was wearing an orange jacket but was not wearing a personal flotation device nor a personal locator beacon. The skipper of the *Sparkling Star* made a "Mayday" call at 12.53 hours and the Coastguard tasked a RNLI lifeboat, a coastguard helicopter, a coastal rescue team and an ambulance to attend. The crew of *Sparkling Star* were unable to lift Mr Monk on board but placed a rope around his chest to keep his head out of the water and took him to a nearby fish farm cage, where he was lifted onto the low walkway and CPR was commenced.

[13] On the advice of the Coastguard CPR was continued during the short crossing from the fish farm cage to Loch Carnan fuel jetty.

[14] At 13.18 hours, Mary Bagley, a paramedic with the Scottish Ambulance Service arrived at Loch Carnan. At 14.09 hours Mary Bagley went onto the *Sparkling Star* with a Coastguard winchman to check for any signs of life from Mr Monk. None were found and his life was pronounced extinct at 14.09 hours. Mr Monk's body was recovered from the *Sparking Star* at Peters Port pier and taken to the mortuary at the Uist and Barra Hospital.

[15] On 29 July 2019, Dr Mark Ashton, Consultant Pathologist, Raigmore Hospital, Inverness performed a post mortem examination and dissection on the body of Michael Monk. The findings and conclusion of the post mortem examination are detailed in Dr Ashton's report (Crown Production 2). As a result of his examinations Dr Ashton certified the cause of Mr Monk's death as drowning.

[16] Toxicological analysis of samples taken during said post mortem examination are detailed in the Toxicology Report (Crown Production 3). That analysis did not reveal anything of significance.

[17] The Marine Accident and Investigation Branch (hereafter referred to as "the MAIB") is the body in the United Kingdom charged with the investigation of marine accidents. The statutory remit of the MAIB is to investigate marine accidents with a view to making safety recommendations and seeking to prevent a recurrence of a similar accident in the future.

[17] The MAIB carried out an investigation into this incident and produced a report (Crown Production 4) but made no further recommendations in view of the fishing industry initiatives and the recommendations made in their report into the fatal man overboard incident from the single-handed fishing boat *Sea Mist*. The MAIB report relating to the *Sea*

Mist investigation is lodged as Crown Production 5. Both reports are available to the public free of charge on the MAIB website.

[18] A Fatal Accident Inquiry into the death of Anthony Masson, the owner and skipper of the *Sea Mist* was conducted at Banff Sheriff Court on 20 November 2020.

[19] The policy of the Maritime & Coastguard Agency (hereafter referred to as "the MCA") on the wearing of personal flotation devices by fishermen and the reasoning behind it is set out in Marine Guidance Note 588(F) (Crown Production 6). The number of man overboard accidents from fishing vessels investigated by the MAIB in recent years clearly demonstrates a significant risk to fishermen. Incidents have occurred because fishermen have fallen, been washed or been dragged overboard after getting tangled in gear. Once in the water, cold shock and hypothermia will quickly make it harder for a person to stay afloat and alert. The risk of drowning is significantly higher if no personal flotation device is worn. The MCA will enforce the use of safety harnesses and/or personal flotation devices as a mandatory requirement where there is a risk of falling overboard. The MCA requires that, unless measures are in place which eliminate the risk of fishermen falling overboard, all fishermen must be provided with and must wear personal floatation devices or safety harnesses. The measures preventing "Man Overboard" must be documented in a written risk assessment.

[20] The MCA utilise maritime and coastal reconnaissance aircraft services to check fishermen's compliance with the requirement to wear a personal floatation device. This process and enforcement action is set out in a document lodged as Crown Production 7. At the end of each flight a report is produced, including photographic evidence, which is sent to the MCA Marine Office closest to the area overflown. A Surveyor of Ships will review the

report. If satisfied that no personal floatation devices are being worn by crew on deck a letter will be sent to the owner of the vessel, asking for an explanation, a copy of the personal flotation device risk assessment and certain crew details. If the information provided is not satisfactory a warning letter will be sent. A second transgression will result in a Prohibition Notice being issued. Any third transgression will be investigated with a view to consideration of criminal proceedings.

[21] A personal flotation device (hereafter referred to as a "PFD") is a device which ensures that if the wearer falls into water they are turned over onto their back, with their head up to keep their head out of the water and improve the chances of their survival.

[22] A personal locator beacon (hereafter referred to as a "PLB") is a device registered to a specific vessel, normally manually activated, which sends a signal containing GPS coordinates to the Coastguard to increase the chances of the wearer being located and to speed up the possibility of rescue.

The evidence

[23] Ms Whyte read out the terms of the Notice to Admit Information. Paragraphs [9] to [20] above are derived from the Notice to Admit Information and the Productions.

[24] William Evans gave evidence that he is employed as a Nautical Inspector with the MAIB. He joined the MAIB in 2017. He has a background on the bridges of ships and commanding ships at sea. He holds the highest available qualification as a Watchkeeper from the International Maritime Organisation. He holds a post graduate qualification in Accident Investigation from Cranfield University.

[25] Mr Evans explained that the MAIB undertake a mandatory investigation into any serious maritime incident and that the death of Mr Monk was clearly a serious incident. He attended at the scene the day after Mr Monk was found in the water. He and another MAIB inspector spoke to witnesses, collated evidence and viewed Mr Monk's fishing vessel, the *May C*. The purpose of these investigations was to try to understand what had happened. In terms of a Memorandum of Understanding with the Police the MAIB are able to gain access to evidence gathered and statements taken by the police in serious maritime incidents. Mr Evans had access to the police evidence in the course of his investigations.

[26] Mr Evans was referred to Production 4 and confirmed that this was the report published by the MAIB following the conclusion of the MAIB investigation into the death of Mr Monk. It was put to Mr Evans that Mr Monk had been seen attending to his creels at 12.00 hours and that the alarm had then been raised at 12.30 hours but there were no witnesses to him falling overboard. The outboard motor had been raised. Mr Evans stated that while he could not be certain he had formed the impression during the investigation that Mr Monk was in the habit of keeping the motor lowered until he returned to harbour and raised it to allow any water to drain out. It was possible that Mr Monk had raised the motor to clear weeds or line which had fouled the propeller.

[27] Mr Evans advised that the hauler for raising the lines of creels out of the water was powered by a separate engine, close to the steering wheel of the vessel. He would anticipate that engine being left running all day. There were no lines on the hauler when Mr Monk was found. There was no sign of any line being wrapped round the propeller of the outboard motor.

[28] Mr Evans stated that no PFD was found on board the *May C* and Mr Monk was not wearing one when he was recovered from the water. Mr Evans explained that a PFD is specifically designed to keep the wearer's head out of the water. He stated that a PFD is often a self-inflating life jacket, worn round the neck, with a waist strap and a crotch strap. Mr Monk had been provided with a PFD. It is now mandatory that a PFD be worn, unless a risk assessment has been carried out and demonstrates that the risk can be managed in another way. Mr Evans explained that had Mr Monk been wearing a PFD it would have self-inflated automatically on entering the water and would have ensured that he was turned onto his back and his head was kept out of the water. There was no PFD on board the *May C*, only a circular life buoy rigged as a means of access to the vessel from the water.

[29] Mr Evans advised that PFDs are not difficult to obtain. Funding had been provided by the European Union to provide fishermen with PFDs. He thought the Western Isles Fishermen's Association had distributed some to local fishermen. A PFD has to be produced when a fishing vessel is subject to an MCA inspection. It became a legal requirement to wear a PFD after Mr Monk died.

[30] Mr Evans stated that Mr Monk had not been wearing a PLB. He explained that a PLB does not prevent someone drowning but it assists in locating a person who falls overboard. Use of a PLB was recommended but not mandatory at the time of Mr Monk's death. It is now mandatory that they are used by single crewed fishermen. The majority of PLBs require manual activation although some of the more recent models activate automatically. A PLB is a small device, about the size of a mobile telephone, often yellow in colour. It is stored in the waist band of a PFD. On entering the water the wearer takes out the PLB and presses a button to activate it. The PLB sends a signal giving the GPS location.

That signal can be picked up by the Coastguard. Each PLB is registered to a particular fishing vessel. On receipt of such a message the Coastguard can alert other vessels in the area to provide assistance and can co-ordinate search and rescue assets to be dispatched to that location.

[31] Mr Evans stated that his report did not give any recommendations as recommendations had been made in relation to a similar fatality from the fishing vessel *Sea Mist*. The report in relation to the *Sea Mist* had been published in November 2019, prior to the publication of his own report in this case, and was lodged as Production 5. He could not say for certainty whether recommendations would have been made in his report, had the *Sea Mist* report not existed. He commented that the international Labour Organisation Rule 188, referred to in Production 7 – Maritime and Coastguard Agency – Enforcement of Personal Flotation devices, has allowed the MCA, who regulate fishermen, a more forceful policy of ensuring that PFDs are used by fishermen. Initiatives were underway at the time Mr Evans was writing his report to make the wearing of PFDs mandatory. It will be necessary to evaluate what effect these changes have over time.

[32] Mr Evans confirmed that publication of MAIB reports and recommendations along with efforts by the MCA and Royal National Lifeboats Institution (hereafter referred to as the "RNLI") were all preaching to the fishing community about the benefits of wearing PFDs. Mr Evans confirmed that he was aware of an MCA publication in relation to single handed fishing, lodged as Production 8, and was aware of the fisherman referred to in the document who had survived falling over board, after an hour in the water, and who had been wearing a PFD. He explained that cold water shock is also a major issue in survivability after a fall overboard incident. A PFD can assist by ensuring that the wearer's

head is out of the water to increase the chances of survival. It may not be 100% effective but it is better than not wearing a PFD.

[33] Mr Evans stated that the MAIB issued a safety flyer containing the main findings of his full report. Safety flyers are provided to a standard distribution list of agencies and organisations connected to the fishing industry, such as Fisherman's Missions. The safety flyers and full reports are all published on the MAIB website, which is freely accessible to the public.

[34] Mr Evans accepted that if Mr Monk was clearing weeds or other material from the propeller of the outboard motor he would have had to climb over the guardrail of the vessel to do so, as shown by one of Mr Evans' colleagues in Figure 5 at page 6 of his report. His colleague was wearing a PFD. Clearing the propeller is quite a physical task requiring you to support your weight on your arms and shoulders.

Crown Submissions

[35] Ms Whyte helpfully produced written submissions, which I quote in full hereunder:

> **"Subsection (2)(a) – When and where the death occurred**
>
> To find that Michael Monk, who was born on 29 April 1962 and resided on the Isle of Benbecula, was found dead at 1300 hours on 24 July 2019 with his death occurring at some point between 1200 hours (last sighting by the crew of Sparkling Star) and 1300 hours. His place of death was in the water off Benbecula between Loch Carnan and Petersport.
>
> **Subsection (2)(b) – When and where any accident resulting in the death occurred**
>
> The accident resulting in the death of Michael Monk occurred between 1200 and 1230 hours on 24 July 2019 in an area of water close to Loch Carnan, South Uist.
>
> **Subsection (2)(c) – The cause or causes of the death**
>
> A post mortem examination carried out on 29 July 2019 established the cause of the said Michael Monk's death as drowning.
>
> **Subsection (2)(d) – The cause or causes of any accident resulting in the death**

The cause of the accident resulting in the death was a man over board event. The precise circumstances of the accident are unknown because the deceased was working alone and no one witnessed the accident.

The MAIB investigation found that the exact circumstances of the accident resulting in the late Michael Monk falling overboard was unknown as his fall was unwitnessed. However, when found May C's outboard engine was stopped and in the upright position, the hauler was running, and the boat was in very shallow water but not in the immediate vicinity of Mr Monk's creels, meaning it was unlikely he was lost overboard whilst actively working creels.

The Analysis section of the MAIB report (page 6 of 8) confirms that when underway May C's engine would be lowered and running continuously, it would be very unusual to find the boat with the engine stopped and in the raised position and the most likely explanation was that the skipper had raised the engine to remove weed or some other obstruction. To reach the outboard's propeller the skipper would have had to climb over the raised guardrail and crouch on the narrow transom, the skipper might have lost his balance when trying to climb inboard over the guardrail.

Subsection (2)(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

Had the late Mr Monk been wearing a Personal Flotation Device (PFD) or similar at the time he entered water, this could have kept his head above water and may have increased his chance of survival. Although the requirement to carry a PLB did not come into force until 23 October 2019, the MCA strongly encouraged fisherman to comply as soon as possible. The MCA 'single handed fishing leaflet' reference MCA/276/2A (Production 8) issued in January 2020 states 'Even if you're wearing a PFD, to survive you need to alert rescuers. Wear a GPS 406MHz PLB or fit one in your PFD. Wear it on the top portion of your PFD; the aerial must be clear to transmit and above the water. If you're in difficulty an alert will be sent to the Coastguard who can use the signal to find you'. Carrying a PLB may have allowed the deceased to alert rescuers to his location resulting in a swifter rescue.

The MAIB report at page 3 confirmed that the deceased was an experienced fisherman who had owned and operated May C for 12 years, he had completed all the mandatory training required to operate a small fishing vessel. At page 4 it is confirmed that May C had been inspected on 22 March 2017.

The Inquiry heard evidence from the MAIB inspector that Maritime and Coastguard Agency (hereinafter 'MCA') regulations and an accompanying Marine Guidance Notes MGN 588(F) came into force in December 2018, making the wearing of PFDs or safety harnesses compulsory unless sufficient measures are in place to eliminate the risk of fishermen falling overboard.

The wearing of a PFD and the carrying of a PLB are reasonable precautions which could have been taken and these might have prevented Mr Monk's death.

Subsection (2)(f) –Any defects in any system of working which contributed to the death or any accident resulting in the death

No obvious systemic failings or defects have been identified in this case.

The Deceased drowned because he went overboard, was not wearing a PFD or similar and was unable to swim.

Subsection (2)(g) – Any other facts which are relevant to the circumstances of the death

It appears that a substantial quantity of material is published by the MCA and also the MAIB and others for the benefit of fishermen and specifically relate to their safety. The MCA publications are detailed and they cross reference multiple pieces of legislation and other publications. These publications have been distributed to fishermen via various platforms including different fishermen federations and organisations.

Fishing vessels such as 'May C', are surveyed once every five years and safety awareness is highlighted to fishermen during the survey. The last inspection by the MCA surveyor had taken place on 22 March 2017, a deficiency was identified which is detailed in page 4 of the MAIB report. Once rectified the MCA issued a UK Fishing Vessel Certificate valid until 16 April 2022. Ongoing validation of the UK Fishing vessel certificate was to be sustained through annual self-certificate assessments; we heard there was no record of the self-certification assessments for 2018 or 2019 and No PFD or PLB was found on board May C.

Looking back over 6 Fatal Accident Inquiries which were conducted between 1 April 2017 and 31 March 2020, it is worthy of note that a recommendation regarding the wearing of PFDs was made in 5 of them.

There is also evidence before the Court regarding the reconnaissance flights and enforcement action that the MCA is taking to educate, promote and enforce the wearing of PFDs.

Subsection (1)(b) – Such recommendations (if any) as to any matters mentioned in subsection (4) as the sheriff considers appropriate

Since Mr Monk's death, further information has been disseminated and enforcement action is being taken by the MCA, it is too soon to tell whether these additional materials and action will reduce the high numbers of fishermen losing their life in the course of their employment when a contributory factor is not wearing a PFD.

It is hoped that the MCA enforcement action now being carried out, will, over time, encourage and promote the wearing of PFDs."

Discussion and Conclusions

[36] I had no difficulty in accepting the information contained in the Notice to Admit Information or in accepting the evidence of Mr Evans. He gave his evidence in a clear and

helpful manner. His evidence was of considerable assistance to me. The MAIB report, Production 4, is a clear and detailed account of the investigation into this incident. The report has been extremely useful in the course of this inquiry. It is publicly available on the MAIB website for anyone interested in this incident to refer to.

[37] There is clearly no dispute that Mr Monk sadly drowned after falling overboard from the *May C*, for an unknown reason, sometime between 12.00 hours and 12.30 hours on 24 July 2019 in the water off Benbecula between Loch Carnan and Peters Port. This is established by the information provided to the MAIB inspectors by the crew of the *Sparking Star* and the conclusions of the autopsy carried out by Dr Ashton. I accept the Crown's submissions in relation to Section 26(2)(a), (b) and (c).

[38] It is equally clear that Mr Monk fell overboard from the *May C*. In her submissions for the Crown in relation to Section 26(2)(d) Ms Whyte properly draws attention to the fact that the outboard motor of the *May C* was raised when the vessel was found and the inferences which have been drawn from that in the MAIB report. There is certainly a logic to all that is suggested in the MAIB report and I do not discount that explanation as a possibility. However, I am not satisfied that available evidence is sufficient for me to make a determination on that point. The explanation provided in the MAIB report is, in my view, too speculative to form a basis for a formal finding.

[39] So far as Section 26(2)(e) is concerned I concur with the submissions of Ms Whyte that the wearing of a PFD is a reasonable precaution which might have avoided the death of Mr Monk, for the reasons put forward by her. It is clear that the use of a PLB in and of itself does not reduce the death itself, but increases the chance of rescue in a shorter period of time thereby increasing the chance of surviving a man overboard incident. I consider the use of a

PLB to be a very sensible and necessary step for fishermen. However, in the particular circumstances of Mr Monk's death, he was found within thirty minutes of last being seen alive. I did not hear any evidence as to the response time likely after any PLB activation. It is possible that had he activated such a device on entering the water the *Sparling Star* would have arrived quicker, with a different outcome, but I am not satisfied that I can say that his death might realistically have been avoided. I do consider PLBs to be of vital importance however, and accordingly refer to PLBs under Section 26(2)(g). Given that the cause of Mr Monk falling overboard cannot be determined with certainty, I cannot make any findings as to reasonable precautions which may have prevented that accident from occurring.

[40] I am satisfied that Mr Monk's failure to wear a PFD while engaged in fishing was part of his system of work for fishing and that accordingly there was a defect in that system of work. The point is essentially the same as that made under Section 26(2)(e).

[41] The matters raised by Ms Whyte in relation to Section 26(2)(g) are certainly relevant to the purposes of this inquiry in learning lessons for the future but I am not satisfied that they are sufficiently relevant to the circumstances of Mr Monk's death as to require to be included under this heading.

[42] I do not consider it necessary to make any further recommendations in this inquiry. The main point to be made, as has been made in several Determinations in the past, is the importance of wearing PFDs.

[43] I am obliged to Ms Whyte for her careful presentation of the evidence in this inquiry and to Mr Evans for the assistance which his involvement gave to the inquiry.

[44] In closing this Determination, may I once again express my condolences to the family and friends of Mr Monk. His loss is a tragedy which is no doubt still keenly felt.