SHERIFFDOM OF GRAMPIAN, HIGHLAND AND ISLANDS AT INVERNESS

[2024] FAI 25

INV-B247-23

DETERMINATION

BY

SHERIFF GARY AITKEN

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

into the death of

CLIVE HENDRY

Inverness, 27 june 2024

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 Clive Hendry, born 23 November 1961, died at 16.30 hours on 18 February 2020 at the Accident and Emergency Department, Broadford Hospital, Skye.

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 about 15.00 hours on 18 February 2020 at the Sea Cap barge on the Ardintoul Fish Farm operated by MOWI on the south side of Loch Alsh, near Kyle of Lochalsh.

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 Clive Hendry was drowning following crush injury to his pelvis.

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 Clive Hendry was his attempt to transfer from the vessel *Beinn na Caillich* to the Sea Cap barge before the said vessel was stationary.

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)

There are precautions which could reasonably have been taken that might realistically have resulted in the death, or accident resulting in the death, being avoided. These are firstly that there should have been a specific risk assessment for the transfer of personnel from large workboats such as the *Beinn na Caillich* to floating structures such as the Sea Cap. Secondly, and following from such a risk assessment, there should have been a safe system of work for such transfers. As a minimum, such a system of work should

have required that the vessel be stationary during transfer and mandate that personnel should only embark or disembark from the vessel when signalled by the master of the vessel that they are satisfied that it is safe to do so.

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)

There were defects in any system of working which contributed to the death or the accident resulting in death. There was no clear system for the transfer of personnel from large workboats such as the *Beinn na Caillich* to floating structures such as the Sea Cap. Ad hoc, informal arrangements were in place. There was no clarity as to how such transfers were to be carried out. Employees did not properly understand their respective expectations in relation to such transfers resulting in a confused and dangerous transfer attempt by Mr Hendry, resulting in a fatal accident.

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

There are other facts relevant to the circumstances of the death of said Clive Hendry. Firstly there were issues in relation to the use of the crotch straps fitted to the personal floatation devices supplied to employees by MOWI and the supervision of such use. Crotch straps are vital, not as a weight bearing device but to ensure that the lifejacket remains in the correct position in the event of immersion in water. At the time of Mr Hendry's death the use of crotch straps was not mandated by MOWI. It should have been and is now. Personal protective equipment is only effective if properly worn by employees and if steps are taken by employers to ensure that such requirements are

complied with. Secondly, while all employees involved in recovering Mr Hendry from the water did so to the best of their abilities and as expeditiously as possible on the day, the evidence demonstrated a lack of familiarity with task and a lack of site specific man overboard training. Such a familiarity is desirable and very shortly after Mr Hendry's death MOWI instituted such training. It is important that training of that kind is repeated at appropriate intervals and the all employees, existing and newly joined, are in receipt of it.

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 Hendry 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 Clive Hendry (hereinafter referred to as "Mr Hendry"). Mr Hendry sadly died on 18 February 2020. At the time of his death Mr Hendry was employed by MOWI Scotland Limited (hereinafter referred to as "MOWI") as the assistant fish farm manager at the Ardintoul fish farm, Loch Alsh. He sustained significant crush injuries while transferring from a work boat to a feed barge

at Ardintoul, causing him to enter the water there. He succumbed to those injuries and to immersion in water later that same day.

[5] Preliminary hearings were held at the Inverness Justice Centre by Webex on 27 October 2023, 27 November 2023, 5 February 2024 and 4 March 2024.

[6] The inquiry proceeded at the Inverness Justice Centre by Webex on 18 March 2024, 19 March 2024 and 20 March 2024. A hearing on submissions proceeded at the Inverness Justice Centre by Webex on 12 June 2024. Ms Gillespie, Procurator Fiscal Depute, represented the Crown. Mr Gray KC, advocate, represented Mr Hendry's employers, MOWI. Mr Rodgers, solicitor, represented Mr Hendry's partner, Ms C. Lockhart. Parties lodged two joint minutes of agreement. I accepted the facts set out in both joint minutes of agreement. The first was a substantial document agreeing significant areas which were accepted by parties to be uncontroversial. The findings in fact listed at paragraphs [12] to [52] and [54] to [72] below are derived from the first joint minute of agreement, supplemented by the parole evidence. The second joint minute of agreement covered two reports lodged as productions on behalf of Ms Lockhart.

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

1. Post Mortem Report
2. Maritime and Coastguard Agency (hereinafter referred to as "MCA") questions to MOWI
3. MOWI Response to MCA questions
4. MOWI Response to MCA questions

5. HMCG Incident Log

6. Image of Ardintoul Fish Farm, Kyle of Lochalsh

7. Image of Sea Cap

8. Image of *Beinn na Caillich* vessel

9. Image of Timeline illustration

10. Chart of Reported Incident 2016 to 2020

11. MCA Vessel Inspection Report

12. MCA Initial Fact Finding Report

13. Death Certificate

14. Photographs – Wellington Boots

15. MAIB Report

16. Statement of Alexander Nairne dated 18 February 2020

17. Statement of Alexander Nairne dated 25 August 2021

18. Statement of Douglas Mackenzie dated 9 March 2020

19. Statement of Kenneth Palmer dated 18 February 2020

20. Statement of Kenneth Palmer dated 25 August 2021

21. Statement of Alistair Jack dated 18 February 2020

22. Statement of James Lowrie dated 9 March 2020

23. Statement of Iain Jordan Fraser dated 9 March 2020

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

1. Personal Floatation Device

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

1. Alexander Nairne
2. James Lawrie
3. Douglas Mackenzie
4. Alistair Jack
5. Conor Mays
6. Iain Fraser
7. Stephen Macleod
8. Emma Noble
9. Kenneth Palmer
10. Jim House
11. William Glen
12. Jay Staff

I heard oral evidence from Alexander Nairne, Iain Fraser, Alistair Jack, Kenneth Palmer and Douglas Mackenzie, in that order.

[10] MOWI lodged an inventory of productions as follows:

1. Clive Hendry RYA/MCA Day Skipper of Sail & Power Craft certificate dated 16 March 2019
2. Clive Hendry RYA/MCA Powerboat Level 2 certificate dated 3 May 2019
3. Email from Connor Mays 9 April 2019 passing on Health and Safety Documents
4. Wellboat Harvest – Smolt Transfer Risk Assessment dated 9 April 2019

5. Workboat Operations – Coming Alongside Circle pens or Steel Groups Risk Assessments dated 9 April 2019

6. Safe Procedures When Wellboats Coming Alongside Safety Alert

7. Photo of *Beinn na Caillich*

8. Safety Over Water Advice on Personal Floatation Devices (PFD's) Advisory Note No 1, 2022

9. Diagram showing position and dimensions of ladder and fenders on the Sea Cap

[11] Ms Lockhart lodged two inventories of productions as follows:

First inventory

1. Report prepared by Duncan Cuthill, Maritime Operations Specialist, dated December 2023

Second Inventory

2. Supplementary report prepared by Duncan Cuthill, Maritime Operations Specialist, dated March 2024

The facts

[12] Clive Hendry was born on 23 November 1961. He was 58 years old at the time of his death. He was employed by MOWI as an Assistant Fish Farm Manager based principally at the Ardintoul Fish Farm located on the south side of Loch Alsh close to Kyle of Lochalsh. He had worked for MOWI for 12 years and in the aquaculture

industry for over 20 years. He was an experienced mariner who, at the time of his death, held a day skipper/watch leader certificate and a commercially endorsed powerboat level 2 certificate, both issued by the Maritime and Coastguard Agency (hereinafter referred to as the "MCA"). These entitled him to operate boats such as the *Beinn na Caillich* during daylight hours. Mr Hendry was in good health and lived with his partner of twenty eight years, Catriona Lockhart.

[13] MOWI own and operate thirty nine fish farms throughout the west coast of Scotland including one at Ardintoul. On the day of the accident the company had approximately one hundred and forty vessels mobilised under the control of area or site managers.

[14] At Ardintoul there are twelve pens, set out in two rows of six, each capable of holding up to 50,000 mature salmon. These pens, around 120 metres in diameter, have walkways around the perimeter allowing for human access to perform the usual fish-farming activities. Adjacent to the pens and slightly inshore of the line closer to the shore is a permanently moored structure known as a "Sea Cap".

[15] The Sea Cap was constructed in 1990. It is a concrete hulled circular structure, ten metres in diameter, free floating within the tidal waters of the loch and anchored to the seabed by concrete blocks. It has a dual purpose as a store for feedstuffs in a large cylindrical void space under the deck and also houses a cabin, which accommodates a galley, toilet and administration area equipped with a bank of screens linked to CCTV cameras to monitor the fish in the pens and a computer terminal to control the delivery of feed to individual pens as required.

[16] While staff taking a refreshment break in the galley on the Sea Cap may remove their lifejackets or flotation suits, signage prominently displayed at the exit requires them to wear lifejackets or flotation suits when on deck or working over water. They are working over water while working on the pens.

[17] The height of the Sea Cap deck above sea level varies with the weight of feed on board. The deck is accessed from sea level by a ladder. This is constructed of metal rungs, 800 millimetres wide and welded to the exterior of the hull. 'D' shaped solid rubber defenders run vertically and parallel to both sides of the ladder rails and project out 375 millimetres (15 inches) from the hull. Anyone climbing or descending the ladder can only safely do so facing inwards and, unless pressed flat against the rungs, their torsos, from hips to shoulders, will be 'proud' of the leading edge of the defenders.

[18] Outside of these defenders on both sides of the ladder are vertical fenders made of tyres stacked sideways on top of each other with a poured concrete core. Both fenders are ordinarily secured by stout chains to the deck of the Sea Cap.

[19] As a result of a collision between a MOWI vessel delivering feed to the Sea Cap, the fender on the right-hand side of the ladder as one would climb it had been detached on 8 February 2020. On the day of the accident it remained on the seabed awaiting retrieval by divers and a vessel suitably equipped with a crane.

[20] As an installation permanently anchored to the seabed, with no means of propulsion, the Sea Cap is not the subject of any maritime regulation.

[21] MOWI employed a health and safety manager and two assistants, experienced in the aquaculture and manufacturing industries. In addition to the management of health

and safety on shore sites and off shore installations, the team monitor the certification and training of the workboat crews.

[22] All those operating the MOWI vessels were appropriately qualified. Those in charge of the vessels were responsible for their safe operation.

[23] MOWI's health and safety team had conducted a wide range of risk assessments and developed and implemented safe systems of work that covered land-based and offshore activities.

[24] MOWI issues personal protective equipment to their staff. There were strictly enforced polices about what was to be worn when employees were working on any of MOWI's offshore locations which employees understood and followed. The company mandates that lifejackets must be worn when working over water, and gas operated lifejackets are provided to employees as personal issue.

[25] These lifejackets were fitted with two restraining crotch straps. These are nylon straps that pass from the tail of the jacket under a wearer's groin and are clipped to the base of the front of the jacket by plastic buckles. Their purpose, when fastened, is to prevent the garment riding up, especially when it has been inflated. They do not have the capability to support a wearer's weight in the event they were suspended from the lifejacket from above and have not been designed to do so. If the crotch straps did so, it would be by chance rather than design.

[26] Any load-bearing function is provided by a waist strap stitched to the jacket which is secured by a metal buckle, and which has a lifting loop.

[27] At the time of Mr Hendry's death MOWI did not mandate the wearing of these restraining crotch straps and left it to the discretion of the wearer. If not worn, the company directed that they were to be safely stowed to avoid them becoming a snagging risk. Since Mr Henry's death, MOWI have made their use compulsory.

[28] For boat operations, MOWI had in place two risk assessments titled "*Workboat Operations – Coming Alongside Circle Pens or Steel Groups*" and "*Wellboat Harvest – Smolt Transfers*". These had been introduced in April 2019 following concerns raised about the dangers to personnel when mooring workboats alongside cages or pens and which were identified in a MOWI Safety Alert. These risk assessments were communicated to the Masters of all MOWI vessels including the *Beinn na Caillich* by e-mail from MOWI's Health and Safety adviser on 9 April 2019.

[29] These risk assessments were primarily directed at the smaller vessels in the company's fleet such as the Polarcirkels (hereinafter referred to a "PC's") and their use to access the offshore structures. However, what was not risk assessed were those situations where employees were transferring between larger vessels such as the one that Mr Hendry had been on and structures such as the Sea Cap.

[30] In the absence of this being suitably and sufficiently risk assessed, there were no stated safe systems of work for carrying out these transfers.

[31] There are several publications that would have been available to MOWI's management that would have provided general guidance and direction in establishing appropriate safe systems of work and properly risk assessed activities in respect of the

safe transfer of employees between vessels and the Sea Cap. These, in chronological order, are as follows -

1. Code of Safe Working Practices for Merchant Seafarers

Hereinafter referred to as the Code, it was Amendment 4 that was in force from February 2015 until October 2020.

It states, within paragraph 31,

31.9.6 Personnel transfer is to commence only if all identified parties have confirmed readiness.

31.9.7 All personnel transfers should only take place after a thorough risk assessment has been completed and a toolbox talk carried out with all personnel involved.

2. Crew Transfer Vessels: Good Practice Guide

This is one of the Workboat Association's own publications and can be downloaded free from its website. The latest (second) edition of this was published in June 2019, the year before Mr Hendry lost his life.

Within this publication, at para 2.12, page 8, it states,

"*Transfer of personnel shall be covered by the company's risk assessment system, however, the variable nature of this operation requires that the risk must be (without record) assessed locally again by the Master on each occasion to determine if it is safe to proceed*.

It goes on to state that any transfer should only take place once all personnel have been briefed and that no-one should proceed to or access the transfer area without being under the direct control of the vessel crew.

3. (MGN) 432 (M+F) Amendment 1

The MCA has also regulated the subject of transfers with the publication of Marine Guidance Note (MGN) 432 (M+F) Amendment 1, titled, "Safety during Transfers of Persons to and from Ships". This is a four-page publication, issued in July 2016. Its preamble states that it is a publication intended for, inter alia, the owners and operators of small commercial vessels.

Within that publication, it directs that transfers should be carried out in accordance with the Merchant Shipping and Fishing Vessels (Health and Safety at Work) Regulations 1997 and relevant guidance (para 1.4, page 2).

Paragraph 1.7.1 of MGN 432 includes the following,

"Except where a vessel has a specially designed and dedicated passenger transfer system the transfer of persons (other than those experienced in the use of pilot ladders) from/to vessels *which are not secured alongside or at anchor* should not be attempted unless it is unavoidable."

4. The Workboat Code

The MCA has also collaborated with the National Workboat Association to produce the Workboat Code, referred to above. This is described on page 1 of the June 2014 edition (in force in February 2020) as "The Safety of Small Workboats and Pilot Boats – a Code of Practice applicable to small workboats operating in

commercial use to sea and all pilot boats. (The Merchant Shipping (Small Workboats and Pilot Boats) Regulations 1998 (SI 1998/1609), as amended)".

5. The Merchant Shipping and Fishing Vessels (Health and Safety at Work) Regulations 1997

These Regulations shall apply to all activities of workers on United Kingdom ships, and of most significance are the following -

5(1)(a): the avoidance of risks, which among other things includes the combating of risks at source;

5(1)(b): the evaluation of unavoidable risks and the taking of action to reduce them.

[32] On Tuesday 18 February 2020, the planned work at Ardintoul was a process to treat the fish for sea lice, which required the extension of a tarpaulin under each cage before the treatment was administered.

[33] It was a process that was expected to take up the entire working day on that site. As no staff live on the company's three offshore sites in the Lochalsh area, any presence there is via one of MOWI's fleet of vessels.

[34] By 15.00 hours, the activities at the pens were winding down. The only employee on the Sea Cap was Mr Mackenzie who had one year's service. Mr Nairne was on board the *Stolt Madah* and was master of that vessel. It is used principally for washing nets. He had worked for MOWI for two years at the time but had previous fish farm experience with other employers. His crewman that day was a local man in his twenties. Three employees, including Mr Fraser and Mr Jack were on a PC. PC's are

open-decked and rigid hulled dories, powered by outboard engines and probably the most common vessel in the MOWI fleet. They are used for transporting staff between shore locations and fish farms, and within the farm complexes themselves, between pens.

[35] The *Beinn na Caillich* is the vessel which was involved in the fatal incident. A photograph of the vessel is shown below.

It is a workboat, constructed in the Netherlands, with two years in service as at February 2020. It is fitted with a hydraulic bow ramp and is used for ferrying personnel, materials, plant and equipment between locations. It is crewed by two MOWI employees, a master and deckhand. Mr Palmer was the master on 18 February 2020. It is nineteen metres long, with a beam of seven metres, a displacement of around ninety five tonnes and an open working deck.

[36] Any person embarking or disembarking can do so via the working deck, by walking onto or off the ramp when lowered. The alternative to this would be by ladder onto the deck on either side of the vessel.

[37] Apart from the bow ramp for access, the working deck has a bulwark gate on the port side just forward of the galley door and two gates on the starboard bulwark. These gates are solid steel, 0.55 metre wide and 1 metre high, the top of the gate being flush with the top of the bulwark. On the starboard side, the two gates are situated three metres fore and aft of midships and are secured either open or closed by deadbolts. Both starboard gates are visible from the steering position in the wheelhouse.

[38] The gates should be closed when at sea and only the gate being used for embarking or disembarking should be opened for as long as is necessary. This did not happen on the day of the accident.

[39] The vessel has the usual inventory of life-saving appliances including solid life rings, a cradle mounted life raft within a fibreglass canister in the event of an abandonment, and a "Markus Life net" man overboard recovery system mounted inboard on the transom. This is a net which can be deployed overboard under a casualty and then able to be connected to the deck crane in order to winch that person inboard.

[40] The vessel was fully compliant with the relevant MCA code for a vessel of its size and type.

[41] On the day of the accident, the *Beinn na Caillich's* was crewed by the master, Mr Palmer a thirty-six-year-old employee with eight years' service, and a twenty four year old crewman.

[42] On 18 February 2020 Mr Hendry, along with colleagues, had been on site since around 0830 hours that morning. By late afternoon, the activities were winding down for the day.

[43] Around 15:00 hours, the *Stolt Madah* was secured on a nearby mooring to be left at Ardintoul overnight, and its crew boarded the *Beinn na Caillich*. The two skippers remained in the wheelhouse while the two crewmen went into the galley. This vessel then pulled alongside pen number 10 on which Mr Hendry was the only employee, finishing off his work there for the day.

[44] The even-numbered pens are situated on the outside of the farm and furthest from the shore. The odd numbered pens are situated closer to the shore, and closer still is the Sea Cap situated midway between pens five and seven and around eighty metres offshore. A vessel the size of the *Beinn na Caillich* could not sail between the pens in the way that a PC could as there is an array of feed pipes and cables linking the Sea Cap to each pen.

[45] Mr Hendry asked for a lift to the Sea Cap, intending to go there and use the galley facilities for a refreshment break. He went aboard the *Beinn na Caillich* using one of the gates on the starboard side. To convey him from pen 10 to the Sea Cap, the vessel required to proceed past pen 12, turn right, sail down the sides of pens 12 and 11, turn right again, sailing past pens 11, 9 and 7 to come alongside the Sea Cap, its starboard side adjacent to the Sea Cap's ladder. The transit from pen 10 to the Sea Cap took around three minutes.

[46] Mr Hendry was the fifth MOWI employee by then on the *Beinn na Caillich*. On boarding Mr Hendry went to the wheelhouse, joining Mr Palmer and Mr Nairne.

[47] He later left the wheelhouse and went onto the deck. Taking up a position on the starboard side, near the forward gate in the bulwark, which had remained in an 'open' position.

[48] The usual practice at Ardintoul was that any transfer between the deck of the *Beinn na Caillich* and the ladder of the Sea Cap would not take place until the vessel was stationary alongside the rungs of the ladder adjacent to either the forward or aft gate on the starboard side, but without any mooring lines being deployed to secure the *Beinn na Caillich* to the Sea Cap.

[49] As the only reason the *Beinn na Caillich* was pulling alongside the Sea Cap was to enable Mr Hendry to disembark, it was not intended that it would have tied up alongside. The deckhands were in the galley and not on deck to handle mooring lines. The technician on the Sea Cap was indoors and not on deck to pass down mooring lines to enable the *Beinn na Caillich* to be secured alongside the Sea Cap.

[50] This is what has been referred to as a 'touch and go' transfer, whereby the *Beinn na Caillich* would stop with one of its gates lined up with the ladder so that Mr Hendry could step through the gate onto the Sea Cap's ladder, after which it would depart for Kyle. Anyone remaining on the Sea Cap would return to Kyle in another company vessel.

[51] As the *Beinn na Caillich* approached the Sea Cap, starboard side on, Mr Palmer estimated its speed as around half a knot, with the engines by now in neutral. This

would have been as a precursor to putting it into reverse to slow the vessel to a stop with the forward gate adjacent to the Sea Cap's ladder in anticipation of their colleague disembarking and using the ladder to access the deck and galley.

[52] While the vessel was still moving slowly ahead but before it had come to a complete stop, Mr Hendry stepped through the gate.

[53] The gate was open before Mr Hendry stepped through it. Mr Hendry was dressed in oil skins and wearing his personal floatation device. The crotch strap was not fastened. He was not carrying anything. Mr Hendry reached onto the ladder with both hands and placed his right foot on the rungs. Both Mr Palmer and Mr Nairne were surprised by his actions. The vessel was still moving. The gate post on the bulwark of the vessel struck Mr Hendry on the right side of his body. The vessel moved backwards slightly and Mr Hendry may also have been struck on the left side of his body by the forward gate post. He Hendry screamed in pain.

[54] If the engine requires to be put from a forward gear into reverse, there is a three second delay between the engines moving the vessel forward to engaging to take it astern.

[55] The crewman from the *Beinn na Caillich* had been taking a break in the galley of the vessel and came on deck when he heard Mr Hendry screaming. He saw that Mr Hendry was struggling and distressed. The *Beinn na Caillich* had moved away from the Sea Cap. He saw Mr Mackenzie holding Mr Hendry by the jacket. He tried to take hold of Mr Hendry's jacket and personal floatation device to push him up onto the deck of the Sea Cap but was unable to do so. He Hendry's arms were wrapped around the

railing of the ladder and Mr Hendry could be heard complaining of severe difficulties with his legs.

[56] At some point, Mr Hendry released his grip on the ladder and fell backwards, slipping through his lifejacket which was still being held from above by Mr Mackenzie, leaving him holding it. As he parted company from both the ladder and his lifejacket, he slipped into the water and submerged for no more than twenty seconds.

[57] It is unclear whether or not Mr Hendry was unconscious at the time he released his grip on the ladder.

[58] When Mr Hendry regained the surface, he appeared lifeless in the water on his back with water lapping over his face.

[59] A life ring from the transom on the *Beinn na Caillich* was obtained but was not thrown to Mr Hendry he did not appear able to grab it or make use of it. Instead, a boathook was used to hook Mr Hendry's salopettes and drag him round to the bow where the ramp had been lowered.

[60] With the ramp down, those on board managed to keep Mr Hendry's head out of the water, one of his colleagues saying, '*Clive, we've got you*' at which he turned his head towards them, but said nothing. It was noted that he was frothing at the mouth.

[61] Due to the height of the bow door edge above the water, and also perhaps due to the Mr Hendry's size and weight, they were unable to bring him aboard, but they were successful in keeping his face out of the water.

[62] Mr Fraser, Mr Jack and another employee were nearby on one of the smaller PC's. They arrived, lifting him on board their boat and cutting his clothing away before

commencing CPR. At one stage, they turned him into the recovery position as he was regurgitating water, and then returned him to a supine position and resumed CPR.

[63] The *Beinn Dearg*, another company vessel which had been involved in the de-lousing salmon that day, was en route to Kyle of Lochalsh and when its crew was alerted, they advised that there was a defibrillator on board.

[64] The PC, with Mr Hendry still on board and with CPR continuing, rendezvoused with the *Beinn Dearg*, whereby the defibrillator was used, to no avail.

[65] The Coastguard were alerted by emergency radio message and the Kyle of Lochalsh lifeboat was despatched. Mr Hendry was transferred to the lifeboat and on the journey back to Kyle of Lochalsh, chest compressions were continued, and oxygen was administered. No response was observed from him during this part of his journey ashore. An ambulance met the lifeboat at Kyle of Lochalsh, and Mr Hendry was taken to Broadford Hospital, Skye approximately nine miles away. He was received into the Accident and Emergency Department by Doctor Sarah Learmonth, a rural emergency physician, who had been alerted to his imminent arrival. She observed bruising and abrasions around his right hip and loins. When his clothing was cut off, she observed the indicators of a pelvic fracture. Fluids were administered, and a rewarming blanket used to attempt to raise his temperature, while CPR continued. At 16.20 hours, his temperature was noted to be 32.6 degrees. The range of normal body temperature for adults is 26.6 to 37.2 degrees. At 16.30 hours, when it was apparent that further efforts were in vain, Mr Hendry's life was pronounced extinct by Dr Sarah Learmonth.

[66] On 21 February 2020 a post mortem examination of Mr Hendry's body was carried out. The pathologists found that Mr Hendry had sustained extensive injuries to the right side of his body. The cause of his death was certified as being drowning following a crush injury to his pelvis.

[67] The circumstances of Mr Hendry's death were investigated by Police Scotland, the Maritime and Coastguard Agency and MAIB. MOWI carried out an internal investigation. That investigation determined that the cause of Mr Hendry's death was that he stepped from a moving vessel onto the Sea Cap ladder. The MOWI investigation also determined that there were no effective systems of work in place for such transfers, no suitable and sufficient risk assessments had taken place in relation to such transfers, the sea gates in the bulwark of the *Beinn na Caillich* had been left open while the vessel was traveling within the work site and life jackets were not being worn properly due to not being tight fitting and not having the crotch strap fastened.

[68] To remedy these failures MOWI concluded that it required a clear risk assessment and safe system of work for embarking and disembarking from boats, where a key control measure would be that the master should always be in control. MOWI acknowledged it had to reinforce that no one should embark or disembark without a clear signal and agreement from the master. In respect of lifejackets, the company required a clear company personal protective equipment (PPE) policy with respect to the correct wearing of lifejackets.

[69] MOWI pled guilty by way of Section 76 Indictment at Inverness Sheriff Court on 9 May 2023 to breaches of the Health and Safety at Work etc. Act 1974, Sections 2(1),

2(2)(a) and 33(1)(a) arising out of the fatal accident which caused Mr Hendry's death and was fined £800,000.

[70] After Mr Hendry's death MOWI introduced appropriate measures to ensure that, so far as is reasonably practicable, an accident of this type should not occur in the future. Central to these control measures are that unsecured "touch and go" transfers have been discontinued, vessels require to be secured alongside each other, it has been reinforced to all that the master of the vessel is always in control and no embarkation or disembarkation occurs without the master's clear signal and agreement.

[71] The implementation of these new policies has been facilitated by investment in an online learning management system whereby mandatory online health and safety training is undertaken by all employees, is monitored and audited. A man overboard rescue pole has been developed, manufactured, tested and certificated by MOWI in response to the inadequacy of rescue poles available in the commercial market.

[72] Insofar as lifejackets are concerned, MOWI has introduced a clear and strict requirement as to the correct wearing of lifejackets. To ensure that lessons may be learned throughout the industry, MOWI's then Head of Health and Safety chaired a working group of the Aquaculture Safety Group to create industry guidance for personal flotation devices, the result of which has been the Group's first advisory document, namely "Safety over Water: Advice on Personal Flotation devices".

The evidence

[73] Considerable reference was made in the course of the oral evidence to the photographs and maps (referred to in the report as "Figures") contained in Crown Production 15 – MAIB Report (hereafter referred to as the MAIB Report). This document is the Marine Accident Investigation Branch Report 6/2021 relating to the fatal accident to a fish farm worker involving the workboat *Beinn na Caillich* at Ardintoul, Glenshiel, Scotland 18 February 2020. That report is publically available on the Marine Accident Investigation Branch Reports website.

[74] The first joint minute of agreement signed by parties contained the detailed factual circumstances of the accident which led to Mr Hendry's death. The evidence from the five witnesses who gave oral evidence to the inquiry provided useful supplementary detail to the facts set out in the first joint minute of agreement but did not contradict it nor add substantial factual evidence to its terms.

Evidence of Alexander Nairne

[75] Mr Nairne gave evidence on 18 and 19 March 2024. He confirmed that he worked as a skipper for MOWI for approximately five years between 2017 and 2022. He has held the appropriate certification as a skipper for over sixteen years. His main duties with MOWI were as the skipper of the *Stolt Madah*, a sixteen metre twin engine net washing boat. He worked on three fish farms operated by MOWI in the Loch Alsh area, including Ardintoul. By reference to Figure 1 in the MAIB Report he explained the relative positions of the three MOWI fish farms and pinpointed the Ardintoul fish farm.

[76] Mr Nairne stated that he had known Mr Hendry for about eight years, both as a colleague at MOWI and during a previous employment.

[77] He stated that on 18 February 2020 he and his crewman had been washing nets. They finished work about 2.50 pm. Normally they would either take the *Stolt Madah* back to Kyle or tie it up and take a PC back to Kyle. On 18 February 2020 Mr Palmer offered to give them a lift back to Kyle on his boat, the *Beinn na Caillich*. Mr Nairne could not remember if that was arranged by telephone or by VHF radio. He and his crewman were picked up by the *Beinn na Caillich*. Mr Nairne thought that the *Beinn na Caillich* might have been involved in harvesting or treating the fish that day. Mr Palmer was the skipper of the *Beinn na Caillich*.

[78] Mr Nairne described the Sea Cap, which is a floating barge containing feed which is blown out through pipes to the fish pens. It is anchored in place. It also has accommodation facilities for staff to have meals, go to the toilet etc. He confirmed that he was familiar with the Sea Cap. Mr Nairne also described two different types of personal protective equipment. Firstly, an all in one suit called a Fladen suit, which is warm, showerproof and is worn with a horseshoe shaped lifejacket on top. That is standard issue from MOWI. MOWI also provide an alternative of two piece oilskins with a waistcoat type lifejacket over them. The waistcoat lifejacket is fitted with crotch straps. Staff were instructed to use the crotch straps but not everyone did. He confirmed that both types of lifejacket were available on the *Stolt Madah*. He usually wore a waistcoat lifejacket. He said that he used the crotch straps about 50% of the time. He estimated that for the majority of his twenty years in the maritime working

environment 70% to 80% of people would not bother with the crotch straps. He explained that the crotch straps can be restrictive and it takes longer to put the lifejacket on if they are used. In a fish farm there are a lot of floating things to grab onto if you fall in the water. Mr Nairne stated that he has become more safety conscious as he has got older and always used crotch straps in open water. The majority of people at that time had employers who said crotch straps were to be used but it was generally left up to individuals whether they did or not.

[79] Mr Nairne stated that the purpose of the crotch straps is to stop the lifejacket coming up over the wearer's head if you land in water. The straps keep the lifejacket in place on the wearer's body so that they work better and the wearer floats in the best position, which can be very important. He did not think that crotch straps were intended to be weight bearing.

[80] Mr Nairne stated that he and his crewman transferred onto Mr Palmer's boat. There was a crewman on the *Beinn na Caillich* but Mr Nairne could not remember who it was. He remembered that it was not the regular crewman as he had recently left his employment. On boarding, Mr Nairne went up to the wheelhouse to talk to Mr Palmer. Mr Nairne's crewman went inside for a coffee. Mr Nairne stated that he had known Mr Palmer for several years.

[81] Mr Nairne was referred to the photograph on the first page of the MAIB Report and confirmed that it showed the *Beinn na Caillich*. That photograph is contained in paragraph [35] above. The area at the top of the boat with the windows is the wheelhouse. After they had been picked up the boat headed to one of the pens.

Mr Nairne thought it was pen 10. Mr Hendry was there tidying up. Everyone else was on the Sea Cap having lunch. They had been working on the pen and were just finishing up. Mr Hendry needed a lift from the pen to the Sea Cap. Mr Nairne thought that might have been arranged before he got onto the boat.

[82] Mr Nairne could not remember Mr Hendry getting onto the boat but remembered him walking across the deck and coming up to the wheelhouse. They were chatting about normal fish farm stuff. It was a quick trip to the Sea Cap. He remembered Mr Hendry mentioning that it was another day with a late lunch. Otherwise Mr Hendry seemed to be in good form. Mr Hendry was wearing a pair of oilskins and a waistcoat style lifejacket. He did not have his crotch straps done up. Mr Nairne remembered that there was a bit of chat in the wheelhouse. Mr Hendry said not to tie up and he would just jump off. That was a routine request and practice. Mr Hendry went down to the deck after that.

[83] Mr Nairne stated that he would expect a vessel to tie up if it was stopping. That would be common practice if working with a regular crewman rather than someone inexperienced. If a regular crewman was on duty, they might have thrown a rope around the ladder to enable someone to get off. Mr Nairne knew that Mr Palmer did not have his usual crewman with him that day. He thought that the crewman might not be so au fait with how things are normally done in the boating community.

[84] He stated that he was sure that Mr Hendry said "Don't worry about tying up, I'll just jump off." Mr Nairne stated that he would not think twice about someone saying that. In this sort of circumstance you would not necessarily tie up. He explained that if

he was getting off, he would wait for the vessel to come along side, wait for the vessel to stop and then get off. He stated that it was possible to tie ropes to either side of the ladder to keep the boat in place, if necessary. He accepted that the skipper of the vessel overrules the crewman. The vessel is always the skipper's responsibility. He stated that, personally, he would tie up the vessel if stopping for any length of time. He explained that primarily this was to secure the vessel to something to stop it drifting. This would be done by the crewman getting off and securing the bow and stern of the vessel with ropes, tying it off against the structure which the vessel was alongside. He stated that it might be possible to loosely tie up to the vertical poles at the side of the ladder on the Sea Cap for a brief transfer. However, a transfer could also be done without tying up at all, as Mr Hendry had suggested.

[85] Mr Nairne stated that transfers carried out by coming alongside, the boat stopping and the person stepping off happen every day, hundreds of times a day, especially from the PC boats. These are small, plastic side boats which are open. It is possible to step off of them if they are moving. He felt that complacency was a major part of what had happened with Mr Hendry. A transfer was so routine. Mr Hendry just stepped off. He wondered if it had not occurred to Mr Hendry that the *Beinn na Caillich* was a different type of vessel than a PC. It was less common to transfer from the *Beinn na Caillich* but very common to transfer for the PCs. That was a routine thing to do. If it had been a PC someone getting off could just grab the ladder and jump off. In those circumstances a PC could still be moving at about two knots and you would be able to successfully get off and transfer onto another structure. The PC is about eight or nine

metres long with a low side that is easy to transfer from. The *Beinn na Caillich* is a different type of boat. He thought it was probably about sixteen or twenty tons. The risks of transferring from it are very different than from a PC. They are very different types of vessel. There are different risks when transferring from them. The gunwales are very different. The gunwales on the PC are about two or two and a half feet high. They are much larger on a larger vessel like the *Beinn na Caillich*. The risk is greater on a larger vessel, particularly if the vessel is moving. Mr Nairne stated that most fish farm sites have at least two PCs. They are found everywhere as site boats. He explained that it is much easier to transfer from a PC. Larger vessels are also higher off the water.

[86] He was referred to figure 3 in the MAIB report and confirmed that it showed part of the Sea Cap. He identified the ladder which he had been talking about in evidence. He explained that the vertical rubber defenders at each side of the ladder stand out about four-hundred millimetres or so to protect the ladder from impact. He stated that the tiers which could be seen on the left-hand side are a fender. The markings on the Sea Cap on the right hand side show where another fender would normally be. He explained that the purpose of the fenders is if a vessel comes in too hard, the fenders protect the vessel and the Sea Cap from damage. He explained that a good enough skipper should be able to bring a vessel alongside without touching the fenders at all. He thought that the photograph looked the same as the Sea Cap was on 18 February 2020, namely that the right-hand fender was missing. He stated that the missing fender should not affect being able to carry out a transfer. He stated that a skipper should not really need to touch the fenders at all, especially if the vessel is being brought alongside

square on, slowly and carefully, when it might just touch them gently. He stated that the absence of one of the fenders would not stop him bringing a boat in alongside or carrying out a transfer.

[87] Mr Nairne was then referred to figure 4 in the MAIB report and confirmed that the yellow section on the left-hand side of the photograph was part of the *Beinn na Caillich.* The ladder on the right-hand side was the one attached to the Sea Cap. The black D-shaped rubber item on the right-hand side is the defender at the side of the ladder which he previously described.

[88] Mr Nairne stated that he was familiar with the gate in the bulwark around the *Beinn na Caillich*. The bulwark is a waist-height handrail fitted on top of the gunwale in the *Beinn na Caillich*. You need to open a door in the bulwark to embark or disembark. He stated that the gate could be left open while the vessel was moving, as long as the vessel was only moving around site. If going any further, he would expect the door to be closed and it is good practice to keep it closed. He explained that there are two gates on the side of the *Beinn na Caillich*. He stated that he entered through one of them. He repeated that, unless the vessel was transiting open water, it would not be absolutely necessary to close the gate. He stated that Mr Hendry had been the last person to get on board the *Beinn na Caillich*. His recollection was that there was a gate on both the port and starboard sides and also one towards the stern. He estimated that the distance from Pen 10 to the ladder on the Sea Cap was approximately two-hundred meters. It was still within the site area. He did not see any need to close the bulwark gate during such a journey and would not be surprised for the gate to left open in those circumstances. He

estimated it would take about three or four minutes to travel from Pen 10 to the Sea Cap. His recollection was that the sea was pretty calm that day, although the wind got up later. In his view, it was not necessary to close the gate during that journey. There was no one on deck to fall out of it. If someone had been working on the deck, the gate would have been closed for transit. If only going slowly and no one working on the deck, it would not be necessary to close the gate. He did not think there was anything unusual about leaving the gate open in those circumstances. He explained that the gate opens inwards onto the *Beinn na Caillich*. It does not obstruct transfer at all.

[89] Mr Nairne stated that he thought that Mr Palmer acknowledged Mr Hendry's comment. None of what had happened to that point had caused him any concern. If he had been concern, he said he would have said something. He thought that the vessel would be stopped before the transfer and he thought that would be understood. He stated that he has never seen someone transfer from the *Beinn na Caillich* while it was moving. He has seen such a transfer done many times and the boat was always stopped. He suggested that stepping off the vessel while it was moving was like stepping onto a train if it was moving. He explained that a rule book was not needed to tell you that.

[90] Mr Nairne estimated that the gate in the bulwark was probably about five-hundred millimetres or so wide. He described it as being smaller than a house door. He stated that he saw Mr Hendry go onto the deck as the vessel was lining up to the Sea Cap. The vessel was well reduced in speed. He estimated that it was travelling at three or four knots as a maximum. It was about fifty metres out from the Sea Cap. He stated

that it is natural when watching another skipper to think of what he would be doing in the same circumstances. He described Mr Palmers handling of the vessel as pretty much perfect and the same as he would have done it himself.

[91] By reference to figure 3 in the MAIB report, Mr Nairne stated that the *Beinn na Caillich* was approaching the Sea Cap from the right-hand side from the photograph. The vessel was parallel to the ladder. He stated that he could not have carried out the manoeuvre better himself. The approach Mr Palmer was taking was pretty much ideal. The correct approach depends on the wind. On that particular day, the wind was basically head-on, which amounted to perfect conditions. Mr Nairne had no concerns about what was happening or about Mr Palmer's handling of the vessel. He was in the wheelhouse with Mr Palmer and he could see Mr Hendry at the forward, starboard gate in the bulwark which was open.

[92] He saw that Mr Hendry was still wearing the personal protective equipment which he had described earlier. Mr Hendry had been the same as he always was, a bit grumpy and moody but in generally good form apart from being hungry.

[93] Mr Nairne stated that the distance to the Sea Cap was reducing and the *Beinn na Caillich* came alongside with the speed of the vessel reducing further. He saw Mr Hendry move onto the Sea Cap. He stated that he uttered an exclamation of surprise as he could not understand what Mr Hendry was doing. He saw Mr Hendry put one foot on the ladder with the boat still moving. He saw that Mr Hendry had put his hand and his right foot onto the ladder. The vessel was still moving but not much, perhaps about one knot, not much but enough. Mr Nairne stated he was surprised that

Mr Hendry had stepped across when the boat was still moving. He was sure that Mr Palmer would have heard his exclamation of surprise. He thought that Mr Palmer had also expressed surprise at Mr Hendry's actions. He was sure that Mr Palmer could also see what was happening. He described Mr Palmer as looking "gobsmacked." He stated that this all happened in milliseconds. Mr Palmer took the vessel out of gear. He did that very quickly. Mr Nairne saw the post on the right-hand side of the gate opening in the bulwark crush into Mr Hendry just as Mr Palmer had put the vessel into reverse. Mr Hendry was half on to the ladder at that time. Mr Nairne stated that the next thing that happened was that the post on the left-side of the gate opening caught Mr Hendry as well. He appeared to be wedged. Mr Palmer had put the vessel into reverse to stop the forward motion and the vessel moved backwards very slightly. Mr Nairne said that, at this point, he was running out of the wheelhouse to where Mr Hendry was. Mr Nairne explained that, on the approach to the Sea Cap, a skipper would remove the vessel from gear to stop the drive to the engine and thereafter nudge the engines into reverse to stop completely. He explained that boats do not have breaks and they are slowed by operating their engines in reverse. He thought that there might only have been about ten centimetres of forward movement but that, even at half a knot, the gap would close very quickly.

[94] He stated that he could see Mr Hendry's back. Mr Hendry was hanging onto the ladder. The boat was drifting slowly away from the Sea Cap to try to stop Mr Hendry being wedged against the ladder. Mr Hendry was hanging onto the ladder with his hands. His left foot was on the ladder. He was screaming. Mr Nairne said that

Mr Hendry was not speaking but was screaming. By this time Mr Nairne was down beside the gate where Mr Hendry was. The vessel had drifted about three or four feet away from the Sea Cap and Mr Hendry was just out of arm's reach. Mr Nairne described how he leaned out of the vessel, trying to reach Mr Hendry. He saw that the two crewmen had heard screams and come out of the galley. Mr Mackenzie, who had been on the Sea Cap, must also have heard the screams. Mr Nairne could see Mr Mackenzie at the top of the ladder on the Sea Cap. He stated that Mr Hendry was two rungs from the top of the ladder, and described Mr Hendry as being close to the horizontal tops of the grey vertical metal poles at either side of the ladder, visible in figure 3 of the MAIB report.

[95] Mr Nairne described how Mr Mackenzie had grabbed the shoulder area of Mr Hendry's lifejacket. He could not really remember any comments being made. Everything happened very quickly, within a few seconds. Mr Nairne described Mr Hendry going limp just after Mr Mackenzie had been able to get hold of his lifejacket with both hands. Mr Nairne confirmed that the lifejacket shown in figure 5 in the MAIB report was similar to Mr Hendry's lifejacket on that day. He confirmed that the crotch-straps go around the thighs and are fixed at the back of the lifejacket. They clip in at the groin. Mr Hendry's crotch-straps were not fastened. Mr Hendry was facing Mr Mackenzie. Mr Hendry's back was to Mr Nairne. Mr Mackenzie was hanging onto the shoulder area of the lifejacket to hold Mr Hendry in place. He succeeded momentarily but Mr Hendry went limp, let go of the ladder, his foot came off and he slipped through the lifejacket. He described Mr Hendry's arm going up and the

lifejacket going over his head. Mr Nairn did not think that the crotch-straps would've made much of a difference. The plastic clips might well have broken. His understanding was that the crotch-straps were designed to stop the lifejacket from riding up, not to hold the weight of a person, particularly Mr Hendry who he thought must have been about eighteen stone. He thought the clips would likely have broken even if they had been done up. He stated that Mr Hendry's foot had come off the ladder and he had fallen into the water.

[96] Mr Nairne described how Mr Hendry had hit the water and had gone under for a few seconds, then came up to the surface. Mr Hendry was lying on his back and floating. The water was over his face. Mr Nairne thought that he was just about conscious and making gurgling noises. He was not communicating. Mr Nairne thought that the incident had taken about two minutes maximum at that point, possibly less. He had been watching it all happen.

[97] Mr Nairne could not remember Mr Palmer shouting anything over the loudspeaker. He described how it felt as though things were taking an eternity. His immediate reaction was to jump into the water but he convinced himself not to do so. He ran to the side of the wheelhouse to grab a life-ring. When he got back, he saw Mr Hendry floating in the water and realised he would not be able to grab the life-ring. Mr Nairne grabbed a boathook. He realised that Mr Palmer had lowered the bow door, which is like a ramp, at the front of the *Beinn na Caillich*. Mr Nairne was able to hook the back of Mr Hendry's waterproofs and drag him to the bow door. Mr Hendry's head was now out of the water. Mr Nairne stated that he had shouted to get the PC on the

radio and get them to come and help. Mr Nairne and his crewman were on the bow door. He remembered his crewman telling Mr Hendry that they had got him. Mr Hendry appeared to turn towards him. He appeared to still be sort of conscious and responding. Mr Nairne was sure he turned his head. Mr Nairne and his crewman were unable to get Mr Hendry up onto the bow door. It was too high above the water. He described one of the PC boats arriving. The crew on the PC boat were able to pull Mr Hendry into it. Mr Nairne confirmed that the bow door only goes down far enough to be parallel with the water's surface and does not lower right down into it. The door was as low as it could go but it was still about a foot and a half above the water's surface and they were just not able to get Mr Hendry into the *Beinn na Caillich*.

[98] Mr Nairne said that the PC arrived very quickly, probably only a couple of minutes from the radio call. The crew successfully dragged Mr Hendry out of the water and into the PC. Mr Nairne did not go over to the PC himself. He realised that the incident was very serious. He went up to the wheelhouse of the *Beinn na Caillich* and called the Stornoway coastguard and told him about the situation. He made a mayday call. The coastguard operator asked him what had happened. He was quite sure that neither he nor his colleagues could have done anything any quicker. He stated that he had known it was serious from the first scream he heard from Mr Hendry.

[99] Mr Nairne stated that he saw the crew on the PC starting CPR on Mr Hendry. He stated that all staff were sent on first-aid courses every five years. So far as he knew, the crew did not stop CPR on Mr Hendry. Mr Nairne stated that he stayed in the

wheelhouse on the radio, relaying updates from the PC to the Stornoway coastguard. Another vessel came to help. There was a defibrillator on that vessel.

[100] Mr Nairne reiterated that the skipper of the vessel, in this case Mr Palmer, is responsible for the safety of the vessel and all the people on it. Mr Palmer was keeping the *Beinn na Caillich* safe, so Mr Nairne concentrated on the radio. There was a lot going on. He thought that Mr Palmer was in shock. It all happened so quickly and unexpectedly. He stated that everyone was trying their best to save Mr Hendry. He did not think things could have happened any quicker. He thought that Mr Jack and Mr Fraser were on the PC. He not think that they would have seen how Mr Hendry's accident occurred.

[101] So far as Mr Nairne was aware, the crew were taking it in turn to do CPR. He thought the coastguard arrived within about twenty minutes. The other boat had been on its way back to Kyle but turned and came back to them. Mr Nairne was not sure where the other boat met the lifeboat. He thought that the PC may have sailed to meet the lifeboat. He was not really sure. The *Beinn na Caillich* remained on site.

[102] He knew that the PC had stopped so that a defibrillator could be tried. He wondered in hindsight if they should have headed straight to Kyle but doubted if that would have made any difference. He said that everything that was done was done with the best of intentions. He anticipated that Mr Hendry had sustained severe crush injuries during the accident.

[103] He did not think that the absence of the fender had made any difference to what happened. He thought, if it had been there, that Mr Palmer would have approached

exactly in the same way. He did not think that the fenders would have increased the gap between the *Beinn na Caillich* and the defenders at the side of the Sea Cap ladder to any extent and the gap would still have been the same between the ladder and the gate post.

[104] Mr Nairne was referred to figure 6 in the MAIB report and confirmed that the fenders would not increase the distance from the ladder to the *Beinn na Caillich*. He estimated the gap to be little more than one hundred millimetres. He confirmed that the fenders are to protect the Sea Cap, not the ladder. He did not think the absence of the fender had played any part in what happened.

[105] In cross examination by Mr Rodgers, Mr Nairne stated that he first saw Mr Hendry on 18 February 2020 when Mr Hendry was going to the Sea Cap for his lunch. He stated that he heard Mr Hendry talking to Mr Palmer. Mr Nairne explained that he expected the boat to stop and Mr Hendry to step off once the boat had stopped, but that the boat would not be tied up. He estimated that the boat was doing about one knot on the approach to the Sea Cap. Mr Hendry grabbed the ladder with his right hand and put his right foot on it. Mr Hendry let out a scream. He had been caught in the gap between the ladder and the boat. Mr Nairne stated that he expected that the boat would not be tied up, but that it would stop and Mr Hendry would then get off.

[106] Mr Nairne said that he saw Mr Hendry at the gate, grabbing the ladder with his right hand and putting his right foot onto it. He said that Mr Hendry's actions took him by surprise. He had never seen anyone step off of a vessel when it was moving. The boat was alongside but was still moving forward at about half a knot. It was barely

moving but it was enough movement that the small gap between the gate and the ladder closed within a millisecond. He confirmed that the gate is not wide. He stated that once Mr Hendry stepped onto the ladder while the boat was still moving, the gap between the boat and the ladder got smaller. The boat was moving from right to left, causing a pinch point.

[107] Mr Nairne said that if he were bringing the boat alongside, he would normally move slightly passed the ladder, then go into reverse and stabilise at a stop directly opposite the ladder. It would then be possible to tie the boat up to the ladder or just to jump across, but only once the boat was at a complete stop. Mr Nairne said that this was the baffling thing. He thought that it had happened due to complacency, Mr Hendry being late for lunch among other things. He indicated that he was not blaming Mr Hendry but was simply explaining what seemed to have happened. Mr Nairne stated that if Mr Hendry had stayed on the *Beinn na Caillich* it would have stopped and he could have got off. He explained that, even once out of gear, momentum would carry the vessel forward. There are no brakes on a boat, only the reverse on the engine.

[108] He stated that Mr Hendry was caught between the ladder and the bulwark post on the boat. It happened in seconds. He thought that as Mr Hendry grabbed with his second hand, he twisted and was crushed. He was half on the boat, half on the ladder and the bulwark post caught him. His body was stopping the boat moving and he was caught between the bulwark post and the D-shaped rubber defender at the side of the ladder. If Mr Hendry had waited a few seconds, it would have been fine, as the boat would have been stationary and possibly tied up. Mr Hendry could then have stepped

across with no risk, as long as the boat was stopped. Mr Nairne said he had not seen this process on the larger boats but it was very common on PCs.

[109] He had not seen any issue with the prospect of dropping Mr Hendry off at the Sea Cap.

[110] Mr Nairne stated he had not received any man overboard training while working for MOWI. His recollection was that he had done some man overboard training during his skipper's qualification. He stated that after Mr Hendry's death, lots of things were put in place. A man overboard rescue pole, which could be attached to the crane on a big vessel like the *Beinn na Caillich*, was obtained within about six months and staff received training on it. Training was done to recover dead weight mannequins. He was sure that all the staff received that training within six months of Mr Hendry's death. Staff were are told that crotch-straps on lifejackets must be used.

[111] He stated that there were risk assessments on the various vessels. He did not think he had seen one for personnel transferring from vessels. He supposed that such a risk assessment should be in place but described it as a day to day activity for skippers. He confirmed that he did not have such risk assessments on his vessel. He stated that after Mr Hendry's death, he still did not have anything on his vessel but he thought that there were risk assessments on the larger vessels.

[112] Information was passed on by word of mouth from the fish farm managers. CCTV was fitted to all the vessels with a hard-drive to record the footage. He confirmed that he left MOWI two years ago. He was not exactly sure when.

[113] He confirmed that as soon as he saw Mr Hendry being crushed, he went down onto the deck. He only saw one impact. The vessel came to a dead stop. He thought there was only one impact and that made the boat drift away by about two or three feet. He accepted there might have been a second impact. The ladder is not visible from the stair leading down from the wheelhouse so Mr Hendry was not in his sight all of the time. He stated that his own vessel was four metres wide and ten metres long, constructed of steel with an open gate to one side to step off. He estimated it to be about a quarter of the size of the *Beinn na Caillich* but slightly larger than the PC boats.

[114] There was no cross examination of Mr Nairne by Mr Gray KC.

[115] In re-examination by Ms Gillespie Mr Nairne stated that he had not received any man overboard training while employed by MOWI but that his training in handling boats and his skipper training had included basic man overboard training. That training was delivered through the Royal Yachting Association of the Maritime and Coastguard Agency. He arranged that training for himself before he was employed by MOWI. MOWI were aware that he held the relevant qualifications in relation to vessel handling.

[116] Mr Nairne stated that a lot of training to be a skipper is carried out on smaller vessels. He expressed the view that you should do training on the vessel you are actually using.

Evidence of Iain Jordan Fraser

[117] Mr Fraser gave evidence on 19 March 2024. He stated that he is currently employed by MOWI as a fish farm manager. He has been employed by MOWI since October 2018. In February 2020 he was a fish farm technician. He received initial training in first aid, sea survival and certification for the use of certain classes of boats when he joined the company. He held a Powerboat Level 2 certification which allowed him to pilot the PC boats used on the fish farm. He confirmed that his employers also provided him with persona protective equipment such as a hard hat, steel toe-capped boots and a life jacket. Wearing a life jacket was mandatory when working over water.

[118] Mr Fraser stated that he was issued with and wore a one piece Fladen suit with a horse shoe life jacket over it, worn over the head and secured with crotch straps. This was what he normally wore but it was weather dependant. Some other people wore two piece oil skins with a different type of life jacket, also issued by MOWI. That life jacket is like a waistcoat with two crotch straps, a zip and a belt round the waist. It was personal preference which type of protective clothing and lifejacket to use. Although slightly different both are made to do the same job. Mr Fraser considered that both life jackets are good and the difference between them is mainly style rather than substance. He described how the crotch straps fasten around the thighs to stop the life jacket coming off if the wearer ends up in the water. He thought that it was mandatory to use the crotch straps in February 2020 and that he always did so. He could not remember seeing anyone who was not using the crotch straps. He thought he would have said something if he did see that. The only reason he could think of for not wearing the

crotch straps was if the wearer found them uncomfortable. He did not find them uncomfortable.

[119] He confirmed that the Sea Cap at the Ardintoul fish farm is a barge used for storing feed for the salmon and with facilities for staff to take breaks. His duties as a technician at Ardintoul included general husbandry of the salmon such as feeding, mortality checks, treatment and involvement in the use of boats. He was aware that MOWI operate two other fish arms on Loch Alsh but he mainly works at Ardintoul and very occasionally at Loch Duich and never at Loch Alsh. The Ardintoul farm consists of twelve fish pens and the Sea Cap. He explained that the pens and the Sea Cap are all separate and it is not possible to walk between them.

[120] Mr Fraser was referred to Figure 5 in the MAIB Report and confirmed that it showed a waist coat life jacket of the type he had been describing. In the photograph the crotch straps appeared to be fastened but the top and the belt were not. He repeated that his understanding was that the crotch straps are there to prevent the lifejacket coming off if the wearer goes into the water.

[121] By reference to Figures 1 and 2 in the MAIB Report Mr Fraser confirmed the position and layout of the Ardintoul fish farm. He explained that there is a separate feeding pipe connecting each pen to the Sea Cap. He confirmed that Figure 3 shows the Sea Cap. The pipes visible on the right of the photograph are feed pipes running to the pens. He explained that there were similar pipes on the left, not visible in the photograph. He explained that because of the pipes it is not possible to sail a boat between the pens or between the two rows of pens and that movement between the pens

must be by boat around the outside of the pens. He also explained that there is a second ladder on the Sea Cap, other than the one visible in the photograph, which is close to the pipes on the left hand side. Due to its proximity to the pipes access to it is restricted and it is more rarely used. Mr Fraser explained that the Sea Cap rises and lowers in the water depending how much weight of feed is stored in it and any particular time.

[122] Mr Fraser said that in February 2020 if someone was transferring from a boat to the Sae Cap the boat should be stationary before the person moved. That was so that the exit from the workboat lined up with the ladder on the Sea Cap. That would make the transfer easier and safer. He thought that might have been included in the boat training he received when he started work and that everyone would know that. He stated that he always waited for the boat to stop before transferring. He stated that he would expect that the skipper of the boat would expect that someone transferring from the boat would wait until the boat stopped before doing so. He said that if he had seen someone getting on the Sae Cap ladder while the boat was still moving he would have said something. He had never seen anyone doing so and would have thought it out of the ordinary if they did.

[123] Mr Fraser stated that the PC's are smaller open boats. They can carry about six people. If he was piloting a PC to the Sea Cap he would stop alongside, tie off the bow and the stern to the vertical bars at each side of the ladder and then you can climb out.

[124] Mr Fraser confirmed that he was aware of the *Beinn na Caillich*. He confirmed that it is shown in a photograph on the first page of the MAIB Report. He explained that the wheelhouse is where the windows can be seen. It is bigger and heavier than a PC.

He accepted that Figure 4 in the MAIB report shows one of the bulwark gates in the *Beinn na Caillich* and that the gate is 55 centimetre wide. He said that he gate would be open for a transfer and you would wait until the boat stopped. He thought that the *Beinn na Caillich* would normally be tied up for a transfer but occasionally it might not be.

[125] Mr Fraser arrived at work at 8 am on 18 February 2020. He stated that they were going to be treating a pen at Ardintoul tool for lice. That was a routine job. He explained that generally two boats are required to do that. A tarpaulin is stretched under the net. Chemicals are put into the pen to treat the lice on the fish. It can be quite a labour intensive job with a number of staff involved.

[126] Mr Fraser was on a PC. They are the most frequently used boats all of the fish farm. There was also the *Beinn Bhreac*. It works around the fish farm too. Mr Fraser stated that he was working with others, namely Mr Mackenzie, Mr Jack and Mr Lawrie. They were working with Mr Hendry too. At about 12 o'clock he, Mr Mackenzie, Mr Jack and Mr Lawrie had their lunch at the Sea Cap. He accepted that he was a little vague about the times. Mr Hendry stayed to monitor how the treatment was going. That was standard practice for a manager. Mr Hendry was the assistant manager at Ardintoul. After lunch he, Mr Jack and Mr Lawrie got back into the PC and did mortality checks. He explained this meant removing dead fish from the pens. This was a daily job. They would generally go around all of the pens in turn, but not a pen that had been treated, such as pen 10.

[127] Mr Fraser stated that they received a message on the radio. He explained that there is a VHF radio built into the boat. They also had access to hand held VHF radio sets. These could be used to contact the other boats. He was aware of an emergency radio message. He thought it came from Mr Mackenzie. It was quite broken up but he thought that Mr Mackenzie said someone was in the water. He instantly knew that it must be in the area near the Sea Cap. They were at pen 2 or pen 4 so went round pen 1 and to the Sea Cap. They came across Clive Hendry the water. The *Beinn na Caillich* was there too.

[128] Mr Fraser was referred to figure 3 in the MAIB report. He stated that the *Beinn na Caillich* was about six or seven metres away from the ladder on the Sea Cap which can be seen in the photograph. Mr Henry was in the water in the general area shown in the bottom left of the photograph. Mr Henry was just floating around. They were able to get the boat over to him and recovered him from the water. Mr Fraser thought that Mr Henry was lying almost on his back, slightly on his side. He did not think that Mr Henry was wearing his life jacket. He thought he was wearing his oilskins but was not sure about his Wellington boots. Mr Fraser was sure that Mr Henry had been wearing his life jacket when they had left him to go for their lunch. They were able to get the PC between the *Beinn na Caillich* and the Sea Cap. They were able to get Mr Henry into the boat. He could see that Mr Nairne was on the *Beinn na Caillich*. Mr Mackenzie was on the Sea Cap deck. They were waving frantically to make the crew of the PC aware of what had happened.

[129] Mr Fraser confirmed that he was in charge of the PC. They carefully came up to Mr Henry. They got him up onto the side of the PC and recovered him out of the water. They did that with a sense of urgency. He estimated that from first seeing Mr Henry to getting him into the PC would be a minute or two at most. Mr Henry was not conscious.

[130] Mr Fraser stated that he was very concerned about Mr Henry. He said that they lifted Mr Henry's legs up and started CPR. Mr Jack and Mr Lawrie were doing the CPR. Mr Fraser manoeuvred the PC to the ladder of the Sea Cap. He could not really hear his radio messages. He stated that he did not recall much after that. He did recall that the skipper of the *Beinn Bhreac* had a defibrillator on his boat. CPR was continuing. He could not remember how long that had gone on for, but estimated about six or seven minutes. Mr Fraser piloted the PC to the *Beinn Bhreac* to get the defibrillator. They went to do that as soon as the skipper had told them that he had one. The *Beinn Bhreac* had been going to Kyle but had turned round to meet them. Mr Fraser went as fast as they could to meet the other boat. The weather was beginning to pick up. There was a small bit of motion on the sea. He thought it might have taken about six minutes to get to the other boat. The skipper gave them the defibrillator. Mr Fraser thought that he had in fact come into the PC with it.

[131] As soon as the defibrillator was aboard the pads were connected to Mr Henry. Mr Fraser was aware that the defibrillator gives instructions. He vaguely remembered that happening but he could not recall it very well. He was still piloting the PC and stayed out of the way while the defibrillator was being used. He did not know if it said whether or not Mr Henry was to be shocked but he knew that CPR continued. He did

not think his colleagues would have used the defibrillator to shock Mr Henry if the machine did not indicate that that was necessary.

[132] Mr Fraser stated that the RNLI lifeboat arrived. He was not really sure how long they took to arrive but estimated that it was 13 to 15 minutes. He explained that the time was not the main thing on his mind. He stated that they were in a rush. He further explained that his vagueness about what was happening at this stage was due to the panic they felt. They all helped to put Mr Henry into the RNLI lifeboat which left immediately. He thought that Mr Jack had gone with them. Mr Fraser took the rest of his colleagues back to the Sea Cap.

[133] He stated that he felt very overwhelmed. It was a lot to take in. He confirmed that from first seeing Mr Henry in the water until transferring him to the RNLI lifeboat they all did everything they could to help. He also confirmed that he and his colleagues on the PC did not see how Mr Henry went into the water. He did not see Mr Henry transferring from the *Beinn na Caillich* to the sea.

[134] In cross examination by Mr Rodgers, Mr Fraser explained what he understood a touch and go transfer to mean. His understanding was that this was when someone got out of a boat without any ropes being tied off and without securing the mooring ropes. PCs could be used for that. He stated that he had done touch and go transfers in the PC in the past. He said they do not do it any more after Mr Hendry's accident. It all changed after Mr Hendry died.

[135] He stated that they had received man overboard training. Generally one of the safety team would come and go over it and then they would do it themselves and film it.

The videos would be sent to the safety team. He stated that they did this every few months, certainly more often now. It is mandatory every six months to a year. They do it more than they ever did before Mr Hendry died. Man overboard training is definitely carried out now.

[136] There was no cross examination of Mr Fraser by Mr Gray KC and no re-examination by Ms Gillespie.

Evidence of Alastair Jack

[137] Mr Jack gave evidence on 19 March 2024. He stated that he has been employed by MOWI for fourteen or fifteen years as a fish farm technician. Mr Hendry was a longstanding friend of his for many years. In February 2020 Mr Hendry was the assistance manager at the Ardintoul fish farm. Mr Jack also worked at the Ardintoul fish farm. On 18 February 2020 Mr Hendry picked Mr Jack up and they went to start work. Their duties that day were to treat the fish for lice. Mr Hendry, Mr Jack, Mr Fraser, Mr Mackenzie and two colleagues went out to pen 10 sat the Ardintoul fish farm by boat. They were using a PC. Two of the larger work boats, namely the *Beinn Bhreac* and the *Beinn na Caillich*, were there as well. Around 11 or 12 o'clock most of them went to the Sea Cap for lunch. Mr Hendry stayed behind at pen 10 to monitor the treatment. Mr Jack stated that after lunch he, Mr Fraser and a colleague went to carry out other general work on the fish farm, such as carrying out mortality checks for dead fish. They were using a PC.

[138] Mr Jack stated that about 3 o'clock he was just about to tie their PC up to one of the pens, either pen 2 or pen 4, when an emergency call came in on the radio. He did not hear the radio message himself but was aware of it and immediately jumped back into the boat and went round to the Sea Cap. The journey took less than a minute. On arrival he could see that the *Beinn na Caillich* was close to the Sea Cap too. He saw that the bow door of the *Beinn na Caillich* was lowered and wondered why. He then saw that there was someone in the water and the crew on the *Beinn na Caillich* were struggling to get them aboard their boat. He had no idea how the person had got into the water.

[139] Mr Jack could see that the person in the water was Mr Hendry and that the crew on the *Beinn na Caillich* were struggling to keep his head out of the water. He and his colleagues were able to get Mr Hendry into their PC, which was lower to the water than the *Beinn na Caillich*. He saw that Mr Hendry was not wearing his life jacket. He knew that he had been wearing it earlier.

[140] Mr Jack confirmed that wearing a life jacket was compulsory. His employers provided two different styles, a horse shoe life jacket and a waistcoat life jacket. Both are fitted with crotch straps. At that time employees did not always fasten the crotch straps. It was common not to. He accepted that for personal safety they should have done so. At that time MOWI did not instruct employees to use the crotch straps but employees were instructed to wear life jackets. It is now mandatory to use the crotch straps and everyone does. At the time Mr Jack did not use the crotch straps and he did not think that Mr Hendry did either. Mr Jack did not think that the crotch straps would

stop you from falling out of a life jacket but accepted that if immersed in water the crotch straps would keep the life jacket in place and stop it coming off.

[141] Mr Jack stated that he had received some training in 'man overboard' procedures prior to 18 February 2020 but had received a lot more since that date. He could not recall any 'man overboard' training prior to Mr Hendry's death in any detail and thought that it might have been included in first aid or sea survival training that he had received when he started work initially. He has now received 'man overboard' training and knows what to do in such circumstances. He thought that the training he received in the sea survival course was more about dragging someone into a life raft rather than recovering them onto a boat.

[142] Mr Jack confirmed that Mr Fraser was piloting their PC when they rescued Mr Hendry from the water. Mr Hendry was not conscious. Once he was in the PC they raised his legs to try to get any water out and started CPR, which they had been trained in by MOWI. They made every attempt to assist Mr Hendry. Mr Jack and one of his colleagues took turns carrying out CPR. There was no improvement in Mr Hendry's condition. He remained unconscious throughout.

[143] Mr Jack stated that one of the other boats had a defibrillator. Mr Fraser piloted their PC to meet that boat. The defibrillator was obtained. Mr Jack had received training in the use of the defibrillator. The defibrillator was attached to Mr Hendry and indicated that it should not be used and that CPR should continue, which is what they did. The RNLI lifeboat arrived and took Mr Hendry to shore. Mr Jack went with him.

[144] Mr Jack was advised that Mr Hendry had died and explained that he went with the police to let Ms Lockhart know what happened. The police then took them to Broadford Hospital to see Mr Hendry.

[145] In cross examination by Mr Rodgers Mr Jack confirmed that he had worked for MOWI for fourteen or fifteen years, all at the Ardintoul fish farm. He still works there now. He was asked about 'touch and go transfers' and explained that his understanding of the phrase was that if a large work boat came alongside a barge, like the Sea Cap, and 'touched' you would go onto the ladder and disembark. The boat would stop before you stepped off. The boat would not be secured to the barge by ropes. He confirmed that he had done 'touch and go' transfers himself. He had seen them done too. He stated that the work boats were not there all the time. He had not been on them often but had seen the process he described happening. He said that it was much easier to transfer from a PC than a work boat. He confirmed that after Mr Hendry's death 'touch and 'go transfers were stopped. They were told not to do them and it had definitely stopped.

[146] Mr Jack described the 'man overboard' training that he remembered having as part of his initial training. He thought it was about getting someone into a life raft rather than recovering them to a fixed structure of boat, which was not quite the same thing. He did not remember having any refresher training prior to Mr Hendry's death. He has received 'man overboard' training from MOWI since Mr Hendry's death. It started off as quite regular but has fallen off a bit and the thought there were some new employees who had been working for a few months who had not had the training.

[147] Mr Jack said that it was common for the gunwale gates on the *Beinn na Caillich* to be open near the pens prior to Mr Hendry's death. The thought there was now an instruction that they should be closed while the vessel was in transit and should not be open around the site. He thought that after this incident he might have heard from the company skippers that they had been given instructions about the gates.

[148] There was no cross examination of Mr Jack by Mr Gray KC and no re-examination by Ms Gillespie.

Evidence of Kenneth Palmer

[149] Mr Palmer gave evidence on 19 March 2024. Mr Palmer confirmed that he is a fish farm worker. He worked for MOWI for about nine years. He left MOWI in March 2021. During the time that he worked with MOWI he was a net washer for five years as a deckhand and then progressed up to be skipper of a new vessel which was taken onto the fleet. The vessel was landing craft. It had a flat bottom, wheelhouse and a ramp at the front. It was used as a harvest and treatment boat. He spent a couple of years on the boat and then moved to the next new vessel which came onto the fleet. That was in late 2018. That new vessel was the *Beinn na Caillich*. He worked as skipper of that boat until he left MOWI in early 2021.

[150] The *Beinn na Caillich* was similar to his previous boat. It was a general assistance boat. It was the same length but had an offset wheelhouse. It operated in much the same way. It was also a landing craft type vessel.

[151] Mr Palmer stated that he completed his skipper tickets early in his employment with MOWI, before he became a skipper. He thought that was in 2013. He explained

that every five years his skipper qualification is sent for commercial endorsement. He stated that he had not received and did not require to receive refresher training. His initial skipper training was provided by outside trainers at Ballachulish. Once a skipper certificate is obtained it lasts indefinitely. He explained that you need to pass a medical every five years. There is no ongoing assessment of competence.

[152] Mr Palmer stated that when he was a deckhand there was not much man overboard training. He said there was not much during the skipper training either. He said that there was not any annual man overboard training. He could not actually remember any man overboard training being carried out during his skipper training. He stated that he and his colleagues knew how to go about doing man overboard drill from discussing it and from doing sea survival training. However, they did not do drills at sea at all. He explained that he had carried out sea survival training when he was a fisherman. He was a fisherman for twelve years before starting to work on fish farms. He stated there had been general discussion of man overboard drills as part of that. He had to be aware of man overboard drills when he was a fisherman. He confirmed that the sea survival training qualification lasts forever too. He thought that there was a newer version of the training which might need to be refreshed every three years or so. He confirmed that he had carried out his sea survival training years before joining MOWI.

[153] Mr Palmer confirmed that he knows Mr Nairne. He was not aware what skipper qualification Mr Nairne had. He accepted that Mr Nairne might have received different skipper training. He stated that Mr Nairne had been at sea a lot longer than himself.

[154] He explained that he remembered brief discussions about man overboard training during his sea survival course and that he had chatted about it with colleagues while he was a fisherman. He confirmed that he had not done any man overboard training on the net boat that he worked on as a deckhand. Nor did he do with any man overboard training on the first boat that was skipper for. Nor did he recall doing any man overboard training on the *Beinn na Caillich*. Any knowledge that he had of man overboard drills was mainly from the time that he was fisherman.

[155] Mr Palmer advised that a lot of man overboard training been done since the incident. He stated that he did feel comfortable at the time of the incident that he knew what to do in a man overboard situation, but commented that no one expects you will never have to do it. He had been at sea for a long time before the incident and had never had to do so.

[156] Mr Palmer confirmed that he was given personal protective equipment by MOWI. He explained that the personal protective equipment available was a Fladen suit or two piece oilskins. The Fladen suit used a horseshoe lifejacket and the oilskins a waistcoat lifejacket. These were all available from their employers. It was easy to reorder equipment if a replacement was needed. He explained that a lot of the time he used oilskin trousers and a waistcoat lifejacket. He found the Fladen suit too bulky.

[157] Mr Palmer stated that all the horseshoe and waistcoat lifejackets have crotch straps. He confirmed that it was compulsory to wear a lifejacket at sea or when working over water and that every buckle should be fastened. He said these instructions came from MOWI. He stated that he had seen employees with the crotch straps not done up,

although he said that the majority of the time people did do them up. He explained that some people got a bit lax. You did sometimes see crotch straps loose. He stated that he always used the crotch straps.

[158] Mr Palmer explained that the crotch straps are there to keep the lifejacket on if you go into the water. He stated that he would expect colleagues to wear them. I f the buckles break it was simple to order a new lifejacket and use a replacement in the meantime. There were always spares for crews that were off shift. It would be possible to use one of their lifejackets under a new one arrived. You should not wear a life jacket that was broken.

[159] He confirmed that as skipper he was the 'driver' of the vessel. The skipper was responsible for the vessel and anyone on it. By 2020 he knew how to pilot vessels and was experienced in doing so.

[160] The *Beinn na Caillich* worked mainly in Loch Alsh. There were three fish farm sites close by. Mr Palmer said that the *Beinn na Caillich* moved around the three farms, assisting with tasks, moving staff and equipment. He stated that the vessel was not often used to move staff because they always had access to fast boats, PCs, themselves. However, sometimes he moved staff. He stated that before 18 February 2020 he had moved staff a few times from pens to the Sea Cap.

[161] Mr Palmer stated that he started work at 6.30 am on 18 February 2020 at Ardintoul. There were about 10 people working and three boats. His boat was assisting the treatment boat. He explained that two work boats are necessary to carry out treatment. Lice treatment was being carried out at pen 10. He confirmed that there are

12 fish pens and the Sea Cap. The Sea Cap is a store for the fish food and provides break facilities for the staff. It is fixed in place.

[162] Mr Palmer stated that at about 3 pm he picked up Mr Nairne and his crewman to give them a lift back to Kyle. They had been working on another boat and were leaving it tied up for the night. One of the PC's was working on the fish pens and the other was at the shore base. Mr Henry asked for a lift from pen 10 to the Sea Cap. Mr Palmer could not recall if Mr Hendry asked for a lift or if someone else mentioned it.
Mr Hendry was on the same pen they were. He asked them to take him to the Sea Cap. He transferred onto their boat. They were tied up against the pen. The boat was stationary.

[163] Mr Palmer described two gates on the *Beinn na Caillich*. They are approximately 55 centimetres wide. Mr Henry came across from the pen through one of those gates. Mr Palmer stated that if transferring from boat to boat the ropes would be tied up. If transferring to the pen the vessel will go alongside, someone would go out onto the pen and secure the boat with two ropes. He stated that he normally tied up to the Sea Cap for any length of time because of the tides in the area. He would certainly tie up if stopping for lunch or to collect. He explained that the *Beinn na Caillich* has a high gunwale and people jump onto the boat. Normally they would tie at least one rope on the back to keep the vessel alongside the Sea Cap. That process is commonly understood by colleagues and they had done it a few times. He explained that the Sea Cap is round, not square, so it is more difficult to tie up to. It is also very tidal at that

location. He explained that everyone would know that. The tide can move the boat if there is a strong current. A vessel might drift or swing in tidal waters.

[164] Mr Palmer stated that once everybody was aboard at the pen they headed round to the Sea Cap. He stated that the Sea Cap is only a couple of minutes away even when going slowly. He was referred to Figure 2 in the MAIB report and confirmed that they sailed from pen 10, round the outside of pens 12, 11, 9 and 7 towards the Sea Cap. The weather and the sea conditions were pretty calm. They were going quite slowly, probably 3 to 4 knots at most. He confirmed that that is quite a slow speed, not much more than tick over. He stated that the pipes leading from the Sea Cap to the pens are all on the inside. There are no real obstructions on the outside of the pens.

[165] He stated that Mr Nairne was in the wheelhouse with him for a chat. He thought that his crewman and Mr Nairne's crewman were both on deck. He found out later that they had been in the galley. Mr Hendry came up to the door of the wheelhouse. The three of them had a chat. As far as he recalled it was mainly about what had been happening that day and the weather. He did not recall any discussion about Mr Hendry's transfer to the Sea Cap. Mr Hendry was only up at the wheelhouse for about a minute and then went back down the stairs to the deck. They were about 30 seconds from the Sea Cap when Mr Hendry went back down to the deck.

[166] Mr Palmer stated that he intended to bring the *Beinn na Caillich* alongside the Sea Cap and see how it was sitting before anyone got off. That is what he would usually do. He explained that it was his usual practice, and his intention that day, to bring the middle of the gunwale of the *Beinn na Caillich* to a halt opposite the ladder on the Sea

Cap. Many of the MOWI boats have an open side but the *Beinn na Caillich* has a closed side, with two access doors. Once alongside the Sea Cap the top of the *Beinn na Caillich's* gunwale rail is about level with the deck of the Sea Cap, depending on tide and how much feed is stored in the Sea Cap, which effects how high it floats out of the water.

[167] Mr Palmer was referred to the photograph of the *Beinn na Caillich* on the first page of the MAIB Report and identified the two gates in the gunwale rail. The gates are in the closed position in the photograph. Mr Palmer confirmed that it was usually always the same side of the boat, the right or starboard side, which he brought up against the Sea Cap or the pens. The right side of the boat is the one shown in the photograph. Mr Palmer explained that when coming alongside the Sea Cap he would usually bring the gunwale rail between the two gates alongside the Sea Cap ladder as it was difficult to line the gates up with the ladder as they were quite narrow. Once alongside someone transferring to the Sea Cap would put their knee on top of the gunwale rail, which I about waist height from the deck of the *Beinn na Caillich*, and then hoist themselves up onto the Sea Cap. The ladder and the gunwale rail would be about 6 inches apart. The top of the gunwale rail is rounded and is about a third of a foot wide. He described this as being the normal way of transferring and the way he expected that Mr Hendry would transfer on that day. He expected Mr Hendry to know that r to remember how it had been done before.

[168] Mr Palmer confirmed that however the transfer was to be done, it should not be done until the boat stopped moving. There should never be a transfer with the boat in motion. If the boat was still moving there was no guarantee that the boat and the other

structure would keep together. He stated that it was not and never had been acceptable to transfer while the boat was moving.

[169] Mr Palmer said that he saw Mr Hendry go to the side of the boat, near the forward gunwale gate. Both of the gates were open. They were usually left open if just moving round the outside of the pens. They were closed for transiting open water. If an experienced crewman was on duty they would have shut the gates without having to be told to do so. However, they were sometimes left open. Mr Palmer thought that Mr Hendry was facing down towards the deck. He was wearing his personal protective equipment with a waistcoat style lifejacket. He could not say whether the crotch straps were fastened.

[170] Mr Palmer stated that as the *Beinn na Caillich* came alongside, flush with the Sea Cap, Mr Hendry went for the ladder out of the forward gate as the boat was still creeping along. He saw that just as it happened. He was not expecting it. Mr Nairne was still in the wheelhouse. It all happened very quickly. Mr Hendry had two hands on the ladder and looked like he was in a lot of pain. Mr Palmer thought that Mr Hendry had been caught between the D shaped defender at the side of the ladder and the gate post of the gunwale gate. He thought that the boat was probably moving at half a knot. To stop a boat you put the engines into reverse to bring the forward motion to a halt.

[171] He said that the boat was still creeping forwards. He had not yet reversed the engines. He was waiting for the middle of the gunwale to be level with the ladder. He was very surprised by what Mr Hendry had done. He said that Mr Hendry had not said that he would go out of the gate. He did not recall any discussions about tying the boat

up. If the boat was going to move or drift when stopped they would put a stern rope on and then keep it alongside with the engine. An experienced crewman would know that. As he came alongside the Sea Cap Mr Palmer did not know that the crewman was in the galley.

[172] Mr Palmer was referred to Figure 3 in the MAIB Report and confirmed that the ladder in the photograph was the one he had been describing. He brought the *Beinn na Caillich* flush alongside the ladder. That was the ladder he saw Mr Hendry holding on to. Mr Palmer said that he moved the boat just off the Sea Cap and someone on the Sea Cap, Mr Mackenzie, came out and grabbed Mr Hendry by the top of his lifejacket. He was holding the lifejacket by the shoulders. After a brief period, maybe a minute of two, Mr Hendry lipped out of this lifejacket and fell into the water. Mr Palmer was trying to keep the boat close to the Sea Cap, but not too close.

[173] Mr Palmer did not think that Mr Hendry went under the water, but he no longer had his lifejacket on. Mr Palmer lowered the bow ramp of the *Beinn na Caillich* and the other people on board grabbed Mr Hendry. A PC boat was coming round. The crew pulled Mr Hendry onto the PC. Mr Palmer was still in the wheelhouse of the *Beinn na Caillich*, controlling the vessel. He was keeping it from getting too close to the Sea Cap. Everyone was trying their best to help. It all happened very quickly and was not what anyone would expect.

[174] Mr Palmer was aware that CPR was being carried out on Mr Hendry. Mr Nairne came back up to the wheelhouse at that time. The PC started heading to Kyle to meet up with the treatment boat, the *Beinn Bhreac*. They tied the *Beinn na Caillich* up alongside

the Sea Cap. He described Mr Nairne as having been in a state of shock and high adrenaline when he came back up to the wheelhouse. Mr Mackenzie had been on the VHF radio but Mr Nairne took over when he came back to the wheelhouse. Mr Palmer described being in a lot of chock himself. He understood that Mr Hendry was transferred to a lifeboat and taken to shore, where he was taken to hospital by ambulance.

[175] Mr Palmer confirmed that Mr Hendry was struck almost instantly when he stepped out of the gate onto the ladder.

[176] He confirmed that there is a bit of a delay getting a boat to stop or reverse but stated that it is possible to stop pretty quickly if the boat is going very slowly.

[177] Mr Palmer accepted that the right hand fender was missing from the Sea Cap. He stated that the Beinn n Caillich would not be up against both tenders unless they were tied up and the boat was swinging. They came in flush to the ladder. The missing fender made no difference to the way he approached the Sea Cap. He would have approached in the same way if the fender was there or not there.

[178] Mr Palmer described the adverse effects the incident have had on him personally.

[179] In cross examination by Mr Rodgers Mr Palmer stated that he did not really remember any conversation but he knew that Mr Hendry was looking for a lift to the Sea Cap. He thought someone might have said that Mr Hendry was going for a late lunch. That situation was not unknown and people had asked for lifts on the *Beinn na Caillich* on a few occasions. He did not recall any discussion about how Mr Hendry

would get off the boat. He did not recall Mr Hendry saying not to tie up and he would just jump off. Mr Hendry left the wheelhouse and went down to the deck as Mr Palmer was moving close to the Sea Cap.

[180] Mr Palmer stated that he expected Mr Hendry to wait until the boat stopped moving and he told him to go once they had tied up securely. He never thought that Mr Hendry would go before the boat stopped. He confirmed that they would normally tie up with the ladder between the gunwale gates. He said that he intended to take the gate Mr Hendry was standing at past the ladder and stop with the ladder in the middle of the gunwale. He expected Mr Hendry to climb onto the gunwale, grab the ladder and step up onto the Sea Cap. Mr Palmer again described the process of jumping onto the gunwale rail with your knee, grabbing the railings of the ladder and going up from there. He stated that there was not much of a gap between the ladder and the gunwale when the boat is alongside. It is quite hard to line the ladder up with the gate if not tied up. He accepted that this process might sound more dangerous than using the gate but explained that it was easier than using the gate when tied up. The gate opening is lower than the gunwale rail so there is further to climb and it is easier to tie the boat up if brining the gunwale alongside. That was how he always did transfers alongside the Sea Cap.

[181] Mr Palmer confirmed that the Sea Cap rises and falls vertically up and down in the water, to an extent, depending how much fish food is stored in it. The height difference between the gunwale rail and the ladder would therefore vary depending on circumstances.

[182] He stated that it took him by surprise when Mr Hendry used the gate while the boat was still moving. The boat was not in the correct position. Mr Palmer intended to be a bit further along. Mr Hendry went earlier than Mr Palmer was anticipating.

[183] Mr Palmer described seeing Mr Hendry grab the ladder with both hands and he thought that he had a foot on the ladder too. Mr Hendry was facing inwards, towards the Sea Cap. He was only o the ladder for 10 or 15 seconds, maybe only 10 seconds before it was clear there was a problem. Mr Palmer could hear Mr Hendry he was in pain. Mr Mackenzie had come out of the Sea Cap because he had heard something. It all happened very quickly. When Mr Hendry stepped out of the gate he must have been caught between the boat and the black D shaped defender at the side of the ladder. Mr Palmer was in the wheelhouse when it happened and the window was open. He heard Mr Hendry. That was when Mr Nairne went down to the deck. Mr Palmer heard Mr Hendry shouting in pain. Mr Mackenzie cam e out of the Sea Cap. Mr Palmer stayed in the wheelhouse to keep control of the boat.

[184] Mr Palmer said that he know something was wrong because of the noise Mr Hendry made. He must have been pinched as soon as he stepped off the boat. He made the noise 10 or 15 seconds later. Mr Mackenzie cam e out of the Sea Cap after the noise, as Mr Nairne was going downstairs.

[185] Mr Palmer stated that normally if there was a proper crewman on board the crewman would be on deck during a transfer. He wouldn't normally go into the galley at that stage. His crewman that day was a farm technician, not a deckhand. He didn't think the deckhand would go into the galley until the boat was secure. The gates were

open and they should have been shut. He would expect a crewman to know that and to know to be on deck for transfers.

[186] Mr Palmer stated that he was not familiar with a process called touch and go transfers.

[187] He confirmed that the skipper is the person in charge of a vessel. He did not recall any conversation about how Mr Hendry would disembark. He assumed Mr Hendry would know what to do.

[188] Mr Palmer stated that he did not know that the fender on the right was missing from the Sea Cap on his approach. It must have gone missing before he came on shift. He discovered afterwards that it was not there. He stated that the tyre fenders are mainly for when a boat is being tied up, in case the boat swings and hits the Sea Cap, potentially causing damage to the Sea Cap or the boat. The fenders are to protect against damage.

[189] Mr Palmer described the two D shaped defenders on either side of the ladder. He was not entirely sure what they were for. He thought they might be to prevent the metal of the ladder rom damaging the plastic sides of smaller boats. He could not say whether the fenders and defenders were all flush with each other or not, or whether they were meant to be flush.

[190] He stated that before 18 February 2020 he had not received any man overboard training or done any man overboard drills while employed by MOWI. He never did any risk assessments for transfers or anything like that. He had never done any risk

assessments for any vessel. He could not remember being told to close the gunwale gates but such an instruction might have been given. They did it anyway, for safety.

[191] Mr Palmer stated that after Mr Hendry's death there had been a big change, particularly in relation to man overboard drills and the provision of rescue poles. There are poles on all vessels. The pole has an adjustable loop on the end. The pole can be used to pull someone out of the water into a boat or attached to the cranes fitted to some boats, like the *Beinn na Caillich*, and lift someone out of the water that way.

[192] There was no cross examination of Mr Palmer by Mr Gray KC and no re-examination by Ms Gillespie.

Evidence of Douglas Mackenzie

[193] Mr Mackenzie gave evidence on 20 March 2024. Mr Mackenzie adopted the terms of a statement which he gave to the police on 9 March 2020. That statement has been lodged as Crown Production 18. The statement was read into the record by Ms Gillespie.

[194] In that statement Mr Mackenzie confirmed that as at March 2020 he had worked for MOWI for about a year as a fish farm technician. Mr Hendry was a work colleague. On 18 February 2020 Mr Mackenzie was engaged in treating the fish in the pens at Ardintoul for lice. He described the personal protective equipment issued to him by MOWI and stated that the use of such equipment was mandatory.

[195] He described the Sea Cap and stated that he and some colleagues had lunch on the Sea Cap. He remained on the Sea Cap monitoring the pens by CCTV camera while

his colleagues attended to other duties. At around 13:30 or 14:00 hours he heard a shout. He went out of the cabin on the Sea Cap and saw Mr Hendry struggling and distressed trying to keep his balance on the access ladder to the Sea Cap.

[196] Mr Mackenzie ran over to assist Mr Hendry. He put his hands under Mr Hendry's arms to assist him. Mr Hendry said that he could not get up and indicated that his legs were not working. Mr Hendry had his arms wrapped around the railing of the access ladder. Mr Mackenzie was crouching down to help him.

[197] Mr Mackenzie described how Mr Hendry released his left arm from the ladder and slipped down out of his life jacket, entering and going under the water before coming back to the surface and floating on his back. He appeared to be in a trance. The *Beinn na Caillich* was about four feet away. He say them lower the bow door and use a boat hook to get hold of Mr Hendry. The crew were unable to lift Mr Hendry onto the bow door.

[198] Mr Mackenzie ran into the cabin on the Sea Cap and made a radio call to his colleagues to come back to help. They were at one of the fish pens and arrived quickly in a PC. He saw that the PC pulled alongside the bow of the *Beinn na Caillich* and his colleagues in the PC were able to get Mr Hendry aboard.

[199] He stated that they tried to keep Mr Hendry warm and started CPR. Mr Mackenzie contacted the RNLI by radio and alerted them to a 'man overboard' situation. He provided details by radio. Mr Mackenzie threw some Fladen suits down to the PC to try to keep Mr Hendry warm.

[200] He stated that the crew on the *Beinn na Caillich* took over radio communications with the RNLI. The skipper of another MOWI vessel, the *Beinn Dearg*, radioed to say he had a defibrillator on board and was coming back to help. Mr Mackenzie saw the PC containing Mr Hendry rendezvousing with the *Beinn Dearg* and the RNLI lifeboat and shortly thereafter the RNLI lifeboat returning to shore.

[201] Mr Mackenzie contacted the manager of the Ardintoul fish farm to tell him what had happened. Mr Mackenzie stayed on the Sea Cap until he was picked up later by PC. He was informed that Mr Hendry had not survived.

[202] He confirmed that he had known Mr Hendry for about two years and considered him a very experienced worker who knew the local tides and everything about the fish farm. He had never seen Mr Hendry do anything which was unsafe. On the day of his death Mr Hendry was wearing oilskins and a life jacket. Mr Mackenzie explained that each employee is issued with their own kit. Mr Mackenzie normally wore a Fladen suit but Mr Hendry always wore a life jacket as he felt the suit restricted his movements. Mr Mackenzie could not say why Mr Hendry had fallen out of his life jacket, unless he had not been wearing the crotch straps on his life jacket. At the time it was not mandatory to do so but that became a requirement after Mr Hendry's death. He had heard that Mr Hendry had been crushed while getting of the boat onto the Sea Cap but he did not see that happen himself.

[203] There was no cross examination of Mr Mackenzie by Mr Rodgers or by Mr Gray KC and no re-examination by Ms Gillespie.

Crown Submissions

[204] On behalf of the Crown, Ms Gillespie made formal submissions in relation to Section 26 subsections (2)(a), (2)(b) and (2)(c) of the 2016 Act. These are in accordance with the evidence and I largely adopt these submissions in my formal determination at the beginning of this document.

[205] In relation to Section 26(2)(d), the cause or causes of the accident resulting in Mr Hendry's death, the Crown proposed two causes. The first was Mr Hendry transferring from the *Beinn na Caillich* to the Sea Cap while the *Beinn na Caillich* was still moving. On the basis of the evidence available there is a clear causal link between this failed transfer between the vessel and the Sea Cap and I reflect this in my finding under this subsection at the beginning of this document. The second cause which the Crown propose is Mr Hendry's failure to secure the crotch straps of his lifejacket, resulting in him entering the water without the benefit of a personal floatation device. Very properly, the Crown did not suggest that had the crotch straps of Mr Hendry's lifejacket been secured that they would have prevented him from falling into the water. The evidence was that the crotch straps are not intended to be weight bearing. Their purpose is to secure the lifejacket in the correct position on the wearer in the event of immersion in water. While the failure to secure the crotch straps, and to ensure their use, is very relevant to Mr Hendry's death I am not satisfied that it is a causal factor in the accident. Accordingly, I deal with this matter under Section 26(2)(g) above, rather than Section 26(2)(e) as the Crown suggest.

[206] In relation to Section 26(2)(e), reasonable precautions that might prevent the death or accident from occurring, the Crown highlighted the lack of a risk assessment and safe system of work for transferring from vessels to structures. Ms Gillespie also highlighted the lack of a clear policy in relation to the correct use of personal protective equipment. It was also suggested that while there was no evidence that any of Mr Hendry's colleagues reacted on the day with anything other than the best of intentions there may be merit in training in rescue techniques. I agree with the Crown submissions in relation to risk assessment and safe systems of work. I consider that the proper use of lifejackets and man overboard training can more properly be dealt with under Section 26(2)(g), as noted above.

[207] The Crown did not make any submissions in relation to Section 26 subsections (2)(f) or (2)(g) of the 2016 Act and did not suggest that any recommendations be made in terms of Section 26(1)(b) of the 2016 Act.

Submissions on behalf of MOWI

[208] On behalf of MOWI, Mr Gray KC broadly concurred with the Crown submissions in relation to Section 26 subsections (2)(a), (2)(b) and (2)(c). He identified Mr Hendry stepping from the *Beinn na Caillich* to the Sea Cap while the *Beinn na Caillich* as the cause of the fatal accident, in terms of Section 26(2)(d).

[209] Mr Gray KC submitted that a reasonable precaution, in terms of Section 26(2)(e) of the 2016 Act would have been for Mr Hendry to have waited until the *Beinn na*

Caillich was stationary before attempting to transfer to the access ladder of the Sea Cap. That is factually correct, but in the circumstances of this particular case Section 26 subsections (2)(e) and (2)(f) must be considered together, as Mr Gray KC rightly recognised in his submission under section 26(2)(f) where he accepted that prior to the fatal accident leading to Mr Hendry's death MOWI did not have a clearly defined system of work for employees transferring from large vessels to structures such as the Sea Cap.

[210] MOWI did not make any submissions in relation to Section 26(2)(g) of the 2016 Act and did not suggest that any recommendations be made in terms of Section 26(1)(b) of the 2016 Act.

[211] In response to the Crown submissions, Mr Gray VC submitted that there was no evidential basis to suggest that if Mr Hendry had fastened the crotch straps of his life jacket it might have prevented his death. As discussed at paragraph [206] above, I concur with that interpretation of the evidence.

[212] In response to the submissions on behalf of Ms Lockhart, Mr Gray KC submitted that recommendations under Section 26(1)(b) of the 2016 Act ought properly be directed towards steps or actions which have not yet been taken and ought to be, rather than to re-inforce steps already put in place.

Submissions on behalf of Ms Lockhart

[213] On behalf of Ms Lockhart, Mr Rodgers concurred that the formal findings to be made in relation to Section 26 subsections (2)(a), (2)(b), (2)(c) and (2)(d) were largely

uncontroversial. He focussed his submissions of Section 26 subsections (2)(e) and (2)(f) of the 2016 Act. He drew attention to the lack of a suitable risk assessment or safe system of work for transfer of personal to the Sea Cap. Mr Rodgers submitted that the evidence did not support the conclusion that use of the lifebelt crotch straps would have prevented Mr Hendry from falling into the water but noted that their use had been made mandatory by MOWI after Mr Hendry's death.

[214] Mr Rodgers submitted that it would be appropriate to make a recommendation under section 26(1)(b) of the 2016 Act to the effect that MOWI continue to drive the message that 'touch and go' transfers are not permitted and that the master of the vessel from which a transfer is taking place retains the responsibility for the "concoction of an effective plan, and the execution thereof" for the transfer. He submitted that MOWI should also be recommended to re-inforce the message that bulwark gates must remain closed while vessels are moving throughout all sites and lifejackets are worn fully fastened, including crotch straps. I discuss aspects of these proposed recommendations at paragraphs [218], [221] and [225] below. These matters are reflected elsewhere in this Determination and I am not persuaded that it is necessary to make formal recommendations in that regard.

$camon $cotland

[215] On 11 March 2024 a fifty three page document bearing to be from a group described as $camon $cotland (formerly Scottish Salmon Watch) was sent to the Crown, although addressed to the inquiry. Having taken Crown Counsel's instructions Ms

Gillespie disclosed this document to the other parties to the inquiry and to the inquiry. The document refers to Don Staniford. A person of that name observed the inquiry proceedings from the virtual public gallery. At no point did $camon $cotland seek to enter the inquiry as a party to the inquiry. The document was not referred to by any of the parties to the inquiry. Its contents do not form part of the evidence presented at the inquiry and I have taken no account of the document in reaching this Determination.

Discussion and Conclusions

[216] The factual circumstances in this tragic case are fairly clear and were not disputed by the parties. Indeed the core circumstances were agreed by joint minute. The parole evidence of the witnesses did not materially add to the joint minute other than providing background and detail. I accepted the witnesses who gave evidence as credible and reliable. They were clearly trying to provide their best recollection of a traumatic event which took place some time ago. The emotional effect on the witnesses of this tragic accident was still very evident. Recounting the incident in detail was plainly traumatic for them. I trust that hearing and seeing their first-hand accounts of events has been of some assistance to Ms Lockhart.

[217] It is also very clear from the evidence, and has already been accepted by MOWI in their plea of guilty by Section 76 indictment, that there were significant failings in this case by the company, primarily in relation to risk assessment and the provision of a safe system of work. The point of this inquiry is try to ensure that such failings do not occur

again. The evidence of Mr Nairne was particularly helpful in relation to what when wrong, and why.

[218] He described how transfers from boats to structures were a routine part of daily life at a fish farm. These were normally from the smaller PC boats. The challenges and risks involved in transferring from the larger workboats like the *Beinn na Caillich* were very different. Transfers involving the larger boats were less frequent. He felt that complacency played a part in events. He clear expectation was that the *Beinn na Caillich* would pull up with one of the bulwark gates opposite the Sea Cap access ladder and once stationary, Mr Hendry would step across. Mr Nairne did not really expect the *Beinn na Caillich* to tie up and from his description of the comments made by Mr Hendry, nor did Mr Hendry. It can be assumed from Mr Hendry's position at the bulwark gate and his decision to step through it that he anticipated that the transfer would be through the gate onto the ladder. In contrast, Mr Palmer's evidence was that he intended to bring the *Beinn na Caillich* alongside the Sea Cap with the Sea Cap access ladder mid-way between the two bulwark gates on the *Beinn na Caillich* and Mr Hendry would then have climbed onto the bulwark rail and accessed the ladder that way. There was clearly no clarity between the personnel involved, particularly between Mr Hendry and Mr Palmer as to what would happen. If the operation had been properly risk assessed in advance and a safe system of work mandated, as has now been done, this accident should not have happened.

[219] It was put to Mr Palmer in cross examination by Mr Rodgers that climbing onto the bulwark rail was inherently more risky that exiting through the bulwark gates and

he disagreed with that proposition. I have to say that there appeared to me to be some force in Mr Rodgers point and I note that the system of work instituted by MOWI post accident, benefiting from a full risk assessment, mandates a very different approach, much more in line with Mr Nairne's expectations but with the clear acceptance and instruction that the vessel must be stationary before any transfer and the requirement that the vessel must be tied up. Both of these requirements appear eminently sensible and, with the benefit of hindsight, very obvious.

[220] In his submission on behalf of Ms Lockhart, Mr Rodgers suggested that the master of the vessel "retains responsibility for the concoction of an effective plan, and the execution therefor." I do not accept the first part of that contention. Plans should not be "concocted" on the spot by the mater of the vessel or anyone else. There should be a clear, safe, system of work thought out in advance, properly distributed so that all personnel know what it to happen and monitored to ensure that the approved system of work is being complied with. It is certainly true, and well established in maritime circles, that the mater of a vessel holds ultimate responsibility and authority in relation to the operation of the vessel and the safety of both the vessel and all on board. I do not consider that it is necessary to make a recommendation in that regard. The master is certainly responsible for ensuring that the approved system of work from transferring to and from his vessel is observed.

[221] The circumstances of Mr Hendry's death serve to re-emphasise the well-known but oft forgotten point that routine, low level, none core activities can carry just as much risk and require just as much fore thought as an unusual, out of the ordinary activity

which is given special planning. That requirement is backed up by common sense, as much as by the Health and Safety at Work etc. Act 1974. Complacency can prove fatal.

[222] Mr Hendry's death raises three other matters which although less directly related to the fatal outcome of this accident are nevertheless points to consider for the future.

[223] The first and most important of these relates to the proper use of personal protective equipment, particularly lifejackets. MOWI issued appropriate lifejackets to their employees and required that they be worn. However, until Mr Hendry's death, whether to use the crotch straps fitted to those lifejackets was left to the discretion of the wearer, with the proviso that if they were not sued they must be tucked up to avoid becoming a snagging hazard. From the evidence it was clear that the use of crotch straps on MOWI sites and generally in the fish farm industry was variable at best. MOWI have now made the use of crotch straps use mandatory on their sites. This was a clear failure, highlighted by Mr Hendry's death, but not contributing to it. Had Mr Hendry been wearing his crotch straps the evidence is that they would likely have broken with the result he would still have fallen into the water without a lifejacket. The crotch straps are not designed or intended to be weight bearing. However, had he entered the water wearing his lifejacket its effectiveness would have been reduced due to the crotch straps not being fastened and that could have had grave consequences in itself. It is not unusual for failures to either use, or use properly, personal protective equipment to be explained by the equipment being restrictive or uncomfortable. Discomfort is preferable to death or injury. Personal protective equipment should be properly used and steps taken by employers to ensure that that is so.

[224] This also re-enforces the point that systems of work are only as good as the compliance with them and that steps need to be taken to monitor and ensure compliance.

[225] While it is not open to me to speculate, the potential consequences of failing to use the crotch straps correctly are fairly clear to see. Failure to properly use, or enforce the use, of personal protective equipment, especially lifejackets, is often at the core of fatal accident inquiries. I consider it appropriate to use the circumstances of Mr Hendry's death to highlight those issues once more.

[226] The second matter relates to man overboard training. While there is no evidence before the inquiry that Mr Hendry's colleagues could or should have done anything different in their efforts to recover him from the water it was clear to me from the evidence that the witnesses did not feel confident about recovering him from the water. Had training been provided in advance their response might have been more confident and come more as second nature rather than conscious decision taken in stressful circumstances. MOWI's decision to provide man overboard training is to be commended but training of that kind need to be repeated for new employees and refresher training provided regularly to existing employees. The provision of an improved rescue pole, described in paragraph [71] above, is commendable but regular training needs to be carried out by employers in MOWI's position to ensure that it can be used as effectively and efficiently as possible.

[227] The third matter relates to the bulwark gates on vessels similar to the *Beinn na Caillich*. Mr Rodgers submitted that a recommendation be made that MOWI re-inforce

the message that such gates must be kept closed as vessels are moving throughout fish farm sites. The evidence before the inquiry was that the gates were expected to the closed if the vessel were transiting open water but not necessarily if it were moving around the fish farm site. I do not consider that the fact that the gate was open played a particular part in the circumstances of this accident. All the evidence is that Mr Hendry intentionally exited through the open gate. He did not fall or stumble through the gate which happened to be open. Nevertheless, best practice is clearly for such gates to be closed any time they are not being used, no matter how short any journey is.

[228] In closing this Determination, may I once again express my condolences to the family and friends of Mr Hendry. He was clearly very well thought of and respected by his colleagues and I have no doubt that he is still sorely missed by all who knew him.