SHERIFFDOM OF LOTHIAN AND BORDERS AT EDINBURGH

[2023] FAI 5

EDI-B1221-22

DETERMINATION

BY

SHERIFF DONALD CORKE

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

into the death of

PETER GRAY

EDINBURGH, 23 January 2023

DETERMINATION

The Sheriff having considered the information presented at the inquiry, determines in terms of section 26 of the Act that:-

In terms of section 26(2)(a) - (when and where death occurred):

Peter Gray was pronounced deceased at 18:35 hrs on 2 May 2021 at the Accident and Emergency Department of the Royal Infirmary of Edinburgh.

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

The death of Peter Gray occurred due to an accident on board the vessel *Saint Peter* while it was approximately 1.2 nautical miles north-east of Torness Point on 2 May 2021 between 08:30 hrs and 10:32 hrs.

In terms of section 26(2)(c) - (cause or causes of death):

Complications of ischaemic and hypertensive heart disease and immersion in water.

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

Mr Gray was on the deck of *Saint Peter* attending to a tangle of creels. The creels were released into the sea. Mr Gray became caught in a bight of rope as the creels released into the sea. It tightened around his right ankle and caused him to be dragged overboard through the shooting gate.

Section 26(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):

The use of deck dividers to keep workers clear of the running back rope.

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

There were no defects in any system of working which contributed to the death or the accident resulting in death.

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

1. The vessel lacked a boarding ladder or overside tyre arrangement.
2. Mr Gray was not carrying a personal locator beacon on his person.

RECOMMENDATIONS

1. In terms of section 26(1)(b) of the 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 present other deaths in similar circumstances):

1. In terms of section 26(4)(a), deck dividers should be used in fishing vessels to keep crew clear of a running back rope.
2. In terms of section 26(4)(d):
    a) Those who operate fishing vessels should install ladders, overside tyres or other safety measures to ensure there is a means to re-enter the vessel once a person has gone overboard.

b) Those who operate fishing vessels and in particular single-handed vessels should carry personal locator beacons on their person when on board their vessel.

NOTE

Introduction

[1] This inquiry was held under the Act into the death of Peter Gray. He sadly passed away in the sea as a result of an accident on board the vessel *Saint Peter* while it was approximately 1.2 nautical miles north-east of Torness Point on 2 May 2021 between 08:30 hours and 10:32 hours. He went to attend to tangled creels. As they became free and were released through the shooting gate, he became caught on a bight of back rope that tightened around his ankle. He was unable to resist the pull from the weight of creels as they fell into the sea and he was dragged overboard through the shooting gate. After he was eventually found in the water he was taken by helicopter to the Royal Infirmary of Edinburgh, where he was pronounced deceased at 18:35 hours on 2 May 2021.

[2] The death was reported to the procurator fiscal on 4 May 2021.

[3] A preliminary hearing was fixed on 18 November 2022 and a further preliminary hearing on 8 December 2022. The inquiry was held by WebEx on 9 January 2023 at which Mr Kerr, procurator fiscal depute, appeared for the Crown. There were no other appearances. The evidence was not in dispute and there was no need to hear any oral evidence. On 9 January 2023, the hearing was continued until 23 January 2023 in case

any further clarification was required, there being no contradictor. That did not prove necessary and this determination has been published accordingly.

[4] The Crown had prepared a substantial Notice to Admit which contained evidence that the court was satisfied was uncontroversial. That has been styled as proposed findings in fact at the court's suggestion. Most of the facts in the proposed findings were accepted but some have been recast and others omitted as appropriate. Also before the enquiry was the following information, as contained in the first inventory of Crown productions:

1. Final Post Mortem Report dated 17 September 2021 by Dr Ralph BouHaidar;
2. Toxicology Report;
3. Accident Report No 6/2022- Marine Accident Investigation Branch (MAIB)1;
4. Safety Flyer - MAIB;
5. Search and Rescue Report - Maritime and Coastguard Agency (MCA);
6. Search and Rescue Mission Report - MCA;
7. Search and Rescue Helicopter Patient Clinical Record - MCA;
8. Incident Report - MCA;
9. Book of photographs;
10. Statement of Neil Barnard;
11. Statement of Declan McSporran;
12. Statement of Gordon McKay;

13. Statement of Gary Fairbairn;

14. Statement of Mark Lawson.

[5] No issue arose as to the credibility or reliability of any of those who gave statements or reports. The findings in fact owe much to the careful MAIB report.

The legal framework

[6] This inquiry was held under section 1 of the Act. Mr Gray died in the course of his employment or occupation and the enquiry was therefore mandatory in terms of section 2(3) of the Act. The inquiry was governed by the Act of Sederunt (Fatal Accident Inquiry Rules) 2017 and was an inquisitorial process. The Crown represented the public interest.

[7] The purpose of the inquiry was, in terms of section 1(3) of the Act, to establish the circumstances of the death of Mr Gray 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 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 course is entitled to reach conclusions based on that information (see Rule 4.1).

[8] Section 26 of the act sets out what must be determined by the inquiry, 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."

SUMMARY

Facts

[9] The Sheriff found the following facts admitted or proved:

1. Peter Gray was born on 22 August 1956 and resided in Cockburnspath, Scotland. He died on 2 May 2021 aged 64.

2. Mr Gray's death was reported to the Crown Office and Procurator Fiscal Service on 4 May 2021 by the Police Service of Scotland.

3. Mr Gray was a self-employed fisherman and skipper of the fishing vessel *Saint Peter* registration number LH22.

4. He had worked as a fisherman for 40 years. He had served in the merchant navy for about 5 years in his early career, before returning to settle in Cove where he also served as a volunteer coastguard. He held a Seafish Under 16.5 meter Skipper's Certificate (Unrestricted), a Global Maritime Distress and Safety System Short Range Radio Operator Certificate and had completed all mandatory training courses to operate a UK registered fishing vessel. He had attended a Seafish Safety Awareness course two months before the accident on 2 May 2021.

5. *Saint Peter* was a 7.8m glass reinforced plastic fishing vessel built by Mr Gray in 1993. It had an enclosed wheelhouse; an open aft deck fitted with a hydraulic hauler, hauling table, and catch stowage area; and a shooting gate in the transom, which had a drop- in closing board. The wheelhouse was fitted with a global position system receiver, chart plotter and very high frequency

(VHF) radio with digital selective calling (DSC) capability. The vessel was powered by a 38 kilowatt diesel engine, fitted to an engine bay below the main deck and had helm and engine throttle controls in the wheelhouse and on the deck next to the hauling table. The wheelhouse throttle control was not operational, and the vessel could only be driven by the controls next to the hauling table.

6. At the time of the accident on 2 May 2021 Peter Gray was operating the fishing vessel *Saint Peter* alone between high tides and catching a mixture of crab and lobster using creels.

7. Each string of creels consisted of 20 creels, spaced 22 metres apart and connected by short leader lines to a 14 millimetre back rope. Cast iron anchor weights, known as end stones, and float lines with buoys and marker flags were connected to each end of the 535 metre backrope.

8. Before shooting, the creels were stacked on the port side of the main deck with the back rope laid out next to them.

9. Peter Gray's routine for shooting a string of creels was to throw the lead marker buoy and end stone overboard with the vessel driving ahead so that the stack of creels would automatically be pulled overboard through the transom gate.

10. A string was recovered by bringing the marker buoy on board and heaving in first on the float line and then on the back rope using the hydraulic hauler. The creels were pulled onto the hauling table, where the catch was

removed and stowed in plastic crates that were stacked in the catch stowage area. Each creel was then rebaited and stacked on the port side ready for the next shoot.

11. In 2017 the Maritime and Coastguard Agency carried out a 5 yearly inspection of *Saint Peter* in accordance with Merchant Shipping Notice (MSN) 1871 Amendment 1 (F): The Code of Practice for the Safety of Small Fishing Vessels of less than 15m Length Overall.

12. The MCA inspection report noted that the risk assessment for fishing vessels had been discussed and made reference to the vessel's Seafish Safety Folder. It recorded that the skipper had been advised that, from 1 October 2019, *Saint Peter* would either need to be fitted with an Emergency Position Indicating Radio Beacon (EPIRB) or that the skipper should carry a personal locator beacon (PLB).

13. MSN 1871 recommended that single-handed skippers should carry both an EPIRB and a PLB.

14. As a result of the MCA inspection in 2017, an EPIRB was fitted to a float free bracket on *Saint Peter*'s wheelhouse-mounted mast. The skipper registered the EPIRB with the MCA in January 2021.

15. An EPIRB transmits a 406 megahertz (MHz) distress signal via satellite to the coastguard when it is activated either manually before being thrown overboard, or automatically as it enters seawater. An EPIRB fitted to an

automatic release mounting bracket should float free and activate in the event of a vessel sinking.

16. A PLB is a smaller version of an EPIRB that can be carried by a seafarer. PLBs have to be manually activated to send a 406 MHz distress signal.

17. Also available are automatic identification system (AIS) 8 Man Overboard (MOB) transponders that can either be manually activated, or automatically activated. AIS MOB transponder distress signals can be received by vessels in the vicinity that are fitted with AIS receiving equipment, and then used to home in on the MOB's position.

18. Although 406MHz PLBs with an integrated AIS are available, the activation of a distress signal over 406MHz has to be done manually. MSN 1871 required EPIRBs and PLBs to have integrated GPS so that their emergency transmission included an accurate location of the casualty, both of which were to be registered with the MCA.

19. Peter Gray's emergency procedures for man overboard location and recovery, as recorded in his Seafish Safety Folder, stated: "…use life jacket while working at sea and have handy rescue quoits + life buoys. And boarding ladder handy Guardian MOB to locate position casualty."

20. At the time of the accident, *Saint Peter* was equipped with lifebuoys but not with a boarding ladder. MOB Guardian was an emergency locator beacon system supplied by the RNLI. There was no record of a beacon being registered to *Saint Peter* and the RNLI withdrew the system from service in 2016.

21. The Seafish Safety Folder contained a risk assessment for shooting and hauling operations, which stated the control measure for unsafe decks was: "…keep decks clear and avoid bights in ropes."

22. The control measure for the risk of a crew member becoming tangled in the back rope when shooting pots was recorded as: "…ropes kept clear of footing/avoid walking on."

23. There was also a general shooting control measure to have knives to hand and shooting door fitted. Following the accident, knives were discovered in the wheelhouse and next to the hauler.

24. At around 06:00 hours on 2 May 2021 Peter Gray left his home in Cockburnspath, Scotland, and drove to his vessel at the nearby harbour.

25. The weather was overcast, there was a light northerly wind, a 0.7 knots north-westerly tidal flow and the sea temperature was cold, at 8 degrees Celsius.

26. Sudden immersion in water temperatures of less than 15 degrees Celsius can result in cold water shock and/or cold incapacitation within 30 seconds to two minutes, or 2 to 15 minutes, respectively. The survival time in calm water temperatures below 10 degrees Celsius is about one hour while wearing work clothes.

27. Peter Gray manoeuvred *Saint Peter* out of the harbour and made his way to his fishing grounds north of Cove. He turned on the chart plotter at 06:12 hours, whilst en route. He started recovering his strings of creels at around 06:35 hours. At about 08:00 hours crew working on a nearby fishing vessel

observed Peter Gray working on *Saint Peter*'s aft deck at an estimated position 2 nautical miles north of Torness Point. At 08:20 hours, *Saint Peter*'s chart plotter recorded the vessel travelling at 5.7 knots, 1.2 nautical miles north-east of Torness Point, then slowing to 0.8 knots, before briefly increasing speed to 3.7 knots. At 08:30 hours the vessel stopped.

28. From 10:32 hours onwards, some of the Mr Gray's friends and family made calls and sent texts to his mobile phone which went unanswered.

29. At some time between 08:30 hours and 10:32 hours on 2 May 2021 creels that Mr Gray were shooting became tangled.

30. Mr Gray went to attend to the tangled creels and as they became free and were released through the shooting gate, he became caught on a bight of back rope that tightened around his ankle. He was unable to resist the pull from the weight of creels as they fell into the sea and he was dragged overboard through the shooting gate.

31. His Personal Floatation Device (PFD) inflated when he entered the water and his boot released from the bight of rope, enabling him to surface. *Saint Peter* stopped as the slack in the back rope was taken up and the end marker buoy became snagged on board. The vessel was then anchored by the float line attached to the string of creels on the seabed.

32. Between 14:00 hours and 15:00 hours on 2 May 2021 Peter Gray's nephew Declan McSporran was driving back from Edinburgh when he noticed his uncle's boat out on the water.

33. At about 14.30 hours on 2 May 2021 Neil Barnard saw Peter Gray's boat about 1.5 miles east of Torness at sea.

34. Declan McSporran knew that Peter Gray regularly went out on a Sunday to bring his lobster pots in, always on his own, but he would normally be home and finished for 12:00 hours.

35. Since it was close to 15:00 hours and later than normal, Declan McSporran was concerned. He contacted Mr Gray's wife. She was concerned that he was overdue, having gone out at 06:00 hours to bring his lobster creels in.

36. At around 15:15 hours Declan McSporran sought the assistance of his employer, Neil Barnard, the skipper of Rachel May, a fishing vessel from Cove. As Neil Barnard headed to Cove he could see Peter Gray's boat in the same position as it was when he had seen it earlier.

37. They failed to raise Mr Gray on the marine radio and so went out on the Rachel May to towards the *Saint Peter*. Peter Gray's creels were hanging out the back of the boat and the rope holding the creels was caught on the corner of the boat. There was no-one on the boat nor anyone visible in the water.

38. Mr Barnard boarded the *Saint Peter* and hauled in the creels on the caught rope. No-one was on the rope. About five creels in the middle of the string were tangled together.

39. He put the *Saint Peter*'s anchor out put in a mayday call reporting that Mr Gray was missing.

40. Messrs Barnard and McSporran followed the tide, which was flowing west, but could not see Mr Gray in the water. They stood by the *Saint Peter* at the request of the Coastguard.

41. At 16:32 hours on 2 May 2021 the Coastguard tasked Royal National Lifeboat Institution (RNLI) lifeboats and a Coastguard helicopter to the incident. The Dunbar all-weather lifeboat (ALB) and inshore lifeboat were launched and began to search north of *Saint Peter*'s anchored position. Other fishing vessels that were in the vicinity joined the search.

42. At 17:51 hours on 2 May 2021, the crew of the Coastguard helicopter spotted Peter Gray, floating on his back and wearing a fully inflated PFD, about 3 nautical miles north of Torness power station.

43. The winchman recovered Peter Gray to the helicopter and the PFD was removed so that emergency first aid could be carried out during the flight to the Royal Infirmary of Edinburgh. Mr Gray was unresponsive.

44. At the same time, the ALB crew returned to *Saint Peter*, cut away the anchor line and towed the vessel to Dunbar Harbour.

45. Mr Gray was pronounced deceased at 18:35 hours on 2 May 2021 at the Accident and Emergency Department of the Royal Infirmary of Edinburgh.

46. On 7 May 2021 Dr Ralph BouHaidar, Consultant Forensic Pathologist, conducted a post mortem examination of Peter Gray at Edinburgh City Mortuary and prepared a Final Post Mortem Report (Crown Production 1).

47. Mr Gray had suffered blunt force injury most noticeable on the left side of the face with no associated underlying injury to a major structure or organ. There was also an abrasion around the right ankle.

48. Mr Gray had pre-existing heart disease associated with an increased risk of potentially fatal dysrhythmic complications.

49. The risk of cardiac complications is further increased in immersion in water.

50. The medical cause of death is as recorded in that report:

1a. Complications of ischaemic and hypertensive heart disease and immersion in water.

51. The statements and reports were made by the persons, in the terms and on the dates upon which they bear to have been made. All are the equivalent of the credible and reliable evidence of their respective authors.

Submissions

[10] Written submissions and proposed findings in fact were very helpfully provided by the Crown. There were no other parties.

[11] The proposed findings in fact form the basis of the findings in this determination.

[12] The written submissions have been taken into account in this determination, with particular aspects dealt with here.

[13] The Crown sought support for the cause or causes of the accident resulting in death (s.26(2)(d)) as recorded above, in (1) the analysis in the MAIB report (Crown

production 3); (2) the evidence of Declan McSporran and Neil Barnard as to the state of the string of creels, as narrated in the findings of fact; and (3) the external findings of injuries to Mr Gray's body, again as narrated in the report and findings in fact.

[14] In terms of section 26(2)(e) (precautions), the suggestion on behalf of the Crown was for the use of deck dividers to keep workers clear of the running back rope, as per the MAIB report. The Crown suggested that the use of deck dividers to keep workers clear of a running back rope is a precaution which could reasonably have been taken and there is a real or likely possibility that, had it been taken, it might realistically have resulted in the accident causing the death being avoided because use of deck dividers would have kept persons aboard the vessel clear of the running back rope whilst enabling persons to work on the deck of the vessel without the risk of standing on the back rope.

[15] No findings were sought by the Crown in terms of section 26(2)(f) (defects in system of working).

[16] In respect of section 26(2)(g) (other relevant facts) the Crown made submissions as to:

(1) the lack of a boarding ladder or overside tyre arrangement to the vessel; and (2) the carrying of a personal locator beacon on Mr Gray's person. These are discussed below in the context of recommendations.

Discussion and conclusions

[17] Sections 26(1)(a) to (c) are formal in nature and the findings follow the evidence and submissions.

[18] As far as section 26(2)(d) (cause or causes of accident) is concerned, the evidence including that relied upon by the Crown in submissions supports the assessment of the MAIB which is set out in the report at page 10:

> "There were no eyewitnesses to this accident, but it is highly probable that *Saint Peter*'s skipper became caught in his fishing gear during shooting while trying to untangle a string of creels and was pulled overboard into the water. He was unable to reboard his vessel and, at an indeterminate time after the accident, suffered a fatal heart attack."

[19] The suggestion of the Crown in terms of section 26(2)(e) (precautions) for the use of deck dividers to keep workers clear of the running back rope, is supported in the MAIB report at page 11 in the following terms:

> "*Saint Peter*'s working deck was cluttered with creels and rope when shooting, making it difficult for the skipper to stay safely separated from the moving fishing gear, especially if the gear became tangled and required manual intervention. An alternative deck layout and fishing gear configuration, possibly with a reduced number of creels, and deck dividers or pound boards could have kept the skipper clear of the running back rope. This would have enabled him to throw the marker buoy and end stone overboard and, if necessary, deal with tangled creels without the risk of standing on the back rope."

[20] The court accepts that suggestion as clearly well founded in terms of the evidence and submissions.

[21] No findings were sought by the Crown in terms of section 26(2)(f) (defects in system of working) and none is made.

[22] In terms of section 26(2)(g) (other relevant facts), there are two aspects.

[23] Firstly, at the time of the accident, *Saint Peter* was equipped with lifebuoys but not with a boarding ladder. As discussed at page 10 of the MAIB report:

> "Once the skipper was in the water, his only option to self-rescue was to swim back to *Saint Peter* against the wind and current and then attempt to reboard by pulling himself through the shooting gate using the float line. This would have been very difficult while wearing saturated clothing that included boots and gloves, and while suffering from the effects of cold water shock. Had he been able to swim back to *Saint Peter*, the rigging of a boarding ladder, as stated in his risk assessment, or MOB (Man overboard) ladder or overside tyre arrangement, as recommended in industry guidance, would have improved his chances of successfully reboarding."

[24] RNLI guidance is to like effect.

[25] The recommendation follows that fishing vessels, and in particular single-crewed vessels should be equipped with a boarding ladder, overside tyre arrangement or other person overboard safety measures to ensure there is a means of re-entering the vessel once a crew member has gone overboard.

[26] Secondly, since an EPIRB was fitted to the vessel it was not a mandatory requirement for Mr Gray to carry a personal locator beacon. The vessel had its EPIRB fitted to a float free bracket on the vessel's wheelhouse-mounted mast. That could be manually operated whilst aboard the vessel. Mr Gray could have also sent a distress signal while aboard, by operating the DSC function of the vessel's very high frequency radio. Once he went overboard, as a sole crew member not wearing a personal locator beacon, he had no means by which to raise the alarm. Time was clearly of the essence given the temperature of the water.

[27] The Merchant Shipping Notice (MSN) 1871 Amendment 1 (F): The Code of Practice for the Safety of Small Fishing Vessels of less than 15m Length Overall

recommended that single-handed skippers should carry both an EPIRB and a personal locator beacon. That is good advice. Those wearing a PLB have a means to alert the Coastguard to the fact that they have entered the water as well as an accurate location. Had Mr Gray had one, that could have avoided the delay that occurred in this case.

[28] Hence the recommendation that those who operate fishing vessels and in particular single-handed vessels should carry personal locator beacons on their person when on board their vessel.

[29] In summary, it is worth quoting from the MAIB report that:

> "(i) The skipper died because he entered the water and was unable to reboard. It is most likely he suffered heart failure because of cold water shock, the risk of which was increased by his pre-existing heart condition.
> (ii) It is highly likely that the skipper moved aft on the deck to untangle some creels that had become snagged while shooting, and his leg became caught in the back rope and he was dragged overboard.
> (iii) The skipper's PFD inflated automatically, which kept him afloat with his airway clear of the water and prevented him from drowning.
> (iv) It would have been extremely difficult for the skipper to reboard *Saint Peter* in saturated clothing and without the aid of a ladder or other boarding device.
> (v) The skipper was not wearing a PLB or other means of raising an alarm.
> (vi) The risk of becoming tangled in the fishing gear was increased while shooting as there was no physical barrier to separate the skipper from the back rope."

Any other information, observation or comment

[30] The court joins with the Crown in extending sincere condolences to the family and friends of Mr Gray. Mr McSporran, Mr Barnard and the rescue services all acted commendably and it is unfortunate that Mr Gray could not be saved.