OUTER HOUSE, COURT OF SESSION

[2021] CSOH 92

PD1159/15

OPINION OF LORD SANDISON

In the cause

DEBBIE WARNER

Pursuer

against

SCAPA FLOW CHARTERS

Defender

Pursuer: Milligan, QC, Pugh; Digby Brown LLP
Defender: Smith, QC; Brodies LLP

3 September 2021

Introduction

[1] The late Lex Warner was born on 15 April 1962 and died on 14 August 2012. On that date, he suffered a fall aboard the vessel *MV Jean Elaine*, which was owned and operated as a dive support boat by the defenders, and subsequently died after diving from the boat. The skipper of the boat was Andy Cuthbertson, who operates the defenders as a sole trader.

[2] This action for damages in respect of Mr Warner's death is brought by his widow Debbie on behalf of their son Vincent, who was nine months old at the date of his father's death. All questions of liability are matters that are in the circumstances already set out governed by the Convention Relating to the Carriage of Passengers and their Luggage by

Sea 1974 (the "Athens Convention"), given force in domestic law by section 183 of the Merchant Shipping Act 1995 and applied to domestic carriage by the Carriage of Passengers and their Luggage by Sea (Domestic Carriage) Order 1987. Moreover, it is the terms of the Athens Convention as at 14 August 2012, rather than those terms as they were subsequently substantively amended, which fall to be applied.

[3] In the event of the defenders being found liable to make reparation to the pursuer, the quantum of damages is agreed in the sum of £290,000 inclusive of interest to 20 April 2020. Although the defenders stated a case of contributory negligence in the pleadings, they explicitly departed from it in their submissions, and accordingly the matter proceeds on an "all or nothing" basis.

[4] A proof in the case was heard between 15 and 23 June 2021. The evidence was heard principally by way of WebEx facility, save that the equipment demonstration and evidence of Eugene Farrell, and the oral evidence of Mr Cuthbertson, was taken in person on the first day of the diet. Submissions were made in writing and amplified orally via WebEx.

Agreed matters

[5] In addition to various technical matters concerning the evidence, the parties agreed the following facts by way of Joint Minute:

[6] On 14 August 2012 the *Jean Elaine* had travelled with nine recreational divers on board, including Mr Warner, to a dive site approximately 15 miles north-west of Cape Wrath, in order to find an unnamed wreck and to enable the divers on board to make a technical exploratory dive to it. The skipper Mr Cuthbertson and a deckhand, Allan Stanger, constituted the crew on board. "Technical" diving is a specialist subcategory of recreational

diving, which uses specialist equipment to permit diving to substantial depths otherwise generally unachievable.

[7] Having arrived at the dive location, each of the divers commenced putting on his diving gear. Each diver was responsible for his own equipment and putting it on. The equipment that Mr Warner and other divers had available included a "rebreather" system, a dry suit, and additional air and gas tanks in various mixes, two of which were intended to be attached to the side of the divers' bodies, with one to each side. The equipment also included diving fins (i.e. flippers worn on the feet). Mr Warner put on his diving gear while at a central location on the boat. Shortly after 4pm, while wearing his full diving gear including heavy equipment strapped to his back, front and sides and while wearing fins, Mr Warner fell onto the deck of the boat. As a result of the fall, he suffered internal injuries, but at the time it was unknown to anyone that he had suffered those injuries, or indeed any material injury. After the fall, Mr Warner was helped back to his feet by the crew of the boat. He was asked if he was fit to dive; he stated that he was and thus elected to continue with his dive.

[8] Having descended to a depth of about 88m, Mr Warner unexpectedly commenced an ascent. At about 60m, he was seen to be in difficulty. He attempted to take in air to rise to the surface. He was assisted by three divers to do so by use of a lifting bag, which resulted in rapid ascent to the surface, where he was found to have stopped breathing. He was evacuated by helicopter to Stornoway hospital, where he was pronounced dead at 18.55 hours. A post mortem was carried out and the relative report recorded Mr Warner's cause of death as "(1)(a) drowning due to or as a consequence of (b) recreational technical diving; and (2) traumatic hepatic injury with haemoperitoneum resulting from fall on dive boat."

The evidence

[9] The evidence in the proof was given orally and by way of the adoption of written reports or previous statements either in supplement of or in substitution for oral evidence. The narration of the evidence which follows groups it into various related topics or themes.

Evidence from those on the fatal trip

The divers

[10] **Neil Plant**, 47, an air ambulance paramedic, qualified to dive in 1998, went into technical diving in about 2001, and used to do about 50 technical dives a year before stopping in 2012. He had dived all around the world off dozens of different boats, in addition to having dived off the *Jean Elaine* on about three previous trips. He was an acquaintance of Mr Warner and had dived with him in quarries previously. The community of technical divers in the UK was not a large one, numbered in hundreds rather than thousands, and most knew each other to some extent at least.

[11] Mr Plant had known Andy Cuthbertson for four years before the fatal trip, and regarded him as a really good skipper who knew what he was doing, was very switched-on, and did not mess about. He had no safety concerns about Mr Cuthbertson's boat as a safe dive platform, or his operation of it. There was no shortage of handrails, and the deck was smooth. The skipper made the sailing decisions and whether it was safe to dive, but the group also had a say. No skipper gave instructions as to how equipment should be put on, whether that was fins or anything else. The skipper was not going around the deck giving instructions. Everyone was experienced and would point out anything obviously wrong with any equipment. Things were just done in a certain way because experience and common sense showed that that way worked. On the trip in question, there had been no

advice or instructions about using the handrails that he could recall; he was familiar with the boat and it was all fairly obvious. On the boat, everyone was personally responsible for health and safety. The skipper could not tell you to do something you were uncomfortable with. If he had instructed that fins should only have been put on at the exit, there would have been a discussion about it, but ultimately if the skipper insisted it would have been done, albeit the group might not then have patronised the boat in future.

[12] Technical divers knew their own equipment and took responsibility for it. Each diver chose his station on the boat and kept his equipment there between dives. Some divers kitted up relatively early for a dive time, others did not. Once the equipment was on, you could not see your feet. Every now and again someone would need help to stand up.

[13] Putting fins on after kitting up was not an option. Doing it at the gate would have caused too many problems, and getting assistance meant relying on someone else, which Mr Plant would not have been comfortable doing. Putting fins on in the water would be impossible; the bulk of the diving equipment prevented that. You put them on before walking to the exit point, and walked in a certain way. Walking with fins appears cumbersome, but you got around it, and the distances to be walked on deck are short. He would not walk with fins if he had the option not to do so, but in this situation it was the easiest and safest way to get into the water. If you had someone assist you to put your fins on, you would have to be confident that they knew the style of your fins and your preferences; he would not have been happy having someone else put his fins on for him. A technical diver's centre of gravity was changed by his equipment, but people became cat-like to some extent. He had seen people (including himself) lose their balance and stumble before, but not fall. No reasonable precautions could prevent that.

[14] Mr Plant was sitting, ready to go, on a bench on the port side of the boat, about 8 to 10 yards from the exit point, on the other side of the hatch cowling from Mr Warner, when the fall happened. He saw Mr Warner stand up and then his view of what happened was obscured by the cowling, but he then saw the upper half of Mr Warner's body aft of the cowling on the starboard side, on his hands and knees, then rolling to the side. It appeared that he had lost his footing and stumbled. He had not been particularly surprised that Mr Warner had fallen. He appeared to have gone about three feet from his seat before falling. Mr Plant could not help as he was already kitted up, he remained seated and thought nothing of it. The skipper and crewman asked Mr Warner if he was OK; he merely seemed embarrassed, and wanted to get into the water. Mr Plant had seen nothing to indicate a problem with Warner's breathing. He had not lost consciousness. If anyone had seen any blood, or signs of discomfort or pain, they would have told him not to dive.

[15] In cross-examination, Mr Plant said that he had not co-operated with Mrs Warner's solicitors as he had had threatening phone calls from members of the Warner family, disputing that he was telling the truth.

[16] **Paul Mee**, 49, a company director, had been diving from the *Jean Elaine* since 1995, and had been doing technical diving since 1994. He had met Mr Warner at diving conferences and had dived with him a few times. Mr Cuthbertson was a friend of his and Mr Mee had been diving from the *Jean Elaine* on perhaps 15-20 previous occasions, but had stopped diving after the incident in question.

[17] Mr Cuthbertson was a very safe skipper, a genius at what he did. Mr Mee had no concerns about the safety of the boat as a dive platform, or about the number or position of the handrails. No boat in the world had handrails guiding you all the way to the exit point, and this boat had more than many others did. Mr Mee could not remember if he was given

instruction about using the handrails. People new to the boat were told where things were. In his police statement taken on 15 August 2012, Mr Mee stated that the skipper gave no information about the dives, he just drove the group around.

[18] Everyone had their own kit routine and was responsible for their own kit. Mr Mee always put his fins on first, as it was very difficult after you had the rest of the kit on. He had never known anyone put on their fins at the exit point. He would not have been comfortable with someone else putting his fins on. Walking with fins would be slightly difficult without handrails or the deckhand to hold onto. It was perhaps seven steps from the position where Mr Warner had been sitting to the exit, four steps if he shuffled along the bench before standing up. Mr Mee was not uncomfortable walking in fins on the deck; you planned your route.

[19] Mr Mee had put on his gear on the middle bench next to Mr Warner, and when his turn to dive came had stood up and held the handrail on the hatch cowling to get closer to the exit point, then crossed the deck to it. The deckhand was available to help. Mr Mee had been in the water by the time of Mr Warner's fall, and had not seen it. He had seen Mr Warner during his ascent at around 70 metres. Mr Warner was struggling to keep his mouthpiece in place as the shot line which he was holding was hitting the pipe serving the mouthpiece. He was hyperventilating, breathing too fast for the unit. Mr Mee caught up with Mr Warner at about 55 metres, by which time he was lying flat and appeared "gone".

[20] **Matthew Phillips**, 47, self-employed joiner, had previously been diving from the *Jean Elaine* 12 or 13 times. He started diving in 1994 and had been doing technical diving since 1999. He had stopped in 2014, partly as a result of Mr Warner's death.

[21] He had no concerns about the safety of the *Jean Elaine*; the provision of handrails was much the same as on any other dive boat. Mr Phillips did not ever recall being instructed

about the use of handrails; it was just common sense to use them. The deck of the *Jean Elaine* had a little camber, and sloped up towards the bow on a shallow gradient. He had no concerns about Mr Cuthbertson's ability to run a safe operation; had it been otherwise, the group would not have returned year after year.

[22] Mr Phillips always put on his own kit, perhaps with some help. Once the side-mounted cylinders were on, it was very difficult to put on your fins. You can walk sideways or backwards in fins, you get used to it, or use the handrails or get help from someone on deck. You would not want to walk far in fins, and would not walk normally in them. Even without fins, you would not want to walk far with the weight of the kit. Someone could help you put your fins on – that would be your choice.

[23] He had been one of the last to go in the water on the day in question. The weather was pretty good, perhaps Beaufort 2 or low 3. He had been sitting on the port side getting ready and could not see the starboard side because his view was blocked by the hatch cowling. It was about 2 metres from where Mr Warner was sitting to the exit. He had heard the noise of Mr Warner falling, but had not seen the fall. He had then heard the skipper repeatedly asking Mr Warner if he was OK. By the time Mr Phillips was ready to enter the water, the incident was over and Mr Warner was already in.

[24] **Paul Warren**, 45, IT consultant, had met Mr Warner a few times on dive trips, but was not a close friend. He had made about 10 trips on the *Jean Elaine* previously, and had been technical diving for about seven years in 2012.

[25] Mr Warren had no concerns about the boat's safety; it felt as safe as any. He had no concerns about handrails, and could not really see how more could have been put in. Mr Cuthbertson was one of the best skippers, who was excellent at boat manoeuvring and put diver safety first.

[26] Mr Warren's own practice was to put on his fins after his hood, rebreather and side mounts, as about the last thing to put on. While movement was restricted with his rebreather and side mounts on, he had no difficulty in putting on his fins at that stage and had never needed assistance to do so. He could not imagine that many people varied from that order of things. You would do that at your station on a bench. Everybody chose their own station for a trip on a "first come, first served" basis. You then shuffled from your station to the exit. His own station had been in the middle of the port rail bench.
Mr Stanger was there to assist when you were getting ready, you could call him if you wanted.

[27] There was a short time window, maybe 20 minutes, to get everyone in the water, which was one reason why people did not adopt a two-stage approach by putting the rest of their kit on first and then their fins at the exit. Putting fins on at the exit point was a bigger task than one might imagine; it could add five minutes to each diver.

[28] Mr Warren had himself fallen on a boat before, but not often. He had dropped to his knees before too. His falls had been due to the movement of the boat. It is harder to move in equipment and fins, a combination of factors caused the difficulties. Falls were rare occurrences, but most people had taken a tumble from time to time.

[29] He was already in the water when Mr Warner fell. The sea was calm and there had been no swell. Mr Warren's police statement, taken on 15 August 2012, noted that he had assisted with the recovery of Mr Warner from the sea. He had been lying in his back in the water with his regulator out of his mouth. He had been unconscious at all times.

[30] **Jaymes Brown**, 37, an offshore worker, had been diving on the *Jean Elaine* two or three times previously and knew Mr Cuthbertson from having done so. He knew the other divers on the trip, some better than others. He did not know Mr Warner well.

[31] He had no concerns about the *Jean Elaine* or the skipper. There were enough handrails on the *Jean Elaine*, more than on some other boats. The handrail positions would be explained at the start of a trip, but not repeated. Mr Cuthbertson had told divers to use the handrails, that was common practice. He was quite strict about weather conditions, but had no concerns about the dive in question.

[32] The skipper would not tell a technical diver when to put his fins on. Mr Brown's practice was to put on his fins after his suit; otherwise, you would struggle. The order that divers put on their kit was a matter of personal preference. Most people tended to do it the same way as him, in his experience. Getting to the exit point in fins was a matter of ability and practice; some struggled, others did not, but there was no other way of doing it. That was what happened in every vessel he had been on. Doing it at the exit would not be very practical, and would require standing up and sitting down again. If you put fins on at the exit with the help of the deckhand, you still needed to stand on one leg, which put the deckhand at risk.

[33] Mr Brown had already been in the water when Mr Warner fell. Mr Warner had approached him in the water at a depth of about 60 metres and was ascending. He had aborted the dive and started to come up. On the descent he had appeared fine, but on approaching from below he appeared distressed, and was struggling with his buoyancy. He was breathing erratically and heavily, panicking and trying to drag himself up the shot line. Mr Brown also ascended and caught up with Mr Warner at about 50 metres where he tried to introduce more air into Mr Warner's dry suit via the inflation valve. Mr Warner appeared more calm. Mr Brown looked away for a moment to deal with his own equipment and when he looked back Mr Warner's mouthpiece was out, his mouth was open, and he was taking in water and drowning. Mr Brown attempted to put the breathing device from the

bail-out cylinder carried by Mr Warner into his mouth, but it would not open far enough to allow the valve in. After 5 or 10 seconds Mr Warner became unresponsive and convulsed. Mr Mee and Mr Phillips arrived on the scene and tried again to put the valve in Mr Warner's mouth, but it would not open and he was still convulsing. He was attached to a lifting bag and sent to the surface.

[34] **Greg Marshall**, 59, car mechanic, had known Mr Warner for two or three years, but not well. He had been involved in technical diving since 1995, and with full closed rebreathers since 2004. He dived about 30 or 40 dives a year over about 30 days, all over the world.

[35] He had been diving off the *Jean Elaine* for about 8 years, and had no concerns about the boat. He had no concerns about the handrails. Handrails were of limited use given the amount of equipment worn, which was cumbersome. People did not usually hold them; rather, they tended to stick their fins behind them as a storage place.

[36] He had no concerns about Mr Cuthbertson's attitude to safety. He gave a first day briefing. Mr Cuthbertson was in charge of the boat, the deckhand was in charge of the foredeck. He would help you get up if you needed it, but most did not. On the day in question the weather was calm, nobody needed help. Mr Cuthbertson steered the boat and told you what the dive time would be, not how or when to put your kit on. People could ask for help to get their kit put on, or to stand up.

[37] There was no standard practice as to when fins were put on. Mr Marshall put them on after his dive weights, others left it later. You did not ask the deckhand to put your fins on for you; you did not want them to be secured incorrectly and then fall off in the water. Walking in fins was not dangerous, you shuffled and did not lift your feet. Putting fins on

at the exit was not feasible, you did not want to have to stand up and sit down again while bearing the weight of all the kit.

[38] Mr Marshall's station had been on the bench by the starboard rail, five places away from the exit. He had been getting ready when he saw Mr Warner fall, but had not seen why. He had not seen Mr Warner shuffle along the middle bench. He got up and fell more or less straightaway, going down forwards onto his hands and knees. Mr Marshall had not seen any steps taken, but it appeared that Mr Warner could have taken one or two steps before falling. There was no handrail adjacent to where he stood up. Mr Warner might have fallen because he leant too far forward. His fins ended up underneath the back of his legs. Mr Cuthbertson came out of the wheelhouse and he and Mr Stanger got Mr Warner upright. They asked if he wanted to continue, and he said he did.

[39] Mr Marshall had been the last man into the water. At 78 or 80 metres, he had seen Mr Warner hurtling upwards past him, his breathing loop still in but his regulator in his hand.

[40] **Steven Slater**, then 41 and now deceased, gave a police statement on 15 August 2012. He had been diving for 24 years, and was a commercial diver for two years. He had various diving-related qualifications, including in the skills needed for technical diving. He had done the deepest recorded non-commercial rebreather dive in the UK, and did 50-60 dives a year. He had known Mr Warner for a year and he appeared knowledgeable and experienced.

[41] Mr Cuthbertson had not said anything to the group before the dive in question as the group had been on his boat before and knew how it operated. There was a slight swell of about 1½ metres. He had assisted with the recovery of Mr Warner from the water. His

valve was not in his mouth. He had checked for a pulse both before and after cutting open Mr Warner's dry suit, but found nothing. He was unresponsive.

[42] **Richard Waring**, 54, attempted to give oral evidence by way of WebEx at the proof but was prevented by connection difficulties from doing so. In his police statement taken on 15 August 2012, he confirmed that he had then been diving for 25 years, doing 30 to 40 dives a year, to depths of up to 120 metres. He had known Mr Warner for about two years. Mr Cuthbertson had given no advice prior to the dive. He had entered the water before Mr Warner and had no knowledge of what had happened to him at any point before returning to the boat, by which time Mr Warner had been airlifted by helicopter from the boat to Stornoway.

The crew

[43] **Andrew Cuthbertson**, 63, was a sole trader under the name Scapa Flow Charters. He had moved to Orkney about 34 years ago and had initially been a scallop diver, but had also skippered boats for many years. He had the Royal Yachting Association (RYA) Yachtmaster qualification and was a member of the Professional Boatmen's Association. He was also interested in recreational diving and had many diving qualifications and a great deal of experience, including in mixed-gas diving.

[44] Diving at Scapa Flow was popular because of the presence of the scuttled WWI German Imperial Fleet. The *Jean Elaine* was originally a fishing boat purchased by him in 1994 and converted to serve as a dive boat. It was kept certified by the Maritime and Coastguard Agency via the certifying authority MECAL (formerly known as the Marine Engineers Certifying Authority Ltd) as a category 2 vessel, permitted to sail up to 60 miles from a safe haven. Full inspections took place every two years, lesser ones every year. Peak

season was March to October, the boat was typically hired from Saturday to Saturday by a group of 10-12 divers, who could live onboard.

[45] Mr Cuthbertson saw his role as skipper on this trip as one of getting the divers where they wanted to be. With a group of experienced divers, he was a taxi-driver only. He would draw attention to anything he saw which was obviously wrong, but did not tell divers when to move about and how to do so. The group of divers with which Mr Warner was associated, "Dark Star", was composed of very experienced technical divers at the top end of the game. They had been hiring the boat once a year for about 10 years at the time of Mr Warner's death. Mr Warner had been with the group the previous year.
Mr Cuthbertson accepted that he was in sole charge of the boat and responsible for the safety of all passengers and crew onboard, but maintained that he was not responsible for the "daft" actions of others. He had assessed risks on board, including risks attending the passage of divers to the exit point; that was why there were handrails in the first place. He considered that a fall of the kind that had happened was quite unlikely, and if it did happen not likely to cause any injury more serious than a broken arm.

[46] At first embarkation on a trip, he would give a safety briefing pointing out the emergency equipment on board. He had had a general chat with the "Dark Star" group when they first came on board about the expected weather and its effect on where they might want to dive. Divers were repeatedly told to hold the handrails while standing by him or the crewman, especially when the boat was underway or rolling, and he made sure that they did so if he was on deck rather than in the wheelhouse. At the time of Mr Warner's fall, the boat was underway in an oblong circular movement which was undertaken between the entry into the water of each group of divers. Mr Cuthbertson could not specifically recall having issued any instructions to hold on to the handrails that day,

although there was a swell and the boat was rolling slightly. The crewman would have done so if he was doing his job properly. There was no briefing by Mr Cuthbertson or (to his knowledge) by anyone else before the dive in question. He had, however, told Mr Warner every day to hold on to the handrails. He would have told Mr Warner to hang on, and not stand up while the boat was in motion, on the day in question because of the slight swell.

[47] In his experience, every single diver would put his fins on at an early stage of the kitting-up process. They preferred to put their own fins on so that they could be sure they were secure, and it was very difficult to put them on once the rest of the equipment had been donned. He would tell inexperienced divers without instructors not to walk with fins, but not experienced technical divers. He did not agree with advice issued by the Professional Association of Dive Instructors ("PADI") that fins should be put on last – that advice was for novice divers. He had seen divers trip on their fins about 15 or 20 times, but none had fallen. It was stupidity to trip over your own gear.

[48] The day of the incident had been the third day of the trip. The group planned to dive a wreck lying off the north coast at a depth of 92 metres. Mr Warner had done one dive on the trip already and had aborted one, perhaps due to a problem with his rebreathing equipment. On the day, he had been sitting on a bench in the middle of the ship, which was the place he had chosen as his spot for the trip, called M2, facing but not directly opposite the exit point, which was on the starboard side. It was two full steps from there to the exit point. The person [Mr Mee] occupying the other place on that bench, M1, slightly nearer the exit point, had gone in the water before, so Mr Warner had shuffled along the bench to that place and risen from there. Other benches ran along both the port and starboard sides of the boat. The divers were entering the water in pairs, the first two pairs to enter having been

pre-arranged amongst the group and having specific tasks to do in relation to setting up equipment, the rest at their own convenience.

[49] Mr Cuthbertson was in the wheelhouse at the time of the fall; the weather was fairly good, there was very little swell, and it was getting calmer. It was perfectly safe to dive. There were only three divers left on deck. Allan Stanger, the deckhand, was helping them get ready and telling Mr Cuthbertson when they were ready to enter the water.
Mr Cuthbertson had heard a thud, looked out of the wheelhouse window, and saw Mr Warner on his hands and knees on deck, facing fore-and-aft about 1 metre away from the exit point. The boat had been rolling and he thought Mr Warner had lost his balance. He left the wheelhouse and by the time he got to the place, Mr Warner had rolled onto his back. At that point Mr Cuthbertson had returned to the wheelhouse as the boat was drifting near some dive equipment in the sea. Having dealt with that situation, he had come back out and with great difficulty he and Mr Stanger had got Mr Warner to his feet. He was wearing his fins and was cursing himself for being so stupid. Mr Cuthbertson had told Mr Warner at that point to "keep hold of the boat" and had asked him if he still wanted to go in, to which Mr Warner had nodded enthusiastically. Having been offered the option to sit out the dive, he was adamant that he wanted to proceed, and quickly did so. There was no reason to suppose that he was injured. From the fact that he was blaming himself and where he fell, Mr Cuthbertson assumed that Mr Warner had stood on his fins and that that had been the mechanism of his fall. At the time, a horizontal handrail had been available on hatch cowling next to the M bench, facing starboard rather than facing the bench itself.

[50] Some time later Mr Cuthbertson noticed a fin sticking out of the water. It was Mr Warner, who was recovered from the water. He was unconscious, his equipment was

intact, but his mouthpiece was out of his mouth. The Stornoway coastguard was called, a helicopter arrived and took him away.

[51] After the incident with Mr Warner, Mr Cuthbertson had become more proactive in relation to diver safety, including by checking everyone's position and telling them as often as possible to hold to handrails. Further horizontal, vertical and diagonal handrails had subsequently been added to the boat, particularly on the hatch cowling next to the M bench. Mr Cuthbertson did not rely so much now on divers' own common sense. There was no point putting up warning signs; people did not read them.

[52] In the course of the Coroner's Inquest into the circumstances of the death of Mr Warner held in Birmingham on 16 December 2013, Mr Cuthbertson gave evidence and it was agreed that the transcript of the proceedings produced in the current action was accurate as to what was said at the inquest. On that occasion, Mr Cuthbertson gave evidence generally consistent with his position in the present case, save that he was rather more circumspect during the inquest as to whether there had been any specific instruction on the day in question to the divers generally or to Mr Warner in particular to hold on to the handrails. He did not think that there had been any instruction that day about how divers should get from their seat to the exit gate. On earlier days, if the boat had been rolling, divers would have been told to hang on. Mr Cuthbertson could not remember if that had occurred during the day in question. He thought that the crewman on deck would have told Mr Warner to hang on, but could not hear if anything of the sort had in fact occurred. That would not be something mentioned in the initial safety briefing, only if the boat was rolling. People tended to forget abstract instruction, so it was reserved until the need for it arose.

[53] On the subject of fins, at the inquest Mr Cuthbertson said that walking in fins was not a problem if one took one's time and walked appropriately. Walking backwards in fins

would probably cause a fall because of the equipment and an inability to see where you were going. Most technical divers put their fins on first because once they had the rest of their equipment on they could not bend down to put fins on. Putting fins on at the gate would involve standing on one leg while wearing the rest of one's equipment and would itself result in a danger of falling.

[54] Mr Cuthbertson said at the inquest that he had considered the recommendations of the Marine Accident Investigation Board ("MAIB") into Mr Warner's fall but had not yet taken any action in relation to them as exploration of the possibilities for extra supports had not resulted in any clear solution which did not raise its own further problems. Discussions with divers about putting an extra seat at the exit gate to enable two divers to put fins on there at one time had led to the conclusion that not all divers on a typical trip would then be able to dive during the optimum period for entry during slack water, which usually lasted for 10 to 15 minutes. Mr Cuthbertson was now a lot more proactive on deck, telling people to hang on to the rails. He also got the crew to go around telling people to hang on. There were still no signs telling people to do that, as they were not read or were ignored. There was no way that Mr Warner's accident could have been prevented. Mr Cuthbertson could not have foreseen what was going to happen. The way things had always been done on the boat had always worked before, with only the odd fall (usually sideways) amongst many walks by divers from their seats to the exit. It seemed that Mr Warner had fallen forwards. Perhaps he had been too enthusiastic that day and in too much of a hurry to enjoy his dive experience. There had been handrails beside him, which if used and followed only required one unsupported step to be taken to reach the exit, but Mr Warner had chosen to move directly towards the exit without using the handrail route.

[55] **Allan Stanger**, 50, self-employed boat worker, was the deckhand on the fatal trip. He had started working on boats at age 14 and had done many mandatory training courses. He had known Mr Cuthbertson for many years and had experience of many technical dive trips on the *Jean Elaine* and another similar vessel. He normally worked on another boat owed by a different person, and only occasionally on the *Jean Elaine*. Technical dive trips like the one in question only usually took place for about four of the weeks of the diving season on any vessel. His job was to cook the meals, look after the divers and do anything else he was asked to do. He had some personal experience of scuba diving from many years ago, but not technical diving. He did not recall having met Mr Warner before the 2012 trip. He had worked on most of the dive boats in the area at one time or another. He no longer worked for Mr Cuthbertson, but was friendly with him.

[56] On the day in question, there had been a slight swell. Mr Warner had started to prepare early so that he would be ready for the dive. He had been fully kitted up and carrying a lot of weight when he got up to head for the gate. At the time of the fall, Mr Stanger was standing about a foot away from the centre of the M bench, facing the stern. One of his jobs was to help people stand up and walk about the deck if they wanted such help, but he did not proactively offer such help. Mr Warner had not asked for help; had he asked, Mr Stanger would have helped him so long as he was not already helping someone else at the time. He saw Mr Warner stand up right in front of him, take one or two steps and trip, seemingly on his fins. He fell quite hard, enough to cause Mr Stanger concern, and ended up hunched up on his hands and knees with his side cylinders underneath him in front of Mr Stanger, who could not get him up on his own. His legs were crossed over each other. Mr Cuthbertson assisted and together they sat Mr Warner on the starboard rail bench near the exit. Mr Stanger told him that he did not have to go in that day, but he was

adamant that he was going in with the rest. He had sworn at Mr Cuthbertson. Mr Stanger did not think that Mr Warner had hurt himself. He had seen similar falls before, it was not uncommon.

[57] As to fins, Mr Stanger said that a lot of divers put them on first, but a lot put them on after the rebreather unit was strapped on over the shoulders. Others left the fins till last; it was a matter of personal choice. Most put them on before the side mounts, but everyone was different. If fins were put on late in the kitting up process, help would probably be needed. The divers would close the straps themselves after the helper had put them in place, as it was a matter of personal preference how tight you wanted your straps. Divers were trained to walk backwards in fins, but few did. Mr Stanger never told divers to walk backwards, what divers did in that or other regards was entirely up to them.

[58] In relation to handrails, Mr Stanger had no concerns that there were not enough handrails, most people managed fine, the diving boats were all very similar, they did not have much in the way of handrails. A lot of divers did not use them as they had their hands full already. Further, divers usually wanted to get into the water quickly to take the unsupported weight of the kit off them and to avoid overheating. Mr Stanger could not recall having said anything to divers about using handrails, except perhaps in the case of female divers struggling with the weight of the kit, and he could not remember having heard Mr Cuthbertson tell divers anything on the subject either, though he might have done; in any event, it was common sense. Some other boats had more handrails, especially in the middle of the deck, and perhaps gave more instructions to use them.

[59] Nowadays, all dive boat operators were much more careful; nobody had thought that something like Mr Warner's death might happen, but it was now a well-known incident

in the diving community. Some boats now had two crew members on deck, to make things easier.

Those not on the fatal trip

Expert evidence on maritime and diving issues

[60] **Ian Biles**, 64, a master mariner, naval architect and marine surveyor, was led as an expert witness by the pursuer and adopted his expert reports in process. Those reports concluded that, in the absence of any formal or documented risk assessment, Mr Cuthbertson had not carried out a risk assessment in accordance with the Maritime and Coastguard Agency ("MCA") Marine Guidance Note – Small Vessels in Commercial Use for Sport or Pleasure, Workboats and Pilot Boats (MGN 280), Annex 3, section 2.10 of which required the skipper to take a proactive approach to safety and consider what particular hazards were likely to arise in the context of work activities on board. A risk assessment was described in the Merchant Shipping and Fishing Vessels (Health and Safety at Work) Regulations 1997 as being intended to be a "careful examination of what, in the nature of operations, could cause harm, so that decisions can be made as to whether enough precautions have been taken or whether more should be done to prevent harm". The risk assessment had to be "suitable and sufficient". An informal and unrecorded risk assessment of a complex diving ship operation could not meet those criteria. Ships in the water were subject to linear (heave, surge and sway) and rotational (yaw, roll and pitch) movements, and a boat subject to a slight swell would experience all six of those types of movement. Given that the boat, the dive platform, was therefore not static, the risk of slips, trips and falls should be included in any reasonable risk assessment of activities carried out on it. The Professional Association of Diving Instructors ("PADI") Open Water Diving Manual noted

the risks of walking with dive equipment given the effect of that equipment on a diver's centre of gravity and balance, and counselled hanging on to handrails and not walking in fins, which it said should be put on immediately before entering the water. A proper risk assessment would have identified simple and effective procedures to reduce the risk of a diver falling when moving about on deck in equipment to as low as reasonably practicable, as by giving a general safety briefing before a dive and imparting a clear understanding of the procedures to be used and the particular risks which might arise.

[61] In a supplementary report compiled after a visit to the *Jean Elaine*, Mr Biles observed that the physical arrangement of available handholds at the time of Mr Warner's fall was such that at some point while transiting from the kitting-up point to the exit point wearing diving fins, he would have had to let go of one handhold in order to reach another, and during that period would have to rely solely on his own balance.

[62] In oral evidence, Mr Biles stated that the captain of a boat is much more than a taxi driver. Traditionally, he is responsible for everything on the vessel; the safety of those on board, the protection of the environment, and the preservation of property. Mr Biles had inspected the *Jean Elaine;* the incline of the deck was 7° to the bow, with a camber of 2°.

[63] In cross-examination, Mr Biles accepted that technical diving *per se* was not within his sphere of expertise. He maintained that the diving witnesses did not understand the safety standards which were supposed to prevail. That they were happy with the boat did not mean that all was in order. They were sports divers and did not understand the risks. They knew what they wanted, but that did not absolve the skipper from his own responsibilities. The skipper was the one who had the experience to determine what was and was not adequate for those for whose safety he was responsible. Even if he could not personally do every task required to that end, the responsibility for seeing to it that it was

done stayed with him. The divers were responsible for their own equipment, but the skipper should stop any operation on board if he believed it to be unsafe. He should know what is going on aboard his vessel.

[64] In this case, the skipper should have carried out an examination of what the divers were proposing to do on board and have identified possible sources of harm. He should have seen a trip and fall hazard, and put in place appropriate mitigation to manage that as much as reasonably practicable. A risk assessment did not need to be written down, but had to be suitable and sufficient, not casual. Mr Biles had no opinion on the practicability of putting on fins last, or of standing up and sitting down frequently as part of the process of kitting-up and entering the water. The skipper should have assessed the risk of walking in fins and, after consultation with the divers and others, and not merely deferring to them, put appropriate mitigations in place. Safety required to be guarded even at the risk of alienating customers. The skipper should ask divers about their preferences and what safety improvements they wanted, not just keep the customers happy. Responsibility for safety could not be passed over the divers completely. A safe system, for example the deployment of two deckhands, was required. A reasonable precaution would be a proper safety briefing, and before each dive another reinforcing chat about conditions, and making sure that those walking with fins knew that they needed to use the deckhand's assistance. The provision of railings, even temporary railings, was another possibility. There were many factors to take into account, and many possible alternatives.

[65] In re-examination, Mr Biles said that the skipper's duty was a matter of introducing and maintaining a safety culture, doing a risk assessment and putting in place a safe system of work to make up for human fallibility. A trip in these circumstances was entirely

foreseeable as a risk. A helping hand would have given additional stability. Although warning signs worked for some people, there was no single panacea.

[66] **Kevin Casey**, 72, is a retired director of diving operations and diving consultant who was led as a further expert witness by the pursuer. He adopted his report as lodged in process. That report concluded that there was no formal or documented risk assessment of deck diving procedures by Mr Cuthbertson, only a rough generic assessment of the vessel itself. In Mr Casey's view, all divers should have been given a toolbox talk detailing the procedures required of all on board in order to dive, and that talk ought to have been repeated to remind them. Walking in fins was too dangerous in the situation in which Mr Warner had been placed. Divers should have been assisted to walk on deck by two deckhands, one on either side. Mr Casey considered that Mr Stanger should have been assisting divers in order to minimise the risk of a fall. Resistance to such assistance from divers was not a good reason for it not to be provided – the skipper was in charge of safety onboard and could and should enforce his safety requirements.

[67] Mr Casey believed that the weight and amount of equipment carried by divers made it difficult for them to prevent a fall even if holding a handrail or rails. The circular movement of the boat at the time of the fall, combined with the swell, would have made it more difficult to use handrails. MECAL certification of a vessel did not specifically address the needs of divers moving about in heavy kit and fins on deck, and did not absolve the skipper of his own responsibilities to carry out a proper risk assessment. Divers should not have been allowed to walk in fins on deck unaided. That was a long-recognised source of danger to divers walking on deck. Fins should have been put on immediately before entering the water, as PADI and the British Sub Aqua Club ("BSAC") recommended, and the skipper should have enforced that requirement, by way of generic and site-specific

briefings and the toolbox talk before diving commenced. Deck crew should have assisted with putting on fins if bulky equipment hampered a diver's own ability to do so. Dive timings should be planned to allow time to put on fins last as an element of dressing safely. The security of the fitting of fins was easily checked once on the surface of the water and before diving further. PADI and BSAC were bodies whose qualifications were approved by the Health and Safety Executive ("HSE"), and their recommendations ought accordingly to have carried weight in the risk assessment that the skipper should have carried out. The fact that technical divers carried more weighty equipment, which caused mobility and vision restrictions and an altered centre of gravity, made it all the more important that those recommendations, which were primarily directed at recreational divers with lighter and simpler equipment, should be followed by them.

[68] In his oral evidence, Mr Casey stated that he knew about technical diving to some extent, but had not himself done it. Each diver had responsibility for his own equipment, and the order of kitting-up depended on the individual. The divers had experience in what they liked to do, but what they did on board so far as safety was concerned was for the captain to regulate. He ruled the boat, not the divers. The divers were amateurs; the captain was the professional. He should have looked at the situation, the issues that might arise, and spoken to the divers about that. He should have seen that Mr Warner (or anyone else kitting up at the seat he had been using) would have to walk three metres, assessed the risk of that activity and thought of ways to mitigate that risk. There were various ways to do that; extra deckhand assistance when rising or walking in equipment was an obvious one, as were more handrails and more seating at the exit. The captain had to understand the divers' decisions, discuss them, ask for suggestions, make suggestions, and find a solution to mitigate the risks of those decisions. You could not just wait for an accident, or for the

divers themselves to ask for assistance. Rather, you had to reinforce safety considerations and eventually they would have sunk in. You do not just do what you have always done, or what other people do. An element of complacency had affected this case. Nobody had assessed the adequacy of the handrails, and they were not sufficient. Divers are not supposed to walk in fins, whether they be technical or sports divers. Walking in fins was an inherently dangerous activity, and divers themselves were not best placed to assess and deal with that risk. The deckhand should have acted proactively in helping divers stand up, and in escorting them. That would have helped avoid the fall, or at least slowed a resultant impact on the deck.

[69] Mr Casey considered that he had more experience of working on deck than the defenders' expert Mr Murray, and understood how deck operations required to be managed. The HSE did not deal with the actual running of operations on deck; the MCA Marine Guidance Notes did that. A risk assessment did not require to be written down. The skipper should do a situation-specific risk assessment and work out procedures before the matter became time-critical. In this case, although there may have been a general talk at the start, no particulars of how to conduct oneself on deck had been given. The MECAL standards were not specific to diving operations. The diver had to be looked after. No diver had ever tripped on a deck managed by Mr Casey.

[70] In re-examination, Mr Casey said that he had been working on decks since 1975, and had seen a dramatic change in safety culture since then. Diving deaths were many fewer than they had been, the Industrial Marine Contractors' Association policed the commercial diving industry; legislation was less demanding than self-regulation. One had to repeat instructions constantly, and never assume things. In Mr Casey's view, the horizontal rail in

place at the time near to the bench where Mr Warner had kitted-up was no use when standing up from the bench.

[71] **Frank Murray**, 75, retired HM Principal Inspector of Diving, was called as an expert witness by the defenders, and adopted his report in process. That report opined that the skipper of a recreational dive boat did not get involved in the planning of the dives. His responsibility was for the safety of the vessel and the management of hazards in connection with the vessel only. The purpose of risk assessment was to make a proposed course of action safer. One identified the hazard and those who could be affected by it, its likely consequences and what could be done to avoid or mitigate those. The process involved assessing the likelihood of the hazard occurring and undertaking a risk/benefit analysis, with the aim of taking appropriate measures to reduce the risk to as low as reasonably practicable. The MCA regulated the *Jean Elaine* and Mr Cuthbertson. The MCA Marine Guidance Note No.280, Annex 3 cited the Merchant Shipping and Fishing Vessels (Health and Safety at Work) Regulations 1997, paragraph 2.10 of which recommended that a skipper take a proactive approach to safety in relation to work activities on board, but that did not apply to the activities of charter guests such as divers. The Regulations did not require a risk assessment to be written down. Mr Cuthbertson had assessed the risk of a diver falling on deck, and considered that it would be adequately dealt with by not operating in poor sea conditions, minimizing the movement of the vessel when divers were preparing to dive by proceeding slowly into the tidal flow, having a non-slip surface on the deck, keeping the deck free from obstructions, providing handrails at the periphery of the deck and advising divers to use them, and making a deckhand available to assist divers if asked. That was, in Mr Murray's opinion, compliant with MGN 280. It was unrealistic that risk assessments for situations capable of changing rapidly should be written down.

[72] The relative MAIB Report had made two recommendations, namely that the risks involved in supporting recreational diving operations should be formally and methodically assessed, and that the employment of crew and positioning of physical supports be considered in order to minimise the risks to divers as they prepared to enter the water. Mr Cuthbertson's risk assessment process was as already described. A deckhand was available to give divers assistance if required, but some divers would resent being given assistance. The handrails fitted at the time of the fall would have allowed Mr Warner to move safely to the exit had he chosen to use them. The PADI Manual, advising against walking with fins, was written for inexperienced divers using more simple equipment. The equipment used in technical diving made putting on fins just before entering the water a very difficult task that Mr Murray had never seen a skipper require. Dives required to proceed according to tight timescales, which a requirement to fit fins immediately before entry might compromise. Divers would be resistant to being assisted to put on their fins, preferring to ensure themselves that such a vital part of their equipment had been properly fitted. Any policy of putting on fins immediately before entry into the water would have encountered resistance from divers. The use of handrails and assistance if required was sensible. MECAL had certified that the provision of handrails on the *Jean Elaine* was adequate in the knowledge that the boat was to be used for *inter alia* diving trips. Mr Warner could have moved safely from his seat to the exit using the handrails available at the time and asking for assistance as and when required. Further handrails, and in particular a central deck handrail, would have hindered day-to-day activities onboard and were not in common use on dive boats.

[73] In his oral evidence, Mr Murray stated that he was familiar with the *Jean Elaine* and had used it for making safety videos after it had been recommended as the best boat in

Scapa Flow. It was possible to rise from the bench where Mr Warner had been sitting by using the handrail that had been there at the time of the incident and to move towards the exit using handrails for most of the way, except perhaps when crossing the starboard gangway. Mr Warner had preferred to wear his gas cylinders slung low, which made it more difficult to move.

[74] In cross-examination, Mr Murray said that he had dived personally from the *Jean Elaine* on a number of occasions and had observed at least one of the ways that the boat was manoeuvred in the water between the points in time at which divers entered the water. The skipper had been obliged to do a risk assessment of hazards for divers on deck. That would have been done constantly in his head for years. The skipper had authority over the divers on deck. Without the new handrail added adjacent to the middle bench after Mr Warner's fall, it would have been wise for a diver there to ask for assistance when standing up, although the pre-existing handrail could have been used by Mr Warner. It was the divers' decision to ask for help if needed; if asked for, it was freely given, even though the deckhand would be busy at that time. It was a huge effort to stand up with all the equipment. The equipment raised the divers' centre of gravity and reduced their stability. The diving mask hindered vision. It was important to a point to repeat instructions to use the handrails, although eventually people ceased to pay heed to that. It was easy to trip when walking with fins if not paying attention. One had to do a penguin shuffle, sliding forward with small steps. Falls were not frequent, often or regular. He had never before heard of one causing death. The seat at the exit could be used to put on fins, but it was up to the divers what to do. Fins can have complex locking mechanisms, which you could not sensibly ask a deckhand to deal with. Divers did not want to be nannied, and should not be

helped unless they require it. Professional divers have a totally different mindset and discipline, and their situation is not comparable to that of technical divers.

Medical evidence - general

[75] **Dr Abigail Oakley**, Speciality Registrar, and **Dr Mark Ashton**, Consultant Pathologist, both of Raigmore Hospital, Inverness, carried out a post mortem examination on Mr Warner's body on 17 August 2012. Their relative report dated 12 September 2012 was agreed to be the equivalent of their evidence. They concluded that there was a significant quantity of blood within the abdomen together with evidence of blunt force trauma causing bruising to the small bowel mesentery and tears to the liver parenchyma. The latter injury was considered to be the source of the free blood within the peritoneal cavity. That injury was almost certainly caused when Mr Warner fell to his knees and the tops of the cylinders strapped to his thighs impacted with his abdomen. It seemed unlikely that Mr Warner was suffering any significant effects when he was asked if he wished to continue to dive. However, something happened as he was nearing the end of the descent which caused him to abort the dive and begin his ascent. It seemed likely that he either developed abdominal pain or was feeling faint because of the intra-abdominal haemorrhage. He was probably falling unconscious during his ascent, causing his mouthpiece to come out of his mouth. His subsequent rapid ascent resulted in marked gas embolism, but it was likely that he was dying or dead as a result of drowning by the time that occurred. The death certificate recorded the cause of death as (i) drowning as a consequence of recreational technical diving and (ii) traumatic hepatic injury with haemoperitoneum resulting from a fall on a dive boat.

[76] **Jacek Rytchtez**, then 59, Consultant Anaesthetist, gave a police statement on 15 August 2012 which was agreed to be the equivalent of his evidence. He had been on duty

at the Western Isles Hospital, Stornoway, on 14 August when Mr Warner arrived by Coastguard helicopter at about 17.40. He had been unconscious, with no heartbeat or electrical activity of the heart. Resuscitation efforts were commenced, but the results of blood tests taken at 18.35 indicated that they would not be successful, and Mr Warner was pronounced dead at 18.55.

[77] **Agnes Munro**, then 60, a Senior Charge Nurse at the Western Isles Hospital; **Derek Spark**, then 44, a Community Paramedic in Stornoway; **Sine Nicolson**, then 32, an ambulance technician at Stornoway; **Peggy MacLeod**, then 57, an emergency nurse practitioner at the Western Isles Hospital; and **Iain Morrison**, then 40, a detective sergeant at Stornoway, gave police statements in August 2012 which were agreed to represent their evidence, and confirmed details of Mr Warner's arrival at and treatment in Stornoway which are for present purposes immaterial.

Medical evidence - experts

[78] **Dr John Drury**, 74, a retired consultant surgeon, was called by the pursuer and adopted his expert report in process, which was based on the post-mortem report and witness statements as to the events of the fatal dive. That expert report noted that Mr Warner's fall had resulted in damage to the small bowel mesentery (i.e. the tissue carrying blood vessels to the bowel) and liver. That was caused by blunt force from his bail-out cylinders impacting on the abdomen. There were three areas of haemorrhage in the mesentery and four lacerations in the left lobe of the liver, none larger than 12mm, with haemorrhagic changes seen on microscopic examination. The liver damage would have been graded between Grades I and II on the six-grade spectrum of liver injury published by the American Association for the Surgery of Trauma. It caused free peritoneal bleeding

of 300ml. This would not have caused immediate clinically obvious physiological upset. It was a Class 1 haemorrhage, which would not have altered Mr Warner's pulse, blood pressure or breathing rate. It was likely that the intra-abdominal bleed caused abdominal pain or discomfort which was not appreciated until during the dive, possibly accompanied by anxiety and some faintness, causing the dive to be aborted. Movement of the abdominal muscles and peritoneum might be related to the incidence of the pain. Compression from the dry suit and increasing depth of water may also have masked abdominal symptoms and limited the rate of bleeding by reducing movement of the abdominal muscles and splinting the peritoneum. The injury was a factor contributing materially to the need to abort the dive. Other factors, which might not be identifiable, would have led to Mr Warner's loss of consciousness and may also have contributed to the drowning. Had he not dived, Mr Warner would have survived.

[79] In his oral evidence, Dr Drury stated that it was likely that the internal injuries sustained by Mr Warner made a material contribution to his death. Pain would have been a factor making him want to ascend. In cross-examination, Dr Drury agreed that liver surgery was now a specialised area, but maintained that he had ample general experience to give evidence about the relevant issues. The fact that only 300ml of free blood was found at post-mortem meant that either the injury was minor or that external pressure acted like a splint and reduced bleeding. Extra pressure could have caused pain in the abdominal wall, which would have been bruised. It was possible that the dry suit had reduced the effect of water pressure, but if pressure had been near atmospheric, one would have expected more bleeding. It was not known when or how the blood had escaped. When Mr Warner's heart stopped, the blood would have clotted. It was possible that the 300ml found post-mortem was more than there had been when he decided to abort the dive. The liver injury was part

of a multi-factorial situation. Something unknown, other than the liver injury, had caused him to become distressed. He had become unable to control his actions. He appeared to be struggling to breathe. The documented loss of blood would not have caused significant loss of motor function or intellectual capacity. Mr Warner had obviously considered himself fit to dive. A fall can give heightened awareness, an adrenaline rush or "fight" response which could mask pain and distress until later.

[80] In re-examination, Dr Drury said that he felt qualified to comment on the matters in question as a result of his training and experience in hepatobiliary surgery. He had done all sorts of emergency surgery and had dealt with liver injury regularly. The liver injury itself would not have been painful, it would have been the injury to the surrounding areas which would have caused pain. Pain would increase blood pressure and thus bleeding. The pain would have become more apparent if untreated. Had the existence of the injury been known, Dr Drury would have strongly advised against diving.

[81] **Ian Beckingham** is a liver and pancreatic surgeon, specialising in that field for 30 years. He was called as an expert by the defenders and adopted his expert reports lodged in process, which were based on the post-mortem report and witness statements.
Mr Warner's fall caused the equipment he was carrying to impact on him, resulting in bruising within the bowel mesentery and four small tears on the left side of the liver. The liver injury was minor, grade I or II. The resultant blood loss of 300ml was not particularly high in the context of an adult normally having about 5 litres of circulating blood. The compressive nature of the diving equipment probably reduced further blood loss. Sudden movements and exercise after that degree of blood loss might induce fainting, especially if there were other causes of oxygen deprivation. The blood in the abdominal cavity would irritate the peritoneum and cause pain. Movement of the abdominal muscles would

exacerbate that pain. The most likely cause of Mr Warner's rapid ascent was pain caused by increasing pressure as he descended further. Mr Warner would probably have survived had he not dived and had instead received reasonably prompt medical attention.

[82] In his oral evidence, Mr Beckingham said that Mr Warner would almost certainly have survived had he chosen not to dive. The fall would have squashed his rib cage, compressing and splitting the liver and causing four small tears which extended into the body of the liver. It was a minor liver injury. It would in other circumstances just have been observed and usually the injury would have settled. Any compressive effect from the diving gear would have reduced active bleeding from the liver surface. There was no doubt that the rapid ascent was the cause of death, causing gas in the tissues. The question was what had caused the ascent. If it was related to the liver injury, it would have been increasing pain, but that was speculation and there could have been many other causes. Anxiety from the injury would have been relatively trivial, and would be unaffected by depth and pressure. The removal of Mr Warner's mouthpiece, or an inability to use it, could not be connected to the liver injury.

[83] In cross-examination, Mr Beckingham said that he had seen the post-mortem report and nothing in it struck him as incorrect. The death certificate stated that Mr Warner had drowned and had a liver injury. The fall might have caused bruising of the rib cage or of intra-muscular tissue just behind the liver. Any pain would probably have come from blood in the peritoneal cavity. Pain would have been less if there had been no movement. Cold would also help pain. Pressure could affect it either way. In other circumstances, Mr Warner could have been treated with oxygen, pain relief, and perhaps some fluids. Mr Beckingham would not have allowed Mr Warner to dive. What happened was consistent with *sequelae* from the blunt trauma. He did not disagree with Dr Drury's report;

it contained a perfectly plausible explanation of how the liver might have been involved, but it was speculation. The blood loss could have caused faintness on exertion, but not a loss of consciousness, and pain was a more likely scenario. There is a large psychological element to these things. Had Mr Warner remained on the boat, the pain would have caused him to sit or lie still. Drowning in the course of the rapid ascent was the cause of death, not the bleeding. It was speculation that the fall caused the ascent. Any change in pain would be gradual, not sudden. One could not know why Mr Warner had suddenly shot up.

[84] **Dr Lynn Sheldrake**, 63, a retired GP, had been Mr Warner's doctor since 2003, and was called by the defenders. She had written a letter to the Birmingham coroner which she had taken from her practice records relative to a consultation on 7 August 2012 between Mr Warner and her colleague Dr Ian Collier, who was a thorough note-taker. The letter stated that Mr Warner:

> "was complaining of a cough again with a sore right side to the chest. On examination there was poor air entry but clear breath sounds. He had a normal respiratory rate, was not distressed but had a harsh cough. He was started on Amoxycillin 500mg tds for a week."

There was a comment in the records that Mr Warner was planning to go diving and Dr Collier had advised him against diving with a chest infection. The dose of Amoxycillin that Mr Warner had been prescribed for his chest infection was a reasonably high dose. One would expect the infection to improve within a week, but not all infections did improve or resolve within that period. It would be impossible to know how Mr Warner would have been a week later. One required to take the full course of antibiotics in order to achieve the best results.

[85] **Dr Ian Collier**, 62, a retired GP, was also called by the defenders, but had no recollection of having seen Mr Warner on 7 August 2012, nor of any advice he might have

given. He was not an expert in diving, but it was common sense not to dive if you had a compromised lung function. No further details would have been given to Mr Warner by him. He would have hoped for some improvement in Mr Warner's condition within a week, but one could not give any definite timescale for such improvement.

Other witnesses

[86] **Eugene Farrell**, 59, was called by the pursuer primarily in order to describe and demonstrate technical diving equipment. He had met Mr Warner in 2001 and had dived with him about 100 times. Almost all his dives with Mr Warner had been technical dives, and he described Mr Warner as well-trained and competent, very careful and confident but not someone who would have dived had he not felt comfortable. Mr Warner, as a heavy smoker, often had a hacking cough, but it would not accord with Mr Farrell's experience of him that he would dive if feeling ill or if he had received medical advice not to do so.
Mr Farrell is a passionate scuba diver with many qualifications who was Chairman of the BSAC for two years. He had much experience in various sorts of diving, including in technical diving, which he described as requiring specific training and involving the use of rebreathing equipment (i.e. closed-circuit breathing apparatus), and which allowed diving beyond the 30 metre or so depth limit of open circuit scuba equipment. Technical divers would take responsibility for their own equipment.

[87] Mr Farrell demonstrated equipment similar to that worn by Mr Warner on his fatal dive. Firstly, there was a thermally lined undersuit, then a dry suit with waterproof seals and a means of letting air in and out in order to address increasing water pressure at depth. He noted that it was not usual to overheat underwater. The rebreather apparatus, which circulates a mixture of gases in a closed loop, removing carbon dioxide along the way, was

worn on the back and weighed between 30 and 40 kilos. Additional "bail out" gas cylinders were worn at the sides to deal with the eventuality of failure of the principal system. Various hoses, reels, computers and other accessories were also attached to the equipment. The equipment as a whole significantly affected the diver's balance and raised his centre of gravity. A hood and goggles were worn, which considerably affected a diver's vision. Fins came in a variety of lengths, widths and materials (and thus varied somewhat in pliability) and there were various means of securing them on the feet. They could be put on as part of the general dressing process, or only at the exit from the boat to the sea. There was no standard practice in that regard. It depended on the situation – what the diver preferred, what the boat skipper preferred, the availability of help, the movement of the boat on the occasion in question, and the distance between the kitting-up point and the dive exit. A diver could put on his own fins while standing (which would involve standing on one leg) or get assistance, but it was not sensible to walk in fins on deck.

[88] **Martin Woodward**, 62, managing director of the National Dive Centre at Stoney Cove, Leicester, was called by the defenders. He described the Centre as a dive facility up to 35 metres deep, which had been populated with a variety of features interesting or instructive to divers. He had himself been diving for 47 years and had done technical and commercial diving. So far as diving organisations were concerned, the core information they published was the same for all divers, but there was specific guidance for technical divers. He had dived from the *Jean Elaine* on many occasions over ten years or so, albeit not technical diving, and knew Mr Cuthbertson as a result of having been one of his customers, rather than as a friend. He had never seen Mr Cuthbertson do anything of concern to him. The core role of skipper was to provide transport to the dive location, put the divers in a position to dive safely, and to recover them. The skipper would let the divers get on with

their business. Divers all had their own ideas about what to do, but if the skipper saw something he thought dangerous, he should step in. In technical diving, fins were put on by most divers when first sitting down to begin the kitting-up process. Once the equipment was put on, it became cumbersome to reach down and put fins on at that point, but it could be done sitting down with kit on. Not many divers put them on at the exit point. Walking in fins was more difficult, but you could easily walk backwards. It was not normal to walk in fins and step as you would without them; rather, you would shuffle. Fins were, on average, 300mm in length measured from the shin. Mr Woodward had never had an issue with handrails on the *Jean Elaine*. The arrangements were the same on all boats, and they were all sufficient. You could hold on to other structures too, or ask the deckhand to assist you.

[89] In cross-examination, Mr Woodward indicated that it was not sensible to walk longer distances in fins. If he saw people walking in fins at Stoney Cove, he would warn them about the risks. PADI and BSAC advised not putting fins on until the last minute before the dive, but that advice was not specifically directed at technical divers. Standing to put fins on was difficult on a moving boat.

[90] **Jim Smith**, 79, retired ship surveyor, had surveyed the *Jean Elaine* and issued a report to MECAL, which had issued the relative certificate. The report was to ensure that the ship was in a seaworthy condition and qualified as a workboat, a recreational dive support vessel. The handrails had been assessed as "satisfactory" for the purposes of the report.

[91] In cross-examination, Mr Smith said that "satisfactory" meant enough under normal conditions to ensure the safety of people on board. Normal conditions included people walking on deck with gas cylinders, and he made sure that they could reach a rail without taking more than one step. That was his own test, there was no statutory test. He did not

take into account more extensive diving equipment or walking in fins. As far as he was concerned, you would put those on last in any event.

[92] **Captain Gavin Pritchard**, Inspector of Marine Accidents at MAIB, gave evidence at the Birmingham coroner's inquest into Mr Warner's death, the transcript of which lodged in this case was agreed to be accurate. His evidence is thus before this Court in an indirect or hearsay form. He read the salient features of the MAIB report to the coroner. The MAIB had formed the view that there was significant risk to divers of tripping and falling when attempting to work on a deck or work boat in open seas when fully dressed and equipped for deep technical diving. The effects of wearing a large amount of heavy diving equipment could significantly exacerbate the results of what might otherwise be considered a relatively minor fall. Although the skipper of the *Jean Elaine* was aware of the demands of his working environment there was no evidence of any formal assessment of the risks to a fully dressed diver moving from the seat and preparation area to the point of entry into the water having taken place. The MAIB had commissioned a second opinion (which was not produced to this Court) on the post-mortem from a consultant pathologist with a specialism in diving and although his conclusion on the cause of Mr Warner's death was different from that of those who had carried out the post-mortem, he did agree that the internal injuries were the result of a diffuse crushing injury by a blunt object leaving an external mark.

[93] The *Jean Elaine* had been built in 1956 as a trawler and since 1994 had operated as a commercial dive work boat supporting recreational and research diving. She was coded as a work boat under MCA MGN 280. She was fitted with handrails behind the central bench seating, fully along the sides of the deck and on the hatch cowling, and across the front of the wheelhouse. Those handrails provided good support in the areas where divers prepared their kit, but there was no physical support immediately available to divers if they crossed in

a straight line from the central dressing bench (where Mr Warner had been seated) directly to the exit gate. Dedicated support from the deckhand to each diver could quickly become unmanageable when several divers needed to enter the water in quick succession. The wooden deck had a non-slip coating. Whilst the skipper had considered the safety of parts of the operation, and had a significant degree of influence over the diving activities, he did not conduct or document a formal risk assessment for the diving support operations. Such an assessment should have identified the risk of a diver falling and found methods to reduce the likelihood of that happening. The MAIB database had identified eight accidents involving falls in or from dive boats, but none of those had proved fatal. It was possible that many minor falls went unreported. Mr Warner had fallen as a result either of losing his balance or tripping as he tried to walk unaided from the central bench seating on the foredeck to the exit gate on the starboard side. He was looking forward while wearing diving fins, which would have created a very significant tripping hazard. His heavy diving equipment raised his centre of gravity and reduced his stability. His visual situational awareness, which could have aided his balance, would almost certainly have been degraded by the fact that he was wearing a diving face mask. The boat was rolling gently in the slight swell, which would probably have contributed to any loss of balance. The MAIB had recommended that the skipper conduct a thorough review of safety arrangements to ensure that the risks involved in supporting recreational diving were formally and methodically assessed, to include the employment of crew and the positioning of physical supports.

Submissions for the pursuer

[94] On behalf of the pursuer, it was suggested that this case was a simple one. Much of the factual background was not in dispute. Mr Warner fell on the deck of the *Jean Elaine* as a

result of the fault or neglect of the defenders. Had he not fallen, he would not have suffered injuries. Those injuries led to his death.

[95] The specific criticisms made of the defenders were (a) that the deck of the *Jean Elaine* is cambered and slopes downwards from the bow and that no handrails were provided; (b) that the defenders had made no suitable and sufficient assessment of risks; (c) that the defenders ought to have been aware of the risk of injury to technical divers from falls on deck; and (d) that the defenders ought to have been aware that fins should be put on immediately before entering the water and should have had a system to reduce the risk of falls from walking on deck in fins.

[96] Of those criticisms, only the first was capable of being characterised as a "defect in the ship" for the purposes of the Athens Convention. The significance of that was that, in terms of Article 3(3) of the Convention as it stood at the relevant time, injury that arose from or in connection with *inter alia* a defect in the ship resulted in a presumption of fault and neglect on the part of the carrier, which was the touchstone of liability under the Convention. In other cases where an incident occurring in the course of the sea carriage caused injury, the burden of proving that the incident was due to such fault and neglect lay with the claimant, in terms of Article 3(1). "Fault or neglect" was akin to common law negligence – *Davis* v *Stena Line Ltd* [2005] EWHC 420 at para 6, per Forbes J.

[97] In relation to risk assessments, the pursuer noted that the Supreme Court in *Kennedy* v *Cordia (Services) LLP* [2016] UKSC 6 at para 110 had indicated that the whole point of a risk assessment was to identify whether a particular operation gave rise to any risk to safety and, if so, what the extent of the risk was, and what could and should be done to minimise or eradicate it. Attention was also drawn to a series of judicial observations made by Smith LJ. Firstly, modern common law required an employer to take positive thought for

the risks arising from his operations – *Threlfall* v *Kingston-upon-Hull City Council* [2010] EWCA Civ 1147 at para 35. Secondly, an employer ought to be treated as knowing what he would have known had he carried out a suitable and sufficient risk assessment – *Allison* v *London Underground Ltd* [2008] EWCA Civ 71, at para 57. Thirdly, while the failure to carry out a proper risk assessment could never be the direct cause of an injury, there were cases in which it could be shown that if a suitable and sufficient assessment had been carried out, it would probably have resulted in a precaution being taken which would probably have avoided the injury. In such cases, the failure to carry out a proper risk assessment was indirectly causative of the injury and liability would follow – *Uren* v *Corporate Leisure (UK) Limited* [2011] EWCA Civ 66 at para 39. In the present case, whilst Mr Warner was not an employee of the defenders, the obligation to conduct a risk assessment arose from Mr Cuthbertson's position as captain of the *Jean Elaine*. As captain, he had complete control over the environment on board ship, the systems of proceeding to be adopted by those on board, and the equipment made available. That distinguished this case from others in which it had been held that occupiers who had no ability to exercise meaningful control over the behaviour of those coming onto their land or premises had no duty to warn those others of natural and obvious dangers there.

[98] As to what precautions ought to have been taken by the defenders, the court in assessing what a reasonable man would do should use a calculus of risk, weighing up the likelihood of injury being caused, the seriousness of such injury, the difficulty, inconvenience and cost of preventative measures, and the value of the activity giving rise to the risk – *Phee* v *Gordon* [2013] CSIH 18 at para 28. What common practice in the field of activity under examination might be was no more than a factor to be considered within that calculus – *Cavanagh* v *Ulster Weaving Co Ltd* [1960] AC 165, per Lord Keith at 165; likewise,

expert or indeed other kinds of evidence could illuminate but not determine the result of the court's consideration of those issues. All evidence required a qualitative assessment by the court in reaching its own conclusion on the nature and extent of the defenders' duty in the circumstances, taking a wider view than that which any single witness, however skilled or experienced, could present.

[99] In the present case, the risk of falling in fins was entirely foreseeable and ought to have been guarded against. In relation to the case based on defect in the ship, the only handrail relevant to the fall was the horizontal one on the starboard side of the hatch cowling, which would have been of limited utility to Mr Warner when he rose and started to walk. Further handrails added after the incident on the advice of the MAIB, in particular the one now installed immediately adjacent to the middle bench where Mr Warner had been kitting up, would have allowed him to stand more easily and to steady himself on rising. The rail now installed diagonally on the starboard side of the cowling gave better support than the previous arrangement, since it extended down closer to the edge of the cowling. On balance, the presence of the additional rails now installed would have enabled Mr Warner to avoid falling as he did. That MECAL assessed handrails as part of their assessment of the overall safety of a boat demonstrated how obviously integral they were to on-deck safety.

[100] The defenders had a duty to carry out a risk assessment, to include risks to passengers and not merely crew members, by dint of Regulation 7(2) of the Merchant Shipping and Fishing Vessels (Health and Safety at Work) Regulations 1997/2962. Even if, contrary to that principal submission, the duty under the Regulations to carry out a risk assessment did not extend to passengers, the general duty on Mr Cuthbertson to take reasonable care for the safety of those onboard was productive of the same obligation.

Although the results of such an assessment in the content of a boat the size of the *Jean Elaine* did not need to be written down, the fact that any such results were not written down made it difficult for the defenders to demonstrate that any assessment that had been carried out was suitable and sufficient. Mr Cuthbertson's evidence on risk assessment was vague and unconvincing. It was unsupported by other witnesses to what had occurred on board. The court ought to conclude that he had not made any meaningful attempt fully to consider the risks to a fully-kitted technical diver walking in fins from his seat to the exit. A proper risk assessment would have identified the obvious and serious risk from such activity and would have resulted in control measures being put in place to promote an altogether better culture of safety on board. It was that modern safety culture that was missing from the *Jean Elaine*. The best way of dealing with the risk would have been to encourage divers to put on their fins at the exit gate, but if that did not prove practicable, secondary control measures, such as additional handrails or a requirement to use the support of a deckhand while moving in fins, should have been put in place and would on balance have avoided Mr Warner falling as he did.

[101] As to questions of causation of the fall and of the death, a robust, common-sense approach was to be taken to those questions – *Stapley* v *Gypsum Mines Ltd* [1953] AC 663, per Lord Reid at 681. On that approach, the fall here had been witnessed and the proper inference from the evidence as a whole was that it was caused by the pursuer having to walk across the sloping deck of the moving boat in full diving gear, while wearing his fins, from the bench where he had kitted up to the exit gate. Specifically, it was caused by him tripping over his fins, either as he stood up, or within the first shuffle or so. There was no handrail onto which he could usefully hold at the point of his fall. As to the cause of Mr Warner's death, the proper conclusion from the medical evidence was that the fall led to

an internal injury, that that injury led to pain or faintness being encountered at depth, resulting in an attempt at a rapid ascent, to Mr Warner's mouthpiece falling out while he was in a distressed and panicked state, and thus to his drowning. No other possible cause of death had been suggested.

Submissions for the defenders

[102] On behalf of the defenders, it was noted that under the Athens Convention, the touchstone of liability was fault and neglect, and that the pursuer had the onus of showing the existence of such fault and neglect unless a relevant defect in the ship could be identified. In either case, it was also necessary for the pursuer to show that the damage in respect of which a claim was made was causally connected to the fault and neglect or defect.

[103] It was further submitted that the defenders' duties to their own employees were different in kind from any duties that might be owed to others, and that the content of one set of duties could not inform the content of the other set. Divers on board were not, unlike employees, required to carry out their activities onboard in any way that the skipper might direct; what they did and how they did it was primarily a matter for their own free choice. In such circumstances, there was no legal requirement to warn them of obvious risks attending those activities; whether or not to carry out an activity with any obvious attendant risks was a decision for them: *Vaughan* v *Ministry of Defence* [2015] EWHC 1404 (QB) at para 37. Regulation 7 of the Merchant Shipping and Fishing Vessels (Health and Safety at Work) Regulations 1997/2962 only required a risk assessment to be carried out insofar as affecting employees, with any benefit for non-employees being incidental only, as a result of that exercise identifying generally safer behaviours for employees. Thus, so long as a risk assessment pertaining to the activities of employees had been carried out, the requirement of

the Regulation was satisfied. To require an assessment to cover every possible activity onboard was unrealistic. If, contrary to that primary submission, there was an obligation to carry out a risk assessment in relation to the activities of non-employees aboard, any question as to the adequacy of such an assessment fell to be answered by reference to the criterion of whether there was a failure to appreciate a risk of an individual falling such that something ought to have been done to prevent it, bearing in mind the reasonably foreseeable outcome of such a fall and the costs, tangible and intangible, of any realistically available preventative measures: *Edwards* v *Sutton LBC* [2016] EWCA Civ 1005 at paras 38, 44-46 and 48. The seriousness of such an outcome should not be confused with the degree of risk that it would occur, and the response to any risk was only required to be reasonable and proportionate in accordance with past experience, and not to guarantee safety. Although witnesses had spoken to having seen or experienced falls or stumbles on deck while in full kit and fins, there was no history at all of such falls or stumbles causing serious injury. The risk of death was so minute that it would be unreasonable to expect the defenders to have taken the desiderated precautions. Further, any failure to carry out an appropriate risk assessment could only be relevant to liability if it could be shown that an appropriate assessment would have resulted in a materially different outcome, which had not been achieved here.

[104] In that connection, the court should pay heed to the opinions of the unbiased and highly experienced divers who had no criticism of the boat's facilities (in particular, the provision and placing of handrails) or the system of operation on board, which involved them putting on fins at their seats and walking in them to the exit gate. Their views were backed up by the defenders' expert Mr Murray, someone who had considerable health and safety experience in the relevant sphere. Further, there was no suggestion that the

Jean Elaine's facilities or system of operations were any different from those of other boats operating in the same line of business at the time. The pursuer's expert witnesses lacked any meaningful experience to comment on the matters in dispute, particularly insofar as relating specifically to technical diving. Moreover, they would not comment on what the outcome of any relevant risk assessment would have been, beyond saying that the divers should have been engaged in the process. That would simply have led to the divers indicating that they were satisfied with things the way they were.

[105] In considering the cause of the fall, the court should not make assumptions or speculate. The fall could have been caused by the weight of the diving equipment, a trip on the fins, or a stumble caused by something else. While inference was an available mode of arriving at a conclusion as to the cause of the fall, it had to have a sufficient evidential basis, which was lacking here. Without knowing why Mr Warner fell, it was futile to speculate on what might have prevented that fall, and the pursuer's case had to fail – *Leonard* v *Loch Lomond and Trossachs National Park Authority* [2014] CSOH 38; [2015] CSIH 44; *Fegan* v *Highland Regional Council* [2007] CSIH 44. The fall had happened next to a handrail, and Mr Warner therefore was or ought to have been holding it. That circumstance in no way supported a case based on lack of handrails, which in any event was not supported by the evidence as a whole. As to the system of operations on board, it was standard practice in the industry and not effectively criticised by any witness whose evidence could be relied on. In any event, Mr Warner's apparent failure to observe the medical advice he had previously been given not to dive with a chest infection tended to indicate that he would not have obeyed any instructions as to how to prepare for entering the water that the skipper might have given him, nor would he have accepted any unwanted assistance from the deckhand.

[106] As to the cause of Mr Warner's death, the pursuer had simply failed to prove why he drowned. The loss of blood he suffered would not have impaired his mental faculties. The pursuer's expert accepted that other unknown factors must have been at play. It would be wrong to start from the fact of drowning and assume that it must have been caused by the injury suffered on board. The defenders made no positive offer to prove what the cause of death was, but that onus did not rest on them.

Analysis and decision

Observations on witnesses

[107] With one limited exception, I found each of the witnesses who gave oral evidence at the proof to be wholly credible and reliable. The defenders submitted that the evidence of the pursuer's maritime and diving expert witnesses, Mr Biles and Mr Casey, was not based on sufficient knowledge or experience of technical diving as to make it admissible as expert evidence, or in any event useful to the court. I do not accept that criticism; it seemed to me that each had sufficient insight based on experience to be capable of assisting the court on the matters to which they respectively spoke. While there is a particular issue with the evidence of Mr Biles and Mr Casey, it is an issue that applies equally to the evidence of the defenders' own relative expert Mr Murray. That issue is that each of those witnesses was prepared to, and did, express views on the nature and extent of duties that might or might not be incumbent on the defenders when those matters lay firmly within the exclusive province of the court. Those views were thoroughly mixed, both in the experts' reports and in their oral evidence, with evidence as to matters of fact and of opinion (e.g. the practicability of possible precautionary measures) which was indeed admissible and useful

as expert evidence in the case. In forming my own view on the matters for the court, I have had regard only to the admissible elements of these witnesses' evidence.

[108] The only exception to the general credibility and reliability of the witnesses I heard related to the evidence of Mr Cuthbertson that he frequently repeated warnings to divers on board the *Jean Elaine*, including those on the fatal trip, to hold onto the handrails provided. That evidence did not gain any substantive support from anyone else on board who ought to have heard such repeated warnings, whether divers or Mr Stanger, and is, further, difficult to reconcile with the evidence on the subject which Mr Cuthbertson himself gave to the coroner's inquest. I do not accept that Mr Cuthbertson frequently repeated warnings to hold onto the handrails to divers on the fatal trip. On the basis of the evidence I heard, it is not easy to see that anything occurred from which Mr Cuthbertson could genuinely have persuaded himself that he did give such repeated warnings. I do not find his evidence that he did so to be credible.

What caused Mr Warner's fall?

[109] I find that Mr Warner fell because he tripped on his fins while attempting to walk from his preparation seat to the dive gate. He did not overbalance while or immediately after rising from his seat. He was not holding any handrail when he fell.

[110] This was not a case where the fall in question was unwitnessed. There was one witness, Mr Stanger, who saw it happen directly in front of him. Two other divers, Mr Plant and Mr Marshall, did not see the fall directly, but became aware immediately of it having occurred and of its location. Mr Stanger's evidence was that Mr Warner stood up, took one or two steps, and then tripped, apparently on his fins. That the fall was not immediate upon his rising from his seat is supported by the evidence of Mr Marshall (who thought that one

or two steps were taken) and of Mr Plant (who estimated the fall to have occurred two or three feet away from the seat). I do not, therefore, consider that Mr Warner lost his balance on standing; the fall did not occur at his seat and there was no suggestion in the evidence that he was stumbling or staggering in any way before the point of the fall about three feet away. Mr Stanger described the cause of the fall as a trip. No one regarded the fall as having been caused by anything on deck over which Mr Warner could have tripped. Rather, one of the risks recognised as attendant upon walking forwards in fins, namely that one stands with the fin on one foot on the fin on the other foot, that a fin bends underneath itself, or that the fins otherwise foul each other, in each case preventing free movement of a foot and causing a trip, appears to have eventuated. That was Mr Stanger's impression of what had occurred from what he observed at close quarters, and it is consistent with the known inherent risk of tripping in fins. Moreover, although he did not directly witness the fall, Mr Cuthbertson's own assessment of what had happened from what he saw and heard after coming out of the wheelhouse to assist was that, because of where the fall occurred (i.e. not directly at the seat) and because Mr Warner was blaming himself for what had happened, he had "stood on his fins". That such was the assessment of an experienced dive boat skipper when coming on the scene of the fall tends to confirm what the more direct evidence also suggests. On the balance of probabilities, then, Mr Warner tripped on his own fins while walking towards the dive gate.

[111] I also note that the evidence does not suggest that Mr Warner was holding a handrail when the trip occurred. A handrail was available in the vicinity of the fall, on the starboard side of the cowling to the hatch entrance, which Mr Warner could have held onto and made sensible use of with his right hand while taking one available route to the dive gate. Mr Stanger did not suggest that he was holding that rail at the time of the fall, and the force

of his fall does not appear to have been broken to any extent, as one might have expected had Mr Warner been able to bear some of his weight on a rail. It may be that the reason Mr Warner was not holding a rail as he fell was because he was, as Mr Cuthbertson suggested (and understandably, given the weight he was bearing), taking the most direct route from his seat to the dive gate, which would have involved him moving away from the superstructure of the boat to which the handrails were fitted. However, given that no issue of contributory negligence remains live in this case, it is unnecessary to make any positive finding as to why he was not holding a rail when he fell; it suffices for present purposes to note simply that he was not doing so.

What caused Mr Warner's death?

[112] Mr Warner died because, while at around a depth of 80 metres below the surface, he became aware of abdominal pain in consequence of the intra-abdominal haemorrhage suffered as a result of his fall on deck. This caused him to attempt to make an emergency ascent in an anxious and ultimately panicked state which was affecting the effectiveness of his breathing. In the course of that ascent, he became unconscious or otherwise unable to retain his breathing mouthpiece, which fell out of his mouth, causing him to drown. The injury suffered by him in the fall materially contributed to the sequence of events leading to his death.

[113] It is not in dispute from the eyewitness evidence of Mr Brown and Mr Mee that Mr Warner chose to make a rapid and unplanned ascent from depth, or that in the course of that ascent he was struggling with his buoyancy, in a distressed state, breathing erratically and hyperventilating, and apparently making greater demands on his breathing apparatus than it was able to respond to effectively. From the uncontradicted evidence of Mr Mee, he

was also hitting his mouthpiece on the shot line he was using to guide his ascent. In those circumstances, eventually his mouthpiece came out of his mouth in the course of the ascent and he became unresponsive and drowned. An examination of Mr Warner's equipment after his death revealed no defect.

[114] What is in some degree of dispute is what caused Mr Warner to make the ascent in the course of which he drowned. In the opinion of the doctors who carried out the post mortem examination, the likely cause of that ascent was pain being experienced from the intra-abdominal haemorrhage caused by the fall. It is not difficult to figure that, although any anxiety caused as a physiological result of the injury itself may have been at worst mild, the appreciation by Mr Warner while he was at a depth from which safe surfacing would normally take a considerable time that he had suffered an abdominal injury that was causing him increasing pain is likely to have been extremely disconcerting. Dr Drury in effect agreed with the assessment of the post mortem pathologists. Mr Beckingham did not disagree that that assessment was a plausible explanation of what had occurred, but advanced the proposition that to conclude that such was indeed the cause of the ascent was speculation. However, no positive suggestion as to what other factor might have been engaged in the decision to ascend or the death was made, even in the abstract. The court was thus presented on the one hand with an explanation for the decision to make an emergency ascent which was variously described as likely or plausible, and on the other with a suggestion that some other unidentified issue may have been at play, the likelihood of the involvement of which in the ascent or subsequent death could not be ascertained precisely because it was unidentified and probably unidentifiable. In these circumstances, while it may be appropriate to regard the cause of the ascent and death as unascertained in medical or scientific terms (which is effectively what I understood Mr Beckingham to be

saying) in legal terms I have little difficulty in holding on the balance of probabilities that the pain from the injury sustained in the fall caused the decision to make the emergency ascent, and that the anxiety and pain which was probably being experienced by Mr Warner during that rapid ascent, together with the effect which the circumstances of the ascent was having on his ability to control his breathing and movements, caused him to become unable to retain his mouthpiece and thus to drown.

[115] It is appropriate to note in this connection that – although he would not himself make any such claim – the efforts of Mr Jaymes Brown, in particular, to assist Mr Warner when his problems manifested themselves went well beyond what might reasonably have been expected of him, and (because of his own rapid ascent to catch up with Mr Warner) were done at considerable risk to his own safety. Although his efforts were ultimately in vain, he nonetheless deserves to be commended for having made them.

Defects in the ship – Article 3(3) of the Athens Convention

[116] As already noted, if Mr Warner's injury is shown to have arisen from or in connection with a defect in the *Jean Elaine*, a presumption of fault and neglect on the part of the defender arises in terms of Article 3(3) of the applicable version of the Athens Convention. The only features of the *Jean Elaine* which were criticised in this respect were the slope of the deck and the arrangement of handrails at the time of the fall, in particular a claimed paucity of their provision at and around the M bench where Mr Warner had prepared himself.

[117] In relation to the slope of the deck, Mr Biles gave evidence that the incline of the deck was 7° to the bow, with a camber of 2°. While it is possible – and I can put it no more highly – that the slope of the deck contributed to the precise mechanism of Mr Warner's trip, there

was no suggestion at all in the evidence that the configuration of the deck fell below any applicable standard, that it was inherently dangerous, or indeed that it should or even could sensibly have been configured otherwise. In these circumstances, I am unable to conclude that the configuration of her deck was a defect in the *Jean Elaine*. Even had I been able so to conclude, the available evidence would not have supported a conclusion on the balance of probabilities that the fall arose from or in connection with the configuration of the deck.

[118] In relation to the provision of handrails, the principal difficulty facing the pursuer is that, as I have found, Mr Warner's fall occurred in the vicinity of a handrail which he could have been putting to sensible use but which in fact he was not using. That was the horizontal handrail on the starboard side of the cowling to the hatch entrance. While further vertical and diagonal handrails have since been provided on that cowling, there is no basis in the evidence for any finding that Mr Warner would probably have used them had they been there at the relevant time. There is, thus, no proper basis for any finding that his fall arose from or in connection with any defect in the *Jean Elaine* which the then absence of those additional handrails might have constituted. In those circumstances it is strictly unnecessary for me to express any view on whether the provision of handrails on the *Jean Elaine* at the time of the fall did or did not represent a defect in the ship.

[119] If it had been necessary for me to reach a conclusion on that matter, I would have decided that there was no defect in the *Jean Elaine* in consequence of the handrail provision at the time of the fall. The ship surveyor Mr Smith's report to MECAL spoken to in evidence confirmed his professional view that the provision of handrails onboard was "satisfactory", that is to say enough to ensure the safety of people on board, which in his view meant being able to reach a rail without taking more than one step. It would be difficult, given that general opinion, which I did not understand to be contradicted by any other witness, to

form any view other than that any difficulty experienced in connection with handrails would be the result of the way in which individuals chose to conduct themselves, rather than the result of any inherent defect in the ship. There was no suggestion in the evidence that the provision of handrails on the *Jean Elaine* was any different or less generous than on comparable boats, a matter which, while not being definitive in itself, again tends to suggest that the provision on the *Jean Elaine* did not fall below generally-accepted standards.

[120] I did not consider that the provision of additional handrails after the event amounted to any sort of tacit acceptance on the part of the defenders that the complement at the time of the fall was in any way defective. Rather, it seemed to me that the somewhat inspecific MAIB recommendation that a review of safety arrangements on the *Jean Elaine* should include assessment of the positioning of physical supports in effect resulted in Mr Cuthbertson placing additional handrails on more or less any surface reasonably capable of accommodating them. The outcome appears to be a present surfeit rather than satisfactory evidence of any previous deficit. I was not convinced that the addition of vertical and diagonal rails on the starboard side of the hatch cowling near to which Mr Warner fell added materially to the support in that area already available from the pre-existing horizontal rail. There was some suggestion that the new horizontal rail added to the cowling next to, and facing, the M bench would have been of assistance to someone rising from the seat there, but it seemed to me that any such benefit from a rail situated on one side of the rising diver only, and situated at a relatively low level, would have been at best marginal, and that the previous absence of such a rail did not fall short of any objective requirement of safety so as to constitute a defect in the ship. In any event, the absence of that rail at the time of Mr Warner's fall had nothing to do with what happened to him, as previously explained. Possible alternative arrangements mentioned briefly in the evidence,

such as central rails in the gangway, moveable rails capable of being deployed only when needed, or overhead rails, were not shown to be practicable and their absence at the time of the fall cannot sensibly be said to have represented defects in the *Jean Elaine*.

[121] In the result, then, I was unpersuaded that there was any defect in the *Jean Elaine*, and it is clear in any event that Mr Warner's injury did not arise from or in connection with any such defect. The pursuer is therefore not able to take the benefit of the presumption of fault and neglect provided for by Article 3(3) of the Athens Convention, and must seek to establish such fault and neglect *aliunde*.

Fault and neglect

[122] The pursuer alternatively seeks to establish fault and neglect relevantly associated with Mr Warner's injury, and thus liability in terms of the Convention, by maintaining that the defenders were at fault in not having made a suitable and sufficient assessment of the risks attending the dive support operations carried out by them, that had they done so, they would have become aware of a risk of injury to divers from falls on deck that required to be addressed and minimised so far as reasonably practicable, and that had measures to minimise that risk to that extent been taken, Mr Warner's fall would probably have been avoided.

Was Mr Cuthbertson under a duty to carry out a risk assessment?

[123] The primary suggestion for the pursuer was that Mr Cuthbertson was under a duty to carry out a risk assessment in terms of the Regulation 7 of the Merchant Shipping and Fishing Vessels (Health and Safety at Work) Regulations 1997/2962, the material terms of which at the relevant time were as follows (*emphasis* added):

"**7.— Risk assessment**

(1) A suitable and sufficient assessment shall be made of the risks of the health and safety of workers arising in the normal course of their activities or duties, for the purpose of identifying–

(a) groups of workers at particular risk in the performance of their duties; and

(b) the measures to be taken to comply with the employer's duties under these Regulations,

and any significant findings of the assessment and any revision of it shall be brought to the notice of workers.

(2) *This assessment shall extend to the risks to the health and safety of other persons on board ship in so far as they may be affected by the acts and omissions of the employer*.

…

(5) *Measures shall be taken*, and if necessary protective equipment supplied, *to ensure an improvement in the health and safety of workers and other persons in respect of those risks identified*."

[124] Reading those provisions short in so far as applicable to the present case, it is clear that they require a suitable and sufficient assessment to be made of the risks to the health and safety of persons on board ship in so far as such risks may be affected by the acts and omissions of the defenders, and that measures are to be taken to ensure an improvement to those persons' health and safety in respect of any risks identified. I reject any suggestion by the defenders that any benefit to non-workers is intended to be incidental only from an assessment of the risks to workers. That construction cannot be reconciled with the words of the Regulation and there is, further, no good reason to suppose that any such construction would be supported by the general intent of the Regulations. That the assessment only requires to address risks to persons insofar as those risks may be affected by the acts and omissions of the employer provides a suitable control mechanism to prevent the employer having to assess the risks that might be generated by activities on board not capable of being affected by its own acts or omissions.

[125] In any event, and perhaps more to the point given that what is being considered is the existence of fault and neglect in terms of Article 3 of the Athens Convention rather than whether a domestic statutory provision was complied with, even if there had been no specific statutory obligation to carry out a risk assessment, there would in any event have been a duty on the defenders, in the exercise of reasonable care for the health and safety of those invited by them on board, positively to consider whether any aspect of the environment on board, or the way in which it was proposed to carry out the planned dive support operations, gave rise to any risk to the safety of such persons, what the extent of any such risk was, and what if anything should be done to minimise it. The analogy which the defenders sought to draw between their own position and that of the owners and occupiers of open spaces where the nature of activities to be carried out by those having effectively free rein to do as they will cannot effectively be controlled, is a false one. The true analogy is with the operators of other facilities to which access is restricted and activities of a particular kind are proposed to be carried out which can be supervised and controlled, as in, for example, skating rinks, golf ranges, indoor swimming pools and enclosed sports arenas. In such situations, the operator ought in the exercise of reasonable care to carry out an assessment of whether the proposed activity may be carried out in a way which poses a risk to the safety of the person doing it or others, and, if so, take appropriate steps to control any such risk, as by having rules of conduct and enforcing them.

Did Mr Cuthbertson carry out a suitable and sufficient risk assessment?

[126] I agree with Mr Murray's suggestion in evidence that Mr Cuthbertson did indeed carry out some form of risk assessment in relation to the dive support operations being carried out by the defenders, even though he may not have called it by that name, written it

down, or recognised it for what it was. Despite his self-description as a maritime "taxi driver", it was clear that Mr Cuthbertson was doing much more than simply taking dive groups to wherever they wanted to go and letting them get on with whatever they wanted to do there. For example, he would not operate when the environmental conditions rendered (or appeared likely to render) diving or dive preparation unsafe, he controlled the movement of the boat appropriately when divers were preparing to enter the water, he provided a non-slip and unobstructed deck for them to walk on, he provided handrails at the deck periphery and on the superstructure for them to hold if they chose to do so (although I have already noted that he did not actively encourage or enforce their use), and he provided the services of a deckhand to be called upon if wanted by them in the course of their preparation and movement towards the dive gate. I have no doubt, too, that if he had seen a diver do something on deck which he subjectively considered to be positively dangerous to the divers or others, he would have stepped in and warned about, or stopped, whatever was going on.

[127] What his risk assessment omitted to do, however, was to recognise sufficiently that walking on deck in fins is an inherently risky activity. That was a well-recognised fact in maritime and diving circles. The diving organisations PADI and BSAC simply and straightforwardly advised against it. To the extent that that advice was aimed only at inexperienced divers (and it is not clear to me that it was) that did not indicate that there was no or lesser risk for experienced divers, merely that their experience would already have instructed them about that risk. In the case of technical divers, the risks were intensified by the weight of the equipment being carried, the raising of the centre of gravity of the diver by the distribution of that weight (thus rendering a trip or stumble more likely to result in a fall) and the restriction on the diver's visual field by the diving hood and mask,

all to the extent that MAIB regarded the risk posed to a technical diver walking in fins as a significant one. According to Mr Casey, the risk of walking on deck in fins was such that no professional commercial diving operation with a deck overseen by him would even countenance permitting it. At the recreational end of the diving spectrum, Mr Woodward would have had an admonitory word with anyone seen walking in fins at the dive centre run by him. The experienced divers on the fatal trip were, by and large, clear that one could reduce the risks by moving in a certain way while wearing fins. While that may well be true, it rather overlooks the fact that the very need for risk minimisation procedures indicates the immanent presence of a risk, and for present purposes the issue is not that the risk could have been minimised, but whether Mr Cuthbertson recognised its existence and the need to consider taking appropriate steps to see to it that it was minimised. Even Mr Cuthbertson's description of Mr Warner's fall as being the consequence of him being "daft" or displaying "stupidity" implicitly recognises that he was undertaking a risky activity, but fails to demonstrate any appreciation that the system of operation which Mr Cuthbertson had set up was permitting or tacitly encouraging the taking of that risk.

[128] I accordingly conclude that Mr Cuthbertson was guilty of fault and neglect in terms of Article 3 of the Athens Convention, in that he failed to recognise that the system of dive preparation he had set up or allowed to develop (i.e. with most kitting-up places remote from the dive gate and it being left entirely to the divers how and at what stage of preparation they made their way from their seats to the gate) permitted or even encouraged divers to walk on deck in fins, and that that was an inherently risky activity to the extent that consideration should have been given to putting in place mechanisms apt to eliminate it or at least bring it under close control.

Content and outcome of a suitable and sufficient risk assessment

[129] The next question is whether Mr Warner's injury arose from or was connected with that fault and neglect on the part of Mr Cuthbertson. Put in more concrete terms, what should a suitable and sufficient risk assessment have concluded about the risk of technical divers walking in fins on deck, and, if any steps which it ought to have concluded were required to mitigate that risk had been taken, would Mr Warner's injury have been avoided?

[130] The risk of a technical diver falling while walking in fins on deck was, as I have noted, well-recognised by the time of Mr Warner's fall. The risk that such a fall might well cause injury ought also to have been appreciated, given that it would involve a diver laden with heavy and solid equipment coming into contact, quite possibly uncontrolled and hard contact, with an unyielding surface (be that the deck, the boat's superstructure, or the equipment itself) without the benefit of any protective garb. The same factors indicate that, whatever previous experience might have been thought to indicate, it would be realistic to figure that any injury might well be more than minor. The MAIB had records of injuries connected with dive boat falls serious enough to have been brought to its attention. Mr Cuthbertson himself recognised that an arm might be broken in such a fall, scarcely a nugatory matter. The fact that an injury might well be sustained at a location where swift medical assistance could be difficult or impossible to access should also have been taken into account.

[131] All of these considerations indicate that thought ought to have been given to the practicability of putting into place measures to mitigate the risk, in order to ascertain where the proper balance of hazard and precaution lay. It is certainly true that divers consulted about the question might have been resistant to any change to the existing situation where they were in effect free to do as they wished when it came to kitting-up and moving to the

dive gate. They would, no doubt, have put forward a variety of objections to any proposal for change, for example that it is difficult to put on fins by yourself at a late stage in the kitting-up process, that they did not trust someone else to put on and secure their fins for them, that standing up and sitting down at the dive gate to put on fins carries its own risks, or that timing considerations arising from the limited duration of slack water would make it difficult for everyone to put on their fins sequentially at the gate. Ultimately, however, I consider that these objections lacked real substance and, given the nature of the risk which had to addressed, could and should have been overcome. The technical divers were on board because they wished to enjoy the experience of deep diving and wreck exploration. No one was on board because he especially enjoyed walking in fins. Where the divers recognised hazards attendant upon their chosen recreational activity, they took measures – often extensive and burdensome – to minimise those hazards. If the defenders, as the providers of the dive support services which the divers were using, had expressed to them genuine and serious concerns about the hazards arising from a practice of walking on deck in fins, there is no good reason to suppose that their opposition to a change in practice would have been implacable.

[132] The defenders expressed puzzlement about just what measures the relative experts led by the pursuer were saying ought to have been adopted. I did not find any difficulty in understanding the suggestion being made, which was essentially that the defenders ought to have expressed concerns to divers about walking in fins at the outset of each hire of the boat, made it clear that their policy was to eliminate or minimise that practice, and invited the members of the dive group to have a dialogue with them about just how that policy was to be put into practice on the trip in question. The evidence established that the exact process of kitting-up was largely a matter of personal preference. Some divers would

perhaps have wished to continue to put their fins on early in the process, and at least some of those could have been accommodated (perhaps sequentially, which would have been a viable change to the existing practice of each diver having a single allocated or chosen seat throughout a trip) at seats provided very close to the dive gate and made a very short walk, assisted compulsorily by the deckhand, to it. Others would have had no or little particular problem with putting on their own fins last at the dive gate, or having them put on for them there, and they could have kitted up at a more remote seat and walked to the gate (a specific route from their seat using the handrails having been designated and clearly explained to them before each dive) before putting on their fins there. Yet others who either did not want to, or because of logistics were unable to, avail themselves of those options could have kitted up at a remote location from the gate and been compulsorily supported by the deckhand via a designated and handrail-assisted route to the gate when their turn to enter the water came. Some changes to the desired order of diver entry into the water, or whether entry was to take place singly, in pairs or more, might have been required. The operation of the agreed system ought to have been observed by the deckhand and strictly enforced by the skipper, to the point of warning that miscreants would summarily be put ashore if need be. The overarching point is that no single and inflexible system of operation had to be implemented on every trip and regardless of individual circumstances, but that a system – whether using all or some of the possible expedients mentioned above, or others – ought to have been devised and executed on every trip so as to avoid, or at least minimise, the practice of technical divers walking on deck in fins.

[133] Had such a system for the promotion of safer fin practices been in place, the likelihood is that it would have performed its intended function of eradicating or minimising the risk of falling and that Mr Warner would not have fallen at all, or if he did,

he would not have sustained a serious injury such as he in fact sustained, because the force of any fall would probably have been broken by him holding on to a handrail or being supported by the deckhand. The injury he in fact sustained can therefore properly be said to have arisen from or in connection with the fault and neglect of the defenders previously identified. I do not regard the evidence from Mr Warner's former GP practice as a sufficient basis for supposing that it is more likely than not that he would not have complied with any system of operation put in place on the *Jean Elaine*. A failure to follow previous general medical advice to the letter is something very different from a failure to obey specific operational instructions issued and to be performed in a supervised environment. In any event, had the defenders instituted appropriate enforcement measures as indicated above, the opportunity persistently to fail to follow the prescribed system would simply not have been available.

Conclusion and disposal

[134] For the foregoing reasons, I find that the defenders are liable to make reparation to the pursuer in terms of Article 3(1) of the Athens Convention. The quantum of damages is agreed in the sum of £290,000 inclusive of interest to 20 April 2020. The case will be put out by order to determine any required increase in the interest element of the decree to be granted. All questions of expenses are meantime reserved.