SHERIFFDOM OF TAYSIDE CENTRAL AND FIFE AT DUNFERMLINE

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DETERMINATION

BY

SHERIFF ALASTAIR N BROWN, ADVOCATE

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

into the death of

ALEXANDER JOHN ROBERT WOOD

DUNFERMLINE, 30 July 2021

This is an Inquiry under the Inquiries into Fatal Accidents and Sudden Deaths etc (Scotland) Act 2016 into the circumstances of the death of Alexander John Robert Wood. Ms Swansey, Procurator Fiscal Depute, appeared for the public interest. Mr Craig, Solicitor, appeared for Forth Ports Limited (who own and operate Burntisland Harbour, where Mr Wood died). Mr Wood's family chose not to participate actively in the Inquiry but members of the family did observe. The Inquiry heard evidence on 7 May 2021. A joint minute was lodged, dealing with uncontroversial evidence. In terms of s26 of the Inquiries into Fatal Accidents and Sudden Deaths etc (Scotland) Act 2016, I make the following findings as to the circumstances of Mr Wood's death:

1) Alexander John Robert Wood was born on 23 March 1953.

2) He lived in Burntisland.

3) Mr Wood suffered severe coronary artery disease (coronary artery atherosclerosis) and minimal ischemic heart disease. As a result, he had an increased risk of dysrhythmic events.
4) He was a self-employed creel fisherman, working out of Burntisland.
5) He operated a boat called "Lea Rig".
6) That boat was about 24 feet long. It had a wheelhouse slightly offset to the port side of the boat, leaving access round the wheelhouse to starboard. The wheelhouse extended from a point about one third of the length of the boat from the bow to a point about one half of the length of the boat from the bow. Approximately the front third of the boat was decked flush with the gunwale. Aft of the wheelhouse, the boat was open. There was an engine box in the well of the boat, immediately aft of the wheelhouse.
7) Forth Ports Ltd owns and operates seven ports in Scotland, including Burntisland Harbour.
8) Burntisland Harbour is split into three areas: the west dock, the east dock and the outer harbour. The west dock is leased to two engineering companies and is wholly fenced off to the public.
9) Mr Wood operated his boat from the outer harbor.
10) There was a davit on top of the quay at the outer harbour. It had been in place for many years.
11) Its visible part was a lifting arm consisting of a simple fabrication of two lengths of pipe joined in an "L" shape by a 90 degree 'elbow' fitting.

That lifting arm rotated around a mild steel tube that projected vertically from a baseplate that attached the assembly to the dock. It had no other support. Gin wheels forming a pulley mechanism were welded to the end of the piping which swung out over the water and over any boat moored at the davit. A rope could be fed through the gin wheels and used to raise or lower loads.

12) The base plate was fixed permanently to the masonry of the outer harbour by means of threaded fixings. It was very secure and was difficult to remove. During the investigation, the nuts holding it down had to be chiseled off.

13) The steel tube which projected from the base plate was heavily corroded, leaving only a very thin and non-continuous ring of solid metal, which could have failed at almost any time.

14) The corrosion was hidden below the visible outer piping but any reasonable inspection by a competent person would have separated the parts of the davit and looked closely at the weight bearing part.

15) Such an inspection would have discovered the corrosion and the risk of failure if the davit was used for lifting or lowering articles.

16) No proper inspection of the davit had taken place for several years at least.

17) On 24 August 2018, while Mr Wood was using the davit to load bait onto his boat, it failed. The vertically projecting tube broke in two. The box of bait and the lifting arm fell onto Mr Wood's boat. Their resulting position was in

the well of the boat at the starboard side, beside and just aft of the wheelhouse.

18) At about the same time, Mr Wood fell into the water.

19) In the course of the accident, Mr Wood sustained a fracture to his right arm, consistent with him having been struck by a falling heavy object.

20) The cause of Mr Wood's death was immersion in water in a man with ischaemic heart disease.

21) Accordingly:

a. Mr Wood died shortly before 10.38am on 24 August 2018 at Burntisland Outer Harbour.

b. Mr Wood's death resulted from his immersion in water.

c. The cause of Mr Wood's death was immersion in water in a man with ischaemic heart disease.

d. The causes of the accident resulting in his death are unascertained.

e. No precautions can be identified which could reasonably have been taken and, had they been taken, might realistically have resulted in Mr Wood's death, and the accident which resulted in Mr Wood's death, being avoided.

f. No defects in the system of working can be identified as having contributed to the accident resulting in Mr Wood's death.

Note

[1] I heard the following evidence:

[2] Stewart Taylor is a Director of Calypso Marine Limited. The company owns premises in Burntisland and leases a berth in the East Dock from Forth Ports Ltd. The company business is the provision of safety boats.

[3] Mr Taylor had known Mr Wood for many years. Mr Wood was a creel fisherman, fishing commercially from Burntisland for lobsters and crabs. Berthing in the East Dock incurs a charge but Burntisland residents are allowed to moor boats at the Outer Harbour free of charge. In the past, there were a lot of boats moored there but latterly only Mr Wood moored at the Outer Harbour. Mr Wood's boat was a typical creel fisherman's boat, about 24 feet long with a round stern, an engine box and a small cabin towards the bow. Mr Taylor identified the boat in a photograph which was a production.

[4] About two thirds of the way down the harbor wall there was a davit which Mr Taylor saw Mr Wood using once or twice to load bait onto his boat. The davit had been there for as long as Mr Taylor could remember. It had a small arm which swung out in use. He himself had never used it and he was not sure of its condition. A person using it would have to be on top of the quay to do so. There was no other equipment for loading bait. There was a crane which was about 100 years old but Mr Taylor has never seen it used. He did not know who installed the davit.

[5] On Friday 24 August 2018 Mr Taylor was working out of Burntisland. He was on site about 6.30am. He thought that the weather was reasonable and that the sea was

fairly flat. It was low water and there was a big tide. From the surface of the water to the top of the quay was over 7 metres. There were ladders and a person in the water would have been able to climb out using a ladder.

[6] Sometime between 10.00am and 10.30am, Mr Taylor noticed a white van near Mr Wood's boat. He thought someone was dumping rubbish so, with his colleague Craig McDonald, he walked down towards the dock. A man at the van, whom he did not know, shouted "Sandy's in the water". No one else was around. Mr Taylor saw a person in the water between the stern of Mr Wood's boat and the quay. He was not sure if the person was face up or face down.

[7] Mr Taylor and his colleague went back to the East Dock for their RIB. It took less than two minutes to get from the Outer Harbour to the RIB. They called the Coastguard. Once they were on their boat, it took between one and one and a half minutes to get to Mr Wood's boat. They recognized the person in the water as Mr Wood. The man from the van was on Mr Wood's boat, holding him. Mr Taylor and Mr McDonald got Mr Wood out of the water and got alongside in the East Dock as quickly as they could. They moved Mr Wood onto the sponsons. Someone attempted CPR. Paramedics came and "put wires on" (I took this to mean that they used a defibrillator.) Mr Wood was not wearing a life jacket. Mr Taylor could not remember Mr Wood ever wearing a life jacket.

[8] Mr Taylor has experience in recovering casualties and bodies from the water. He formed the opinion that Mr Wood had been in the water for some time.

[9] Mr Taylor had a look at Mr Wood's boat. He saw at least two fish boxes with bait, one of which had spilled, and the remains of the davit hauler inside the boat.

[10] Detective Constable Brendan Moyles was called to Burntisland in the early afternoon of Friday 24 August 2018 to serve as the scene manager. He put up cordons. He saw a boat beside the dock with a winching area above it. There was an L-shaped metal item lying in the boat. The winching arm was rusted and old. He took possession of the arm, which weighed 18 kg. He removed fish and crates from the boat. They weighed 46 kg. He could not recall if the arm was attached to a fish box. It was put to him that, in his statement, he said that one of the boxes was tied to a rope, which was connected to the L-shaped piece of metal. He said that his statement was correct.

[11] Sheldon Taylor. Mr Taylor is an HSE Specialist Inspector (Mechanical Engineering). After serving an apprenticeship in a machine shop, he obtained a B Eng (Hons) in mechanical engineering. He provides specialist support to HSE inspectors. He was contacted soon after Mr Wood's accident and asked to examine the machinery and site. He prepared a report, which was a production. His conclusion was that the davit failed due to the severe corrosion of the pipe that was welded to its baseplate.

[12] Mr Taylor found that the davit was fixed permanently to masonry by means of threaded fixings. The base plate was very secure and was difficult to remove. The nuts holding it down had to be chiseled off. A steel tube, 60 cm in diameter, was welded to the base plate, from which it projected vertically. It was corroded. The davit was a simple rotating arm with a diameter of 83 cm with attachment points for lifting

equipment. The rotating section appeared to be made up of two lengths of pipe joined by a 90 degree 'elbow' fitting. When fitted to the base this would form an inverted L shape. The rotating arm had a height of 1560mm. Plates were attached to the rotating section and these carried shackles that held two gin wheels. A length of 60mm diameter pipe protruded from the base of the rotating section as recovered. When offered to the pipe which projected from the base plate it appeared that the two sections had originally been parts of the same length of pipe. (I understood Mr Taylor to mean that the rotating arm, which had a greater diameter than the pipe which was welded to the base plate, sat over that pipe and rotated on it and that the pipe which was welded to and protruded from the base plate snapped, leaving its upper part within the rotating arm).

[13] Mr Taylor pointed out that lifting equipment must be thoroughly examined either at fixed intervals of 6 or 12 months (depending on use) or in line with an examination scheme devised by a competent person. The 60mm diameter pipe which failed was so heavily corroded that it would have been clear (to a competent person) for an extended period, before the incident, that it was not serviceable and should be removed from service. Mr Taylor expressed the opinion that, given the very serious corrosion of the 60mm pipe, the baseplate had not been the subject of an adequate thorough examination for a period in excess of 12 months.

[14] Gary Miller Mr Miller is an HSE Inspector with 35 years' experience. He was called to the site and arrived after everyone else had left. He saw, and took photographs of, the base plate. He sought permission from employees of Forth Ports Ltd to remove

the base plate but they told him that Forth Ports Ltd were not the owners of the davit. They did, however, accept that they had overall control of the harbour.

[15] Stuart James Wallace Mr Wallace is Chief Operating Officer of Forth Ports Ltd, which owns and operates Burntisland Harbour. Forth Ports recognised an ancient right enjoyed by Burntisland residents to moor boats at the harbour. Almost all of the West Dock is tenanted. Forth Ports' operations take place in the East Dock. They had not used the Outer Harbour for some time. This meant that different levels of controls applied. They took a much more documented and procedural approach in relation to those areas for which they had responsibility. They regarded the use by residents of the Outer Harbour as the residents' own responsibility.

[16] Following Mr Wood's death, Forth Ports commenced a review across their whole estate to determine whether there were any other items of third party equipment and identify the owners. Where owners were identified, they were required either to remove the equipment or maintain it. If no owner was identified, equipment was removed. At Burntisland, they removed 4 ladders.

[17] In an affidavit, Mr Wallace explained that if local users of the jetty installed an item of equipment "then they would maintain that equipment" and that, because Forth Ports Ltd had no operational or commercial activity on the jetty, and because any ladders there were provided by those using the jetty, Forth Ports did not need to provide ladders or carry out any maintenance on them. They did not provide any moorings or other items, including the davit that failed at the time of the accident, and therefore did not maintain or check those items.

[18] Leanne Taylor Ms Taylor is now Deputy Harbour Master at Burntisland but has worked for Forth Ports for about 9 years. In an affidavit, she said that in January 2018 she met Mr Wood to discuss payment for berthing his boat. He asserted "Grandfather's Rights" not to pay a fee. On 24 August 2018 she was working at Leith Docks when she received a telephone call from Stewart Taylor to say that he had just pulled Mr Wood out of the water and that "it didn't look good".

[19] James Stewart Watson Mr Watson is employed by Forth Ports as Engineering Manager. In an affidavit he explained that he oversees a team which is responsible for utilities, life belts and safety equipment belonging to the company. Burntisland Outer Harbour is his responsibility as far as navigation lights, and 4 ladders are concerned. He was told about Mr Wood's death and he checked the area. The ladders which were installed were below company standards but it would be possible to use them to climb out of the water. In another affidavit, he said that the old ladders have now been replaced with ladders which are on the Forth Ports maintenance schedule.

Analysis

[20] It is beyond doubt that Mr Wood met his death in an accident and that it involved the failure of the davit; but it is not possible to determine at this stage what the mechanism of that accident was or what part the davit played. Various hypotheses can be advanced but the evidence does not point to any one of them being more likely than another. It is clear that the davit had not been inspected for several years (if ever). It appears that the reason for that is that Forth Ports recognised an historic right in

residents of Burntisland to use the Outer Harbour without paying any charges and that they took the view that equipment installed on the outer harbour was the responsibility of those who used it.

[21] In my opinion, there is a strong argument that the davit had become the property of Forth Ports Ltd by accession. A range of criteria are considered in determining such a question. In this case, the fixture might well be described as permanent, in view of the difficulty experienced in removing the base plate. However, the fact that the mechanism of the accident cannot be ascertained - in particular, that I cannot say that the failure of the davit was causally connected with Mr Wood's death - means that I do not have to decide the question.

[22] In addition, it is arguable that Forth Ports Ltd had certain duties arising from their control of the outer harbour; but for the same reason, I do not have to decide that.

[23] I make no recommendations. I have drawn the inference that the failure of the davit which was installed on the quay at Burntisland Outer Harbour occurred at or about the same time as Mr Wood entered the water but it is not possible to reach any conclusion about whether or what part it played in the events which led to Mr Wood's death. Forth Ports have acted responsibly. They have carried out a review across their whole Scottish estate to determine whether there were any other pieces of equipment installed by third parties and to either remove any such equipment or ensure that it is maintained properly. The conducting of such a review is the only recommendation which might conceivably have been appropriate. Since it has already been conducted, to make such a recommendation would be redundant.