SHERIFFDOM OF GRAMPIAN, HIGHLAND AND ISLANDS AT TAIN

[2017] FAI 18

B36/17

DETERMINATION

BY

SHERIFF CHRISTOPHER DICKSON

UNDER THE FATAL ACCIDENTS AND SUDDEN DEATHS INQUIRIES (SCOTLAND) ACT 1976

into the death of

ALEXANDER JOHN ROBBINS

Tain, 7 September 2017

The sheriff, having resumed consideration of the Fatal Accident Inquiry into the death of Alexander John Robbins, Determines, in terms of section 6 of the Fatal Accident and Sudden Deaths Inquiry (Scotland) Act 1976 (hereinafter referred to as "the 1976 Act)", as follows:

1. **In terms of section 6(1)(a) of the 1976 Act:**

   That the late Alexander John Robbins, born 19 November 1954, died at Raigmore Hospital, Inverness at 15.33 hours on 31 March 2016.

   That the accident resulting in death took place at a cliff top field near Daill House, Achiemore, Kyle of Durness, Sutherland, on 31 March 2016 between the hours of 11.20 and 13.15.

2. **In terms of section 6(1)(b) of the 1976 Act:**

   That the cause of Mr Robbins' death was:

1(a) Multiple injuries, due to a:

1(b) Fall from a cliff while riding a quad bike.

That the accident resulting in death arose by way of the quad bike, which Mr Robbins was riding, going through a cliff top fence, over the edge of a cliff top and falling approximately 60 feet to a rocky beach below.

That the cause of the accident resulting in death is unknown.

3. In terms of section 6(1)(c) of the 1976 Act:

There are no reasonable precautions whereby the accident resulting in the death of Mr Robbins might have been avoided.

4. In terms of section 6(1)(d) of the 1976 Act:

There were no defects in any system of working which contributed to the death of Mr Robbins or the accident that resulted in his death.

5. In terms of section 6(1)(e) of the 1976 Act:

The other facts relevant to the circumstances of death are:

1. That quad bikes, as compared to other four wheeled machines, have some peculiarities in their operation and handling;

2. That different makes and models of quad bikes can operate and handle differently;

3. That it is therefore of particular importance that quad bikes should only be driven by persons who have received appropriate training to allow the safe driving of the particular make and model of the quad bike that they are going to use;

4. That an employer, in addition to providing adequate training for employees using quad bikes, should assess their competence to drive quad bikes, continue to monitor their competence and provide refresher training as required.

5. That in order to safely use a quad bike, it is essential to carry out safety checks and maintenance in accordance with the manufacturer's recommendations. In particular, pre-ride safety checks should always include checks of the tyre pressure, brakes and throttle.

6. That those persons using quad bikes should always wear, and be trained to wear, an appropriate helmet.

FINDS IN FACT

1. That Alexander John Robbins was born 19 November 1954 and was 61 years old at the time of his death on 31 March 2016. Mr Robbins had been married to his wife, Anne Robbins, for approximately 30 years. Mr and Mrs Robbins resided at Rhigolter Farm, Durness by Lairg, Sutherland, IV27 4QG. Mr and Mrs Robbins had resided at that address for approximately 26 years and Mr Robbins had been employed as shepherd with Rhigolter Farm for the entirety of that period. Mr Robbins was a very experienced shepherd who was a conscientious worker, worked without complaint and knew the land that he worked well.

2. That for approximately 10 years prior to the accident on 31 March 2016, Mr Robbins had been diabetic. At the time of the accident on 31 March 2016, this medical condition was well controlled and not causing Mr Robbins any issues.

3. That at the time of his death on 31 March 2016, Mr Robbins was employed as a shepherd by Mr David Elliot, who was and is the owner of Rhigolter Farm.

4. Rhigolter Farm has an area of approximately 8000 acres and is split into two parts geographically. The main part is on the east side of the Kyle of Durness where the sheep and deer are normally kept. The second part is an area of approximately 300 acres at Daill, Achiemore, Kyle of Durness, Sutherland.

5. That at the time of his death on 31 March 2016, Mr Robbins was in the course of his employment and was engaged in the task of gathering young ewes (known as gimmers) which had spent the winter at Cape Side near Daill House, Achiemore, Kyle of Durness, Sutherland. The young ewes were to be taken back around the Kyle to re-join the flock at Rhigolter Farm on the mainland. On 31 March 2016 Mr Robbins was supposed to have been assisted by another man but he failed to turn up and Mr Robbins was working alone.

6. That on 31 March 2016 there were two farm quad bikes available for farm use namely a Green Suzuki quad purchased in January 2014 and a Red Honda Foreman 450 quad. Neither of these quad bikes were kept at Daill.

7. That a third quad bike, namely a Honda Big Red Quad 300 (hereinafter referred to as the "Honda Big Red Quad"), had previously been available for use by persons employed at Rhigolter Farm. The Honda Big Red Quad was owned by Mr David Elliot. At some point prior to 31 March 2016, The Honda Big Red Quad was removed from Rhigolter Farm when a replacement quad bike was purchased. The Honda Big Red Quad was then kept at either Daill House or in a shed of a Mr James Mather in Durness. After being removed from Rhigolter Farm, the Honda Big Red Quad was mainly used by Mr David Elliot and his family for leisure purposes. However, it was, on occasion, still used to conduct work on Rhigolter Farm. Mr David Elliot considered that after the Honda Big Red Quad had been removed from Rhigolter Farm, Mr Robbins required Mr David Elliot's express permission to use the Honda Big Red Quad. Mr David Elliot considered that Mr Robbins required his express permission to use it on 31

March 2016. Mr David Elliot did not give Mr Robbins express permission to use the Honda Big Red Quad on 31 March 2016.

8. That a Mr James Mather carried out remedial works and other works, such as oil changes, to the Honda Big Red Quad as a favour to the Elliot family in order to keep it in a useable condition for the Elliot family to use when they visited Daill.

9. That around 11.00 hours on 31 March 2016 Mr Robbins spoke to his wife on his mobile telephone and confirmed that he had gathered the sheep at Daill and was planning to bring them back to the main part of Rhigolter Farm that afternoon. Mr Robbins was happy during the telephone call and was making arrangements for the forthcoming weekend.

10. That at around 11.20 hours on 31 March 2016, Mr Robbins met Stuart Ross on the Cape Side and informed him that he had gathered the majority of ewes and was going to collect the last ewes from the Cliff Park, being a fenced area north east of Daill House.

11. That the location of the accident which resulted in the death of Mr Robbins is a cliff top field of grassy scrub land, located within Cliff Park, near Daill House, Achiemore, Kyle of Durness, Sutherland. To reach that location an open ferry with an outboard motor must be taken across the Kyle of Durness and then a rough road leads about 11 miles to the lighthouse at Cape Wrath, the most North-Westerly point in the mainland of the United Kingdom. There is also a rough track approximately 4 miles long, which leads over the hill down the west side of the Kyle and round the head to join the main road at New Grudie House. Daill House is approximately 4 miles along the road on the east side of the Cape. There is a 'V' shaped cove there where the Daill River joins the sea. Daill House is on the north bank of the river, approximately 175 metres from the precise location of the accident, which was at the cliff top also on the north side of the

cove. The approximate grid reference is E361, N685 on Ordnance Survey sheet number 9.

12. That the relevant part of the cliff top on the north side of the cove was a large area known as Cliff Park. Cliff Park was bounded by wire fencing with wooden posts. An old stone dyke ran from the cliff edge in a northerly direction and split Cliff Park into two fields. To the east of the old stone dyke was a field with short grass (hereinafter referred to as "the short grass field"). To the west of the old stone dyke was a field with grassy scrub land (hereinafter referred to as "the grassy scrub land field"). There was a wire fence with wooden posts running adjacent to the cliff edge (hereinafter referred to as "the cliff edge fence"). The cliff edge fence was set a few metres back from the cliff edge. A separate wire fence with wooden posts ran from close to the cliff edge, in a northerly direction, along the cliff top (hereinafter referred to as "the northerly running fence"). To the east of this fence was the grassy scrub land field, the stone dyke and the short grass field. The northerly running fence and the stone dyke were close to being parallel with each other with the grassy scrub land field in between. The cliff edge fence ran between the northerly running fence and the stone dyke. At the south west corner of the grassy scrub land field, at the intersection between the northerly running fence and the cliff edge fence, there was a gate in the northerly running fence. Opposite the gate in the northerly running fence was a hole in the stone dyke. The said hole was of sufficient size to allow a quad bike to drive through the stone wall from the short grass field to the grassy scrub land field or vice versa.

13. That between 11.20 and 13.15 hours Mr Robbins was riding the Honda Big Red Quad in the grassy scrub land field in between the northerly running fence and the stone dyke. For unknown reasons, the Honda Big Red Quad struck the cliff edge fence close to a wooden fence post located at the approximate mid-point of the part of the cliff edge fence running between the northerly running fence and

the stone dyke. The Honda Big Red Quad knocked over the said fence post, which resulted in the cliff edge fence, in that location, being pushed over flat onto the grassy scrub land. The Honda Big Red Quad then went over the cliff edge fence and over the cliff edge at a slow speed. Both the Honda Big Red Quad and Mr Robbins fell to the rocky beach located approximately 60 feet below the cliff edge. Mr Robbins was not wearing a helmet at the time of the accident.

14. That at approximately 13.15 hours on 31 March 2016, Mr James Mather, driver of Cape Wrath minibuses, was driving past Daill House and noticed sheepdogs belonging to Mr Robbins on top of the cliffs north east of Daill House. Mr Mather made his way to the area below the cliff and found Mr Robbins lying injured on the rocky beach. Mr Mather also found the Honda Big Red Quad in the water nearby. Mr Mather then telephoned the emergency services.

15. That at around 13.30 hours on 31 March 2016, Mr James Mather flagged down Mr John Ure, owner of the café at Cape Wrath lighthouse, who had been driving from the lighthouse to the ferry, for assistance and at around 14.00 hours, a Mr Stuart Ross was also flagged down by Mr James Mather, again for assistance.

16. That at 13.29 hours on 31 March 2016 ambulance personnel based in Sutherland were contacted by the Ambulance Control Room in Inverness to advise that an emergency '999' call had been received in relation to a person who had fallen from a cliff onto rocks in the Daill area of Cape Wrath and that a quad bike was in the water. The Coastguard Search and Rescue helicopter based in Stornoway had also been tasked to attend at the scene. While on their way to the location of the accident the ambulance personnel were advised that the Durness General Practitioner was also on the way and would meet the ambulance at the ferry point. On arrival at the ferry point, after organising their equipment, the ambulance personnel, doctor and the local policeman, George Silcock, all got into

the ferry and were conveyed to the Cape Wrath side where they made their way to the location of the accident.

17. That at 14.20 hours on 31 March 2016 the Coastguard helicopter landed and a paramedic from the crew went to Mr Robbins with medical equipment. The ambulance personnel, doctor and PC Silcock arrived a couple of minutes later. The various medical personnel at the location of the accident assessed Mr Robbins. It was clear that he had sustained serious injuries. Mr Robbins was conscious and responding to verbal stimuli but his replies were incomprehensible. It was noted that Mr Robbins had a good air output on his right side, but not on the left side of his chest. He was given oxygen and a saline drip was started. He had a significant head wound which was approximately six inches long and quite deep. This wound was dressed by the ambulance personnel. A collar was put on to support his neck and a strap was placed round his pelvis. At this time Mr Robbins had a weak, thready pulse. However, the pulse stopped. Accordingly, it was agreed that Mr Robbins required immediate medical evacuation.

18. That at approximately 14.50 hours on 31 March 2016 the Coastguard helicopter took off and Mr Robbins and the winchman paramedic from the helicopter crew were winched directly from the rocky beach to the helicopter. As soon as they were aboard the helicopter it departed for Raigmore Hospital, Inverness and a radio call was made requesting that a specialised medical team, known as the Crash Team, should be available at Raigmore Hospital to meet the helicopter.

19. That during the flight the medical condition of Mr Robbins deteriorated and approximately five minutes into the flight he suffered a cardiac arrest. Cardio Pulmonary Resuscitation (hereinafter referred to as "CPR") began and adrenaline was administered. A defibrillator device was used to re-start his heart on two occasions. This treatment was carried out by the paramedic from

the hospital crew and continued for at least twenty five minutes until the helicopter arrived at Raigmore Hospital.

20. At approximately 15.25 hours on 31 March 2016 the helicopter arrived at Raigmore Hospital, Inverness. Mr Robbins was placed on a trolley and CPR continued as he was taken from the helicopter to a Resuscitation Room within the hospital. Despite the efforts of the helicopter crew and the medical staff at Raigmore Hospital these resuscitation efforts were unsuccessful and at 15.33 hours one of the doctors at Raigmore Hospital confirmed that Mr Robbins had died.

21. That at 18.21 hours on 31 March 2016 Ms Pamela Wilson, Force Support Officer, Police Service of Scotland, attended at the location of the accident and carried out a scene examination. A visual examination revealed that on the grassy scrub land above the cliff edge there were faint quad bike tyre marks leading downwards from the top of the hill in the grassy scrub land field to the cliff edge. There were no signs of acceleration marks on the grass. A fencepost, in the cliff edge fence, at the bottom of where the tyre marks ended had been dislodged and there was soil along the post, which was a strong indication that the quad bike itself had gone over the cliff at that point. The Honda Big Red Quad could be seen upright on the land directly below the post at a drop of approximately 60 feet. There was an area of apparent blood staining on the rocks below the fence post just a few metres away from the said Honda Big Red Quad. Also present next to the apparent blood staining were a few small pieces of debris, most probably from the Big Red Honda Quad. The Honda Big Red Quad was still in gear and showed significant damage to the tyre rims and both the front right and rear axle areas.

22. That at approximately 13.00 hours on 1 April 2016 Iain Leslie Mathers and Martin Ian Macrae, both Constables, Road Policing Division, Police Service of Scotland, Dingwall attended at the location of the accident and examined the

Honda Big Red Quad which, although removed from the sea water by this point, had remained on the beach since the accident the previous day. Both Constables had previous experience in the examination of motor vehicles in connection with their duties. The Honda Big Red Quad was a four wheel drive quad motor cycle, model number TRX300FW, with a frame number of 478TE1505TA809897. It had been manufactured in the United States of America in 1995. The power output was 13.7 KW (Kilowatts) and the dry weight was 239 kilograms. The Honda Big Red Quad had extensive damage to all sides and the drive to the rear wheels had detached. The throttle operation appeared free and the Honda Big Red Quad was found to be in gear 'SL', which is an abbreviation for 'super low'. An inspection of the braking system revealed that the front offside brake was inoperative, with the wheel cylinder corroded and seized. The front nearside brake and rear brakes were working, although the front nearside brake had diminished effectiveness.

23. That the Honda Big Red Quad had the following offside handlebar mounted controls:

    (1) A front brake lever; and

    (2) A throttle lever positioned for operation with the rider's thumb.

    When the front offside break lever was pulled it ought to have engaged the front nearside and front offside brakes. On 31 March 2016, as a result of the front offside brake being inoperative, the pulling of the front offside brake lever would only have engaged the front nearside brake.

24. That the Honda Big Red Quad had the following nearside handlebar mounted controls:

    (1) A sliding on/off switch; and

    (2) A lever for actuating the rear brakes.

The Honda Big Red Quad had an offside foot operated lever that could also be used to apply the rear brakes. It was steered by a conventional handlebar. The Honda Big Red Quad had a nearside foot lever which controlled the gears. The gears ascended reverse, neutral, SL, 1, 2, 3, 4. Pressing down on the gear lever allowed the rider to go down the gears and lifting the gear lever allowed the rider to go up the gears.

25. That on 4 April 2016 at the instance of the Scottish Fatalities Investigation Unit (North), Dr Mark A. Ashton FRCPath, Consultant Pathologist, Department of Cellular Pathology, Raigmore Hospital, Inverness carried out a post mortem examination on the body of Mr Robbins and certified the cause of his death as 1(a) Multiple injuries, due to: 1(b) fall from cliff while riding quad bike.

26. That the said post mortem examination carried out by Dr Ashton did not establish any physical evidence for any sudden medical event prior to the death of Mr Robbins. However, sudden medical events can occur without leaving any forensic features that could be identified on a post mortem examination.

27. That Mr Robbins died as a result of physical injuries sustained in the fall from the cliff, which were cumulatively unsurvivable.

28. That forensic samples obtained post mortem from Mr Robbins were received by Dr Duncan W. S. Stephen BSc (Jt Hons) PhD MSc FRCPath etc, Forensic Toxicologist, Department of Clinical Biochemistry, Aberdeen Royal Infirmary, Foresterhill, Aberdeen and analysed. The results of these tests showed that Mr Robbins did not have any alcohol in his system when the accident on 31 March 2016 occurred.

29. That whilst Mr Robbins did not receive any formal training in the use of quad bikes he was, nevertheless, very experienced in the use of them. Mr Robbins normally drove quad bikes in a slow and careful manner.

NOTE

Introduction

[1] This was a fatal accident inquiry (hereinafter referred to as "FAI") into the death of Alexander John Robbins who died in the course of his employment as a shepherd on 31 March 2016. As such the FAI was a mandatory inquiry held in terms of section 1(1)(a)(i) of the 1976 Act. The inquiry took place over two consecutive days, namely 22 and 23 August 2017. Mr Aitken, Procurator Fiscal Depute represented the Crown. Mrs Watt represented Mr Robbins' employer, Mr David Elliot of Rhigolter Farm, Durness and Mr McGowan represented Mrs Anne Robbins, the wife of Mr Robbins.

[2] The parties had concientiously agreed the majority of the evidence and a substantial joint minute of agreement was read on the first day of the inquiry. The only witness to give oral evidence was Dr Norman Schouten, HM Inspector of Health and Safety. Dr Schouten was called by the Crown. His evidence was not seriously challenged and I found him to be a credible and reliable witness. At the conclusion of the evidence each representative produced helpful and considered written submissions. My findings in fact are based on the agreed evidence and the evidence I accepted from Dr Schouten.

The Purpose of a Fatal Accident Inquiry

[3] The critical section here is section 6(1) of the 1976 Act. But before considering that section it is first important to recognise the purpose of an FAI. In *Black v Scott Lithgow Limited* 1990 SC 322 at p 327, Lord President Hope said:

> "There is no power in this section [*sec 6(1) of the 1976 Act*] to make a finding as to fault or to apportion blame between any persons who might have contributed to the accident. This is in contrast to sec. 4 (7) of the 1895 Act, which gave power to the jury to set out in its verdict the person or persons, if any, to whose fault or negligence the accident was attributable. It is plain that the function of the sheriff at a fatal accident inquiry is different from that which he is required to perform at a proof in a civil action to recover damages. His examination and analysis of the evidence is conducted with a view only to setting out in his determination the circumstances to which the subsection refers, in so far as this can be done to his satisfaction. He has before him no record or other written pleading, there is no claim of damages by anyone and there are no grounds of fault upon which his decision is required."

In Sheriff Kearney's determination in the death of Mildred Allan (issued on 14 November 1985 and an extract reproduced in Carmichael, *Sudden Death and Fatal Accident Inquiries*, 3rd Ed at para 11-07) he stated:

> "The essential purposes are the enlightenment of those legitimately interested in the death, *i.e.* the relatives and dependents of the deceased, as to the cause of death (and any accident resulting in death) and the enlightenment of the public at large, including the relatives, as to whether any reasonable steps could or should have been taken whereby the death might have been avoided so that lessons may be learned or, at least, the attention of further inquirers directed into ways whereby practices which contributed to the death can be improved."

[4] It is therefore clear from those passages that an FAI is concerned with fact finding and not fault finding. The purpose of an FAI is not to apportion blame to any person but to inquire into all the circumstances of the death and accident resulting in death in order to discover the truth, identify any reasonable precautions which might have been taken and ascertain if any lessons can be learnt which might serve to prevent the re-occurence of any similar accident.

[5] Section 6(1) of the 1976 Act provides:

> At the conclusion of the evidence and any submissions thereon, or as soon as possible thereafter, the sheriff shall make a determination setting out the

following circumstances of the death so far as they have been established to his satisfaction:

(a) where and when the death and any accident resulting in death took place;
(b) the cause or causes of such death and any accident resulting in death;
(c) the reasonable precautions, if any, whereby the death and any accident resulting in death might have been avoided;
(d) the defects, if any, in any system of working which contributed to the death or any accident resulting in death;
(e) any other facts which are relevant to the circumstances of the death."

In this Note I propose to approach matters by considering each subsection, together with the evidence led in respect of each subsection, separately.

Discussion

Section 6(1)(a) of the 1976 Act

[6] Section 6(1)(a) of the 1976 Act identifies two questions:

(1) When and where the death took place; and

(2) When and where any accident resulting took place.

In this FAI there was no dispute about the answer to these questions and I had no difficulty in determining from the undisputed evidence:

(1) That the late Alexander John Robbins, born 19 November 1954, died at Raigmore Hospital, Inverness at 15.33 hours on 31 March 2016.

(2) That the accident resulting in death took place at a cliff top field near Daill House, Achiemore, Kyle of Durness, Sutherland, on 31 March 2016 between the hours of 11.20 and 13.15.

Section 6(1)(b) of the 1976 Act

[7] Section 6(1)(b) of the 1976 Act also identifies two questions:

(1) The cause or causes of death; and

(2) The cause or causes of any accident resulting in death.

In this FAI there was no dispute as regards the answer to question (1) or as regards the nature of the accident resulting in death. Therefore I had no difficulty in determining from the undisputed evidence:

(1) That the cause of Mr Robbins' death was:

1(a) Multiple injuries, due to a:

1(b) Fall from a cliff while riding a quad bike.

(2) That the accident resulting in death arose by way of the quad bike, which Mr Robbins was riding, going through a cliff top fence, over the edge of a cliff top and falling approximately 60 feet to a rocky beach below.

[8] The cause of the accident resulting in death was not so straightforward. Dr Schouten, in his evidence, explained that a number of possibilities had been explored. Dr Schouten considered that the tyre tracks on the cliff edge (see finding in fact 21) demonstrated that the Honda Big Red Quad had approached the cliff edge fence at an angle between 45 and 90 degrees. However, there was no evidence of any turf tracks or turf damage that would be consistent with braking while travelling at speed or cornering. Dr Schouten noted that he had examined the cliff face immediately underneath where the Honda Big Red Quad was thought to have gone over the cliff. That examination showed that small tress had been broken in the fall. Dr Schouten

explained that had the Honda Big Red Quad been travelling at speed it would have been likely to have cleared these small trees. Given that it had not, Dr Schouten explained that he was of the opinion that the Honda Big Red Quad was likely to have been travelling at a slow speed when it went over the cliff. He was fortified in this view by the discovery that the Honda Big Red Quad was found to be in the SL (super low) gear. Dr Schouten explained that the speed of travel of the Honda Big Red Quad in SL gear would have been likely to be a slow walking pace.

[9] Dr Schouten considered four possible causes of the accident. First, he considered a medical cause. Dr Schouten explained that Mr Robbins was a diabetic and it was also discovered, on post mortem examination, that he had coronary artery disease. Dr Schouten explained both conditions could potentially have caused Mr Robbins to have reduced levels of consciousness which could then have resulted in Mr Robbins unintentionally driving through the fence and over the cliff. Dr Schouten considered that a medical cause was the most likely explanation for the accident but he made clear that there was no positive evidence to support it and accepted that he was speculating.

[10] Second, Dr Schouten considered a mechanical cause. He confirmed that: (1) the front offside brake was seized and did not operate; (2) the left front brake was working with diminished effectiveness; (3) that the rear brakes were working correctly. He considered that the operation of the front offside brake lever would have resulted in the front nearside brake operating and that the fixed transmission would have caused the rear wheels also to slow. He also pointed out: (1) that often quad bike operators would be more likely to use the nearside brake lever and offside foot brake pedal because that

then allowed the right hand to be used solely for the throttle lever (rather than the right hand operating both the offside brake lever and the throttle lever, which results in a delayed braking manoeuvre); and (2) that quad bike operators often rely on the gears to slow them down. On the information available, Dr Schouten thought it unlikely that the defect with the front offside brake could have caused the accident.

[11] Third, Dr Schouten considered operator error. Dr Schouten considered that it was potentially possible that Mr Robbins could have made an error in operating the Honda Big Red Quad. For example, Mr Robbins could have driven up to the cliff edge fence and stopped. He then could have made an error in changing gear (by being mistakenly in a forward gear rather than a reverse gear) and then throttled up and gone forward without having sufficient time to react. Dr Schouten thought that this scenario may have been more probable if Mr Robbins had been riding side saddle (which he was known to do on occasion due to suffering from a sore hip) as this would have meant that he would not have been able to use the offside foot brake and may have meant that only his right hand was on the handle bar (with his body and left hand being turned backwards, away from the cliff edge, in anticipation of conducting a reversing manoeuvre). However, Dr Schouten noted that there were not any tyre tracks which indicated any signs of acceleration and accepted that Mr Robbins was known to be a very experienced and careful driver of a quad bike. Again Dr Schouten accepted that there was not any evidence to suggest there was any error on Mr Robbins part.

[12] Fourth, Dr Schouten considered whether there may have been any obstacle that Mr Robbins could have sought to avoid and, in doing so, inadvertently driven over the

cliff. Dr Schouten explained that despite a careful examination of the location of the accident he could not find anything to suggest that there was any sort of obstacle that Mr Robbins had tried to avoid.

[13] Dr Schouten had clearly carefully examined the circumstances of the accident and had quite properly considered a number of potential causes. Unfortunately, the evidence available did not allow him to pinpoint a particular cause. In the circumstances, I am unable to determine the cause or causes of the accident resulting in death.

Section 6(1)(c) of the 1976 Act

[14] Carmichael at para 5-75 sets out what I consider to be the correct approach to section 6(1)(c) of the 1976 Act:

> "This finding is closely linked with that mentioned in section 6(1)(b) … If the cause of an accident is known, then it may well be possible, even with what is now said to be the "wisdom of hindsight" to point to something which, if done, might have avoided or even prevented the death or accident resulting in death. Questions of foreseeability may not be easily dealt with in an inquiry and will be better left to any action of reparation which may ensue. The precise wording of section 6(1)(c) must be kept in mind. What is required is not a finding as to reasonable precautions whereby the death or accident resulting in death "would" have been avoided, but whereby the death or accident resulting in death "might" have been avoided … Certainty that the accident or death would have been avoided by the reasonable precaution is not what is required. What is envisaged is not a "probability" but a real or lively possibility that the death might have been avoided by the reasonable precaution."

[15] It was suggested by the solicitor for Mrs Robbins that a finding ought to be made to the effect that a reasonable precaution whereby the accident resulting in death might have been avoided was to have maintained the Honda Big Red Quad in an efficient

working order. This was of course based on the fact that the offside front brake was inoperable. The Crown and the solicitor for Mr David Elliot submitted that no such finding ought to be made.

[16] The above passage in Carmichael makes clear if the cause of an accident is known, then it may well be possible to point to something which, if done, might have avoided or prevented the death or the accident resulting in death. I have set out in para 7 to 13 why it has not been possible to determine the cause of accident resulting in death. That being so, I do not consider it possible to identify any reasonable precaution to an accident of an unknown cause. Accordingly, I am unable to make a finding under this section.

Section 6(1)(d) of the 1976 Act

[17] Sheriff Kearney in his determination in the death of Mildred Allan (an extract of which is set out in Carmichael at para 8-99) set out what I consider to be the correct approach to section 6(1)(d):

> "In deciding whether to make any determination (under s6(1)(d)) as to defects, if any, in any system of working which contributed to death or any accident resulting in the death the court must, as a precondition to making such a recommendation, be satisfied that the defect in question did in fact cause or contributed to the death. The standard of proof and rules of evidence (apart from consideration that evidence does not require to be corroborated) is that applicable in civil business (1976 Act, s4(7)) and accordingly that standard of proof is the balance of probabilities."

[18] It was suggested by the solicitor for Mrs Robbins that findings ought to made to the effect that: (1) the Honda Big Red Quad was "work equipment" for the purposes of

the Provision and Use of Work Equipment Regulations 1998 and that Mr David Elliot was in breach of regulation 5 and 9 of those Regulations; (2) the system of work was defective and contributed to accident resulting in death because, (a) the Honda Big Red Quad was not maintained in efficient working order, and (b) Mr Robbins had not received adequate training in the use of the Honda Big Red Quad. The Crown and the solicitor for Mr David Elliot submitted that no such findings ought to be made.

[19] I have, at para 3 and 4, set out the purpose of an FAI. It is not the role of the FAI to consider civil liability. The question of whether or not the Honda Big Red Quad was "work equipment" for the purposes of the Provision and Use of Work Equipment Regulations 1998 and whether regulation 5 and 9 of those Regulations were breached, may be important in a reparation action but I do not consider that it is necessary for my determination in this FAI to reach a concluded view on those issues. The passage from Sheriff Kearney, set out at para 17 above, makes clear that I can only make a finding under section 6(1)(d) of the 1976 Act if I am satisfied that the defect in question did in fact cause or contribute to the death. I of course accept that the front offside brake was inoperable at the time of the accident and that Mr Robbins did not receive any formal training on the use of the Honda Big Red Quad. It does, however, appear that the Honda Big Red Quad was subject to reasonably regular maintenance, that the pulling of the offside brake lever would have activated the front nearside brake (although that brake was operating with a diminished effectiveness), that Mr Robbins was a very experienced and careful driver of quad bikes and that he had driven the Honda Big Red Quad over terrain, prior to the accident, which would have been likely to have required

the operation of the brakes. In the end, given that the cause of the accident is unknown, I am unable to say whether either defect, advanced by the solicitor for Mrs Robbins, did in fact cause or contribute to the accident resulting in death. Accordingly, I am unable to make a finding under this section.

Section 6(1)(e) of the 1976 Act

[20] Section 6(1)(e) of the 1976 Act, unlike sections 6(1)(c) and (d) of the 1976 Act, does not require there to be any causal connection with the death (see Carmichael at para 5-77). I consider that this section gives the court wide scope, in the public interest, to make findings under this section. I consider that this FAI has identified a number of issues as regards the safe use of quad bikes and that it is therefore appropriate to make findings, in the public interest, to remind users of the key aspects of the safe use of quad bikes.

[21] Dr Schouten, in his evidence, highlighted that quad bikes do not operate and handle like other machines (and indeed that different makes and models of quad bikes can operate and handle differently). He explained: (1) that the rider positioning is vital to operate them correctly; (2) that a quad bike may not have a rear differential and that may make them handle differently from other machines (the Honda Big Red Quad did not have a rear differential); and (3) that the transmission can affect engine breaking. Dr Schouten was therefore of the view that it was of particular importance that the driver of a quad bike undergo adequate training in order to allow the safe driving of the

particular make and model of the quad bike that they are going to use. I respectfully agree with that observation.

[22] Dr Schouten also drew attention to the following Health and Safety Executive (hereinafter referred to as "HSE") publications:

(1) HSE Guidance – Agricultural Information Sheet No 33, Safe Use of all-terrain vehicles (ATV's) in agriculture and forestry;

(2) The Approved Code of Practice on the Provision and Use of Work Equipment Regulations L22; and

(3) HSG 136 A guide to workplace transport safety.

These publications provide clear and sensible guidance which should be followed by all persons involved in the use of quad bikes.

[23] I consider the following other facts are relevant to the circumstances of death:

(1) That quad bikes, as compared to other four wheeled machines, have some peculiarities in their operation and handling;

(2) That different makes and models of quad bikes can operate and handle differently;

(3) That it is therefore of particular importance that quad bikes should only be driven by persons who have received appropriate training to allow the safe driving of the particular make and model of the quad bike that they are going to use;

(4) That an employer, in addition to providing adequate training for employees using quad bikes, should assess their competence to drive quad bikes,

continue to monitor their competence and provide refresher training as required.

(5) That in order to safely use a quad bike, it is essential to carry out safety checks and maintenance in accordance with the manufacturer's recommendations. In particular, pre-ride safety checks should always include checks of the tyre pressure, brakes and throttle.

(6) That those persons using quad bikes should always wear, and be trained to wear, an appropriate helmet.

Postscript

[24] At the outset of the FAI I extended my condolences to Mr Robbins' family. I was joined in those condolences by all parties. I wish to formally repeat my condolences to Mr Robbins' family in this determination.