**SHERIFFDOM OF SOUTH STRATHCLYDE, DUMFRIES AND GALLOWAY AT AIRDIR**

**[2017] FAI 19**

B476/16

DETERMINATION

BY

SHERIFF DEREK O'CARROLL

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

into the death of

**ALISTER JOHN WILSON**

AIRDRIE, 15 SEPTEMBER 2017

The Sheriff, having resumed consideration of the Fatal Accident Inquiry into the death of Mr Alister John Wilson, Determines in terms of section 6 of the Fatal Accidents and Sudden Deaths Inquiry (Scotland) Act 1976, as follows:

(1) In terms of section 6(1)(a) of the Act, Alister Wilson died on 25 January 2015 at 00.35 at the Southern General Hospital, Glasgow as the result of an accident which occurred between about 07.00 and 07.15 on 15 January 2015 at the entrance to the premises of Moseley Distributors Ltd, Condorrat Road, Glenmavis, Airdrie.

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

(a) the cause of death was head injury (sustained at work)

(b) the head injury was the result of an accident which occurred when Mr Wilson was engaged in opening the external heavy metal gates to the Company premises, in high winds, when he was struck on the front of his head by one of the gates which caused Mr Wilson to fall with accelerated force striking the back of his head against the ground.

(3) In terms of section 6(1)(c) of the Act, the death might have been avoided if the external heavy metal gates were lighter, smaller and less apt to be caught by high winds or if Mr Wilson had been assisted by another person in opening the gates.

(4) In terms of section 6(1)(d) of the Act (defects in system of work), no finding is made.

(5) In terms of section 6(1)(e) of the Act, no findings are made:

**Makes the Following Findings in Fact:**

(1) Mr Wilson was employed by the Mosely Distributors Ltd (“the Company”) as a parts manager for over twelve years before his death.

(2) The Company is a well-established medium-sized enterprise which specialises in repairs and the provision of parts for motor coaches.

(3) The Company has its principal operation in Glenmavis, Airdrie. The site of the Company’s operations is on elevated ground, about 500 feet above sea level.

(4) The entrance to the principal Company workplace is via a private roadway leading from the public road.

(5) At the entrance of that private roadway, until 2015, was a set of two large metal gates ("the external gates").

(6) Each external gate was made from galvanised steel in a palisade style comprising a large number of V shaped vertical struts linked by a number of horizontal cross-pieces. Each gate was around 6 feet in height and 12 feet wide. The distance between the road surface and the lowest horizontal cross-piece was about 12 inches. The distance between the road surface and the lowest point of the vertical struts was around 6 inches. Each gate weighed about 120 kg. Each gate had a vertical movable pin which was used to secure the gate in an open position when placed into a cradle located on the edge of the roadway.

(7) The external gates were normally closed at night, secured by padlock, and opened in the morning by the first keyholder employee to arrive who would always arrive in a motorised vehicle.

(8) The external gates had to be opened separately. To open each external gate required the employee to raise the pin, then to move the gate bodily from the closed position forward through about 90 degrees, then to secure the gate in the open position by lowering the pin into a metal cradle set into the ground in a raised position to the side of the roadway. If the pin was not properly engaged into the cradle, the gate would be unsecured and might move.

(9) Having opened the first external gate (which due to the design of the external gates will always be the right-hand gate), the operation was repeated in similar manner for the left-hand gate.

(10) The employee was then free to re-enter his vehicle, move the vehicle along the roadway a short distance where he would encounter a second set of gates ("the internal gates") set at an angle to the external gates. Those gates were similar in design and function to the external gates.

(11) On reaching the closed internal gates, the employee would then halt, open each gate, secure each of them in similar manner to the external gates, return to his vehicle before then proceeding to the Company workplace car park.

(12) There was no artificial light source near the external gates. In winter, the employee might need to use his vehicle headlights or mobile phone to illuminate the gates.

(13) One of Mr Wilson's duties was to arrive early each morning to open the gates. He had done this most weekdays throughout his employment with the Company. He would always leave home at about 06.35 to arrive at the external gates at about 07.00.

(14) Mr Wilson was of slighter than average build weighing 72kg (11 st 5 lbs) and being 5'9" tall. He normally wore glasses and was careful about his appearance.

(15) On 15 January 2015, Mr Wilson left his home as normal around 06.35 hrs to go to work by car. He was not injured in any way when he left his home, in which he lived with his wife Mrs Sandra Wilson. He would have arrived at the external gates at the usual time.

(16) At 07.00 that day, it was dark. It was exceptionally stormy and windy. There were consistently strong gusts of wind with maximum speed of at least 52 mph and an

hourly mean wind speed of 32 knots (37 mph) at that time, which constituted near gale conditions in the area of the external gates. There was no rainfall at that time.

(17) Mr Wilson was first seen that day by another employee of the Company, George Gray who arrived at the gates area at about 07.15 that morning.

(18) On arrival Mr Gray saw that both external gates were open and secured as normal. However, the internal set of gates was still closed.

(19) A short distance in front of the internal gates was parked Mr Wilson's vehicle. Mr Wilson was sitting upright in the driver's seat.

(20) Mr Gray exited his vehicle, opened and secured the internal gates. The wind blew the gates against him and forced him back. He had to use a lot of force to open the right-hand gate, putting his shoulder to it. The left-hand gate was easier to move.

(21) Mr Gray is tall (6'2") and well-built (15 st/95 kg).

(22) Mr Gray had no discussion with Mr Wilson at that time. He saw Mr Wilson was moving his head from side to side.

(23) Mr Gray then drove to the car park at the Company workplace and entered it.

(24) Later, Mr Wilson drove to the car park at the Company workplace and parked there at his usual spot. He did not however get out of his vehicle.

(25) After a short while, Mr Gray and others grew concerned that Mr Wilson had not exited his vehicle. Mr Gray went out to find out what was wrong. Mr Wilson appeared confused, was moving his head around, said he was looking for his keys but had his keys in his hand. A short time later, Mr Wilson said he was looking for his glasses which were not on his head.

(26) Mr Gray saw blood on the ground near Mr Wilson's car door. Alarmed, he and the managing director, Mr Tweedie, eased Mr Wilson from his car to take him to hospital. As Mr Wilson exited the car, a patch of blood could be seen on the back of his head. Mr Wilson gave no explanation for the injury then, or at any time.

(27) Mr Tweedie took Mr Wilson to A&E at Monklands General Hospital. On examination, Mr Wilson was confused and agitated and speaking confusedly. He had a head injury to the back of his head towards the left ear with concomitant bruising and blood from that ear. Mr Wilson also had a developing right black eye and (discovered later) significant bruising under the scalp around that eye. He also had minor abrasions to both his shins, and his left ankle (on which were later found extensive bruising on the inner aspect of the right lower shin and left ankle (on the inside)).

(28) At some point at Monklands General Hospital, Mr Wilson's glasses were found to have been in his jacket pocket. Those glasses were dirty and heavily scratched on the lenses. They were not in that condition when he set off for work that morning.

(29) Mr Wilson's condition began deteriorating. He was transferred the same day to the neurosurgical Department at the Southern General Hospital in Glasgow. He was found to have suffered an intra-cerebral haemorrhage in the left occiptito-parietal region. There was also extensive contrecoup haemorrhage in both frontal lobes, subdural and subarachnoid haemorrhage in the left temporal region. There was hydrocephalus and a fracture of the left occipital bone extending into the petrous bone. The injuries were catastrophic.

(30) The injuries led to a fairly rapid deterioration in his condition. He lost consciousness and never regained consciousness. Despite treatment for his injuries, Mr Wilson lost consciousness that day and never regained it.

(31) Mr Wilson died at 00.35 on 25 January 2015 at the Southern General Hospital. The cause of death was a head injury.

(32) The head injury was most likely to have been caused by Mr Wilson having been accidentally struck on the front of his head, around the right eye, by one of the gates, the gate having been caught by the wind. Mr Wilson was thereby knocked backwards, with some force, off his feet resulting in the back of his head striking the road surface, his shins and left ankle also being injured at some point in that accident. That accident caused Mr Wilson's glasses to fall off his head and suffer extensive scratching and scuffing to the front of the lenses.

(33) It is impossible to be more specific as to the precise mechanism leading to the initial strike of the gate against his head.

(34) The head injury was not likely to have been caused by Mr Wilson having been struck by his car door, by human agency or other accident.

(35) Even though having suffered a fatal head injury, though initially in a confused state, Mr Wilson's mental functioning was sufficient to complete the opening and securing of both external gates, drive to the internal gates, park, restart his car once Mr Gray had opened the internal gates, drive further to his usual parking space and park there. His ability to complete those actions are consistent with the

type of injury he suffered and the early stage in the development of his injuries he had reached.

(36) Mr Wilson had previously experienced some difficulty in opening the external gates in windy weather as had some, but not all, employees to some degree.

(37) Mr Wilson had never formally expressed concern about such difficulty to the Company although he had made on occasion jovial comments concerning his experience of opening the gates in windy weather. Such comments did not reasonably put the Company on notice that the gates might be dangerous in windy conditions.

(38) No employee had ever expressed, formally or informally, a view to the Company that the gates might pose a danger to an employee opening the gates in windy weather. Mr Tweedie honestly did not believe that the gates posed such a danger

(39) Mr Wilson had never expressed any concern or worry to his wife about any problems arising from opening the gates in windy weather. If he had had such a concern, it is likely he would have told her.

(40) Prior to the incident leading to Mr Wilson's death, there had never been any similar incident whether resulting in injury or otherwise.

(41) No risk assessment was ever made by the Company specifically focused on the operation of the gates before Mr Wilson's death. There was no good reason before Mr Wilson's death to do so.

(42) Following investigation into the death of Mr Wilson, the Company risk assessed the gates.

(43) The Company replaced the gates with a set requiring manual opening in a similar fashion to the original gates. No alternative mechanical or electrical opening mechanism was reasonably practicable. However, the replacement gates are shorter, comprise tubular struts and cross-pieces, thus significantly reducing wind resistance, and are lighter by about 20kg each. These gates are significantly easier to open and secure in high wind conditions than the original set.

(44) Following the death of Mr Wilson, investigations were carried out by Police Scotland to determine whether Mr Wilson's injuries might possibly have been attributable to some other cause that morning including injury at his own home and garage, assault and road traffic accident. The enquiries eliminated all such causes.

**NOTE:**

***Introduction***

[1] This was a Fatal Accident Inquiry into the death of Alister John Wilson who died on 25 January 2015 following an injury apparently sustained on 15 January 2015 whilst in the course of his employment with Moseley Distributors Ltd ("the Company"). A Fatal Accident Inquiry must be held whenever a person dies whilst in the course of their employment in terms of Section 1(1)(a)(i) of the Fatal Accident and Sudden Deaths Inquiry (Scotland) Act 1976 ("the Act"). This is the Act that governs this Inquiry despite the passing of the Fatal Accidents and Sudden Deaths etc (Scotland) Act 2016, which came fully into force on 15 June 2017, since the application to this Court for

this Inquiry was made before that date: see Regulation 4 of the Transitional Regulations (SSI 2017/155).

[2] This contains my Determination as required by section 11 of the 1976 Act. In terms of section 11(3) of the Act, I consider that it is not reasonable to fix an adjourned sitting of the enquiry for the sole purpose of reading this Determination in public. A copy of this Determination has been sent to the parties and will be placed on the SCTS website.

[3] Ms Eileen Beadsworth, senior procurator fiscal depute, appeared for the Crown in the public interest. Ms Victoria Anderson, solicitor of BLM Solicitors, appeared for the Company. Mr Ruthven Bell, solicitor of Digby Brown solicitors, appeared on behalf of Mrs Sandra Wilson, the widow of the deceased. I am grateful to each of those representatives for the considerable and helpful assistance that they each provided to the Court in this Inquiry and for the clarity of their presentation and submissions. No other parties were present or represented.

[4] Mrs Sandra Wilson gave evidence and attended each day of the Inquiry with other relatives of Mr Wilson. I would like to take this opportunity to extend the condolences of the Court to Mr Wilson's family and friends for their sad and untimely loss.

[5] The petition by the Crown seeking the fixing of this mandatory Inquiry, where no criminal prosecution was ever commenced, was presented at Airdrie Sheriff Court on 1 November 2016, about 21 months after the date of death. The preliminary hearing, at which procedural matters are considered, was held on 13 December 2016 and three

days for the Inquiry were originally set down for April 2017. However, at a further preliminary hearing on 3 March 2017, appearance was first made on behalf of the family of Mr Wilson and an adjournment of the Inquiry was sought to permit funding to be sought. I granted that motion and new dates were set down. Following a further preliminary hearing on 24 April 2017 at which a number of detailed matters were discussed as regards the content and scope of the Inquiry, days for the hearing of evidence were set down for 9 to 11 May 2017. Further days were required and two more days of evidence were heard on 5 and 26 June 2017. The entering into two joint minutes by the parties dealing with what turned out to be uncontroversial evidence, avoided the need for further days of evidence. Final oral submissions, including discussion of the parties' written submissions which had previously been circulated between the parties' representatives and lodged in court in advance, were heard by the Inquiry on 26 July 2017. I am grateful to the parties' representatives for the content and quality of those submissions which greatly assisted in focusing the principal matters in question.

[6] The Inquiry heard evidence from the following witnesses (all called by the Crown):

(1) Mrs Sandra Wilson, widow of Mr Wilson
(2) George Gray, employee of the Company
(3) Iain Brown, employee of the Company
(4) Terrence Hill, employee of the Company
(5) James Mathieson, employee of the Company
(6) Dr Elmer Campbell, consultant neurosurgeon

(7) Dr Gemma Kemp, pathologist

(8) Graham Higgins, employee of the Company

(9) Detective Sgt Alex Clark

(10) Detective Constable Iain Hughes (who was recalled)

(11) Elizabeth Gray, local authority health and safety inspector

(12) James Tweedie, managing director of the Company.

(13) Jim Tassell, health and safety consultant

In addition, the parties entered into two joint minutes.

**Law and practice at a Fatal Accident Inquiry**

[7] I should first say something about the law and practice relating to Inquiries of this kind. The purpose of the Inquiry, in terms of section 6(1) of the Act, is for the Sheriff to make a determination setting out the following circumstances of the death so far as they have been established to the satisfaction of the Sheriff:

(a) where and when the death and any accident resulting in the death took place;

(b) the cause or causes of such death and any accident resulting in the death;

(c) the reasonable precautions, if any, whereby the death and any accident resulting in the death may have been avoided;

(d) the defect, if any, in the system of working which contributed to the death or any accident resulting in the death;

(e) any other facts which are relevant to the circumstances of the death.

[8] A Fatal Accident Inquiry is not the proper forum for the determination of criminal or civil liability. It is not a function of the Court in a Fatal Accident Inquiry to make findings or express opinions on questions of fault or liability or to attempt to apportion blame. In *Black* v *Scott Lithgow Limited*, 1990 SLT 612,615, Lord President Hope said:

> "There is no power in [section 6(1) of the 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 Section 4(1) 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 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, insofar 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."

[9] I agree with the view expressed by Sheriff Reid, Q.C. in her Determination in relation to the death of Sharman Weir issued on 23 January 2003 (which view was also endorsed by Sheriff Pettigrew in his Determination concerning the death of John Willock, 2013 FAI 15) where she said:

> "In my opinion a Fatal Accident Inquiry is very much an exercise in applying the wisdom of hindsight. It is for the Sheriff to identify the reasonable precautions, if any, whereby the death might have been avoided... The purpose of a Fatal Accident Inquiry is to look back, as at the date of the Inquiry, to determine what can now be seen as reasonable precautions, if any, whereby the death might have been avoided and any other facts which are relevant to the circumstances of the death... The purpose of any conclusions drawn is to assist those legitimately interested in the circumstances of the death to look to the future. They, armed with the benefit of hindsight, the evidence led at the Inquiry, and the Determination of the Inquiry, may be persuaded to take steps to prevent any recurrence of such a death in the future."

[10] As regards section 6(1)(c) [reasonable precautions whereby the death might have been avoided], I accept and endorse what was said by Ian H B Carmichael in his work *Sudden Deaths and Fatal Accident Inquiries* (3rd ed.) where he states at paragraph 5.75:

> "what is required is not a finding as to a reasonable precaution whereby the death... "would" have been avoided, but whereby the death... "might" have been avoided. Certainty that... the 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".

[11] That formulation appears to closely reflect what was said by Sheriff Kearney in his Determination in relation to the death of James McAlpine issued on 7 January 1986. Like Sheriff Liddle in his Determination in the Inquiry into the circumstances of the death of Kieran Nicol issued on 3 June 2010 and Sheriff Pettigrew in his Determination referred to above, I agree with and adopt what is said in that text.

[12] Sheriff Lockhart, (as he then was), stated in his Determination of 20 July 1993 in relation to the Newton rail crash:

> In my opinion, a Fatal Accident Inquiry is very much an exercise in applying the wisdom of hindsight. It is for the sheriff to identify the reasonable precautions, if any, whereby the death and any accident resulting in the death might have been avoided and the defects, if any, in any system of working which contributed to the death or any accident resulting in the death. The sheriff is required to proceed on the basis of the evidence adduced without regard to any question of the state of knowledge at the time of the accident. The statutory provisions are concerned with the existence of reasonable precautions or defects in the system at the time of the accident or death and are not concerned with whether they could or should have been recognised. They do not relate to the question of foreseeability of risk at the time of the accident. The statutory provisions are widely drawn and are intended to permit retrospective consideration of matters with the benefit of hindsight and on the basis of the information and evidence available at the time of the Inquiry. There is no

> question of the reasonableness of any precaution depending on the foreseeability of risk. The reference to reasonableness relates to the question of availability and suitability or practicality of the precautions at the time of the accident resulting in death."

Like Sheriff Scullion in his Determination concerning the death of Caroline McCall, 2014 FAI 7, I respectfully endorse that view.

[13] For a finding to be made under Section 6(1)(d) there must be defects in a system of working which contributed to the death. There must be evidence on the normal civil standard, that of the balance of probabilities, to justify any findings. As Sheriff Kearney observed in the Determination referred to above:

> "In deciding whether to make a determination under Section 6(1)(d) as to the defects, if any, in any system of working which contributed to the death..., the Court must, as a precondition to making any such recommendation, be satisfied that the defect in question did in fact cause or contribute to the death. The standard of proof and rules of evidence is that applicable to civil business... and accordingly the standard of proof is that of the balance of probabilities".

In other words, there must be a causal link, proven on the balance of probabilities, between the defect or defects, and the death. I, like Sheriff Scullion in his Determination referred to above, agree with that. By system of working is included consideration of any system of working including a lack of a system of working in my view. As is said in *Macphail* at paragraph 28.18,

> "it is important to note the fundamental difference between (c) and (d): the former allows the sheriff to base his finding on a reasonable precaution whereby the death "might" have been avoided, the latter requires a positive finding that the defect in working actually contributed to the death."

With that, I respectfully agree.

[14] As regards findings under section 6(1)(e) of the Act, the terms of that provision are cast wide and indicate that no causal connection between such findings and the death need be established (in contradistinction to paragraphs (c) and (d)), though any such findings must bear some relevance to the circumstances of the death. Ian H B Carmichael, in his work referred to above, states at paragraph 5.75:

> "The provisions of section 6(1)(e) are still wider and, in my view, entitle and indeed oblige the court to comment upon, and where appropriate make recommendations in relation to any matter which has been legitimately examined in the course of the Inquiry as a circumstance surrounding the death if it appears to be in the public interest to make such comment or recommendation."

I endorse that view which appears to be closely based on the view expressed by Sheriff Kearney in the Determination referred to above.

[15] I also note that it is said by the authors of Macphail, *Sheriff Court Practice,* at paragraph 28.17 that:

> "… speculation must be avoided; as with all the paragraphs of section 6(1) of the 1976 Act, there has to be evidence which satisfies the Sheriff on the material points."

I accept that.

[16] It is the duty of the Procurator Fiscal to adduce evidence with regard to the circumstances of death: section 4(1) of the Act. The Court proceeds on the basis of the evidence placed before it and although described as an Inquiry, the Sheriff's powers do not go beyond making a determination in relation to the circumstances established to his/her satisfaction by evidence following upon investigation by the Procurator Fiscal and any other party appearing at the Inquiry.

*Findings in Fact and Disputed Issues*

[17] A substantial part of the background and circumstances leading to the unfortunate demise of Mr Wilson are clear and undisputed. Some agreements on the facts were incorporated into the joint minutes and other matters were undisputed in evidence. Those matters, where relevant, are set out above in my findings in fact. A number of important matters were not however agreed, were controversial or were otherwise unclear and required evidence and determination. The matters are as follows

(a) What caused the injuries to Mr Wilson's head? Were they due to an accident involving the external gates? If so, what was the mechanism and what factors were involved? If not due to that cause, what was the cause, if that is possible to say?

(b) If the injuries were due to an accident involving the external gates, whether the Company knew or ought to have known that the gates posed a risk to employee safety and if so, whether the Company ought to have done something about them and if so, what?

[18] I now summarise the evidence of the witnesses focusing for the most part on their evidence so far as it is germane to those disputed issues and the findings that this Inquiry is bound to consider making. The evidence was tape recorded in the usual way but has not been transcribed. The summary is taken from my notes and the productions. I will then briefly summarise the respective contentions of the parties before explaining my conclusions on those matters.

***The evidence in summary***

[19] *Mrs Sandra Wilson.* She is the widow of Mr Wilson and had been married to him for 40 years. He was a stickler for the time, a workaholic and in good health. He awoke every morning at 6 a.m., got up and left for work at 6.35 a.m. He used to arrive at around 7 a.m. He never altered his timing. He had a Company car. Nothing unusual had happened in the days leading up to 15 January 2015. He had not hurt or injured himself before that day. She would have known if he had had any problems. If Mr Wilson had even cut his finger, he would have told her. He had no injuries to any part of his body before 15 January 2015. He had never said anything to her about any difficulties in opening the external gates to the Company premises. He looked after his appearance. His glasses were immaculate before that day. She had never seen again, till giving evidence, his glasses, recovered on that day, which were scraped and scuffed. Mr Tweedie told her that morning that he thought the cause of the injury was the Company external gates. The gate to the garage in their house is a metal door. It opened by being pushed up from the inside. The weather that day was horrible: windy and stormy and more extreme than normal. Mr Wilson would talk about his work every day with her when he returned from work at about 7 p.m.. He would tell her funny things. He never told her he had problems with opening the external gates.

[20] *Mr George Gray.* He is the parts manager with the Company and had been working there since March 2014. His boss was Mr Wilson. He worked closely with Mr Wilson. He had opened the external gates about 6 times in total. They opened freely. The gates were each about six feet high and 15 feet wide. He had not had to open the

gates in windy conditions until that day, 15 January 2015. After the incident, he opened the gates once in windy conditions and he struggled with them in the wind. The gate did not open freely on that occasion because the wind was pushing against it requiring more force than usual to open it. To open the gates, you would have to put your hand through the gate to lift the pin and then push the pin to the right-hand side. At that point, the left-hand gate remains secure. You then walk with the gate until you can secure the gate in the open position and then repeat the operation for the other gate.

[21] On 15 January 2015 he arrived for work at 07.15. There was a big storm and he heard on the radio that the winds were about 80 miles an hour. The winds were exceptionally bad. It was not raining and the ground was not wet. It was dark. When he arrived, the external set of gates was open and secured. He saw Alistair Wilson's car parked by the internal gates. He parked beside him. He thought that Alistair Wilson might have been on the phone and was moving his head from left to right. He did not stop to speak. He just wanted to get the internal gates opened. He went to open the internal gates. There was no lighting. He used his mobile phone to illuminate the padlock to open it. He would normally leave his car headlights on as well.

[22] He weighs 15 stone and is 6′ 2″ high. When trying to open the first internal gate, the force of the wind forced him back and at first he could not get that gate open. He then put more force into the operation to get the gate open and succeeded in securing the right-hand internal gate in place. The left-hand gate was easier to open. He walked past Alistair Wilson's car. Alistair Wilson's head was down and it appeared as

if he was looking for something. He then saw Alistair Wilson drive ahead and park in his usual spot in the car park.

[23] Mr Wilson did not get out of his car. He approached the car. Mr Wilson said he was looking for his car keys but they were in his hand. Later, he went out again and this time Mr Wilson said he was looking for his glasses. Mr Wilson did not have his glasses on him or in his car. He was unsuccessful in coaxing Mr Wilson out. He went out on a third occasion and noticed a patch of blood on the ground outside the driver door which rang alarm bells for him. Then Mr Tweedie, the managing director of the Company, arrived and he was informed of the situation. Mr Tweedie said that Mr Wilson needed to be taken to hospital and he would do that. As Mr Wilson was eased out of his car, he saw a patch of blood beside Mr Wilson's left ear, matted blood on the back of his head and on the back of the driver's seat. He asked Mr Wilson what had happened but he got no reply. The witness told Mr Tweedie where he had found him. Mr Tweedie took Mr Wilson to hospital. Mr Wilson did not appear to be either wet or dirty.

[24] No one had ever told him about problems in opening the gates before that date. Mr Wilson had jokingly said in the past, perhaps 2 or 3 times, if the weather was bad something like "It's not the first time I'll end up in the fields." He did not know if such a comment had been made to anyone else at any time. There were no special instructions given to him or anyone else about opening the gates in windy weather. To open the gates in windy weather he would use his full body weight at an angle to push them open. When trying to secure the gate, one would need to make sure that the pin

was above the cradle before dropping the pin in. On that day, it would have been difficult to put the pin in the cradle because of the severe wind and the resulting movement in the gate.

[25] *Mr Iain Brown.* He is a sales executive with the Company and has been employed there for 24 years. He would occasionally have to open or shut the external gates. He had not encountered any great problems with opening and closing the gates even in windy conditions and putting the pin into the cradle was fairly easy. He was not aware of any of his colleagues having problems with opening the gates in windy weather.

[26] *Mr Terrence Hill.* He was a sales executive with the Company until December 2016. He had worked with the Company for 5 years and was a keyholder. He opened the gates only twice and not while it was windy. He had never had a problem opening the gates and he was not aware of his colleagues having problems opening the gates.

[27] *Mr James Mathieson.* The witness has been workshop manager with the Company for 23 years and is a keyholder. He closed the gates most nights. Now he opens up most mornings. Mr Wilson used to open them most mornings. Mr Mathieson had opened the gates when it was windy and did not have any problems in doing so. He found it easy to put the pin into the cradle. In the dark, he would rely on the light from a lamppost from the public road. The wind did not affect the ability to put the pin in. It was he who put a new pin in the gates and a new cradle for one of the gates about 10 years ago.

[28] On 15 January 2015, when he arrived at the Company premises at 07.45, it was windy and it had been wet.

[29] He heard that something had happened to Alistair Wilson near the gates. Mr Wilson had gone off to hospital by this point. He went to examine the area, the gates and to look for Mr Wilson's glasses. He looked at both sets of gates and did not see anything unusual. He looked for but did not find any blood on the gates. He did not find the glasses. He did not see anything untoward on the ground. He was not aware of anyone ever having had problems in opening the gates. In windy weather, on occasion, he had had to push the gates hard. In such conditions, there might be a difficulty in placing the pin into the cradle depending on wind direction. Occasionally Mr Wilson had mentioned a problem with regard to the gates and the wind saying something like: "I was swinging from the gates". But that was just his way of saying that it was windy. He had said this on more than one occasion over the years. The witness was responsible for health and safety in the workshop and also for dealing with problems associated with manual handling. He did not believe that the gates required a risk assessment to be made under the manual handling regulations.

[30] The gates were in good condition and were no more than about 20 years old. He did not believe that Mr Wilson had been struck by either of the gates since Mr Wilson had finished opening and securing both gates.

[31] After the incident, he had worked with Mr Tweedie to see whether there was anything that could be done to change the operation of the gate. For technical reasons, an electric gate or a hydraulically operated gate could not be used and neither was a

sliding gate a possibility. No risk assessment had been done of the gates because it was not thought to be necessary. Although the gates were replaced, that was Mr Tweedie's decision and personally he would not have replaced them. The new gates have circular struts instead of V shaped struts so they do not catch the wind. They are easier now to operate in windy conditions. The original gates had a clearance of about 6 inches between the road and the bottom of the gate with about a 12-inch clearance from the roadway to the lowermost horizontal bar. The height of the gates was about 6 feet.

[32] *Dr Elmer Campbell.* She is a consultant neurosurgeon, with the usual qualifications, based at Queen Margaret Hospital in Glasgow. She was involved in the treatment of Mr Wilson and spoke to Mr Wilson's medical records and the contents of paragraph 1 of the first joint minute which contained formal agreement as regards the content of hospital records. On admission, minor abrasions and wounds were noted to Mr Wilson's lower limbs. He had an injury to the front of his head and also to the back of the head. He was confused but obeying commands and speaking spontaneously. On admission, an explanation had been given as to his injuries, being due to being struck by a heavy gate. That explanation did not come from the patient. A CT scan revealed occipital skull fracture and evidence of early contusions in both frontal and left temporal lobe. There was also less extensive right temporal lobe injury. He was suffering from critically raised intracranial pressure and underwent a left frontotemporal parietal decompressive craniectomy with resection of his left temporal lobe and also the contusions in his frontal lobe. Despite treatment, his condition continued to deteriorate.

[33] In general, the most common causes of head injuries are blunt traumatic events and the great majority of those result from road traffic accidents, falls and assaults. In the case of head injuries resulting from assaults, there might or might not be other injuries. Falls from a height and simple falls from the vertical might each result in a head injury. The injuries found on Mr Wilson are consistent with a heavy blow to the head but she could not say what the cause of the blow was, a fall or a strike from a gate. They were also potentially consistent with a slip or a trip or from a blow from an object. Given what was seen of Mr Wilson after admission, he would have been capable of driving a car a short time before admission. He would also have been able in that condition to have opened and secured a gate in position. She could not say when Mr Wilson had sustained the injury. All she could say was that there had been a rapid deterioration from admission onwards. Mr Wilson's brain injury was a contrecoup type, where the main force is one to the back of the head resulting in brain injuries to the front of the head as the brain moves internally and strikes the inside of the skull at the front.

[34] *Dr Gemma Kemp.* The witness is a consultant forensic pathologist who qualified in 2004 and became a consultant in 2014. She spoke to Crown production 2, being the post-mortem report on Mr Wilson which she prepared with Dr Julie McAdam. She spoke to that report and her findings. On examination, she found that there was a right-sided periorbital haematoma, that is to say a right black eye. There was also extensive internal bruising of the right frontal scalp around the right eye. There was also an injury

on the opposite side of the head towards the left and at the back. There she found two fractures and bruising.

[35] She concluded that Mr Wilson had suffered a blow to the right-hand side of the front of the head around the right eye which accelerated him to the ground causing the injuries found at the left rear side of his head caused when the back of his head struck the ground. That led to the brain being injured when moving within the skull in a contrecoup type injury. That mechanism is consistent with all her findings at the post-mortem. In her opinion, the fall to the ground was an accelerated fall. In her opinion, a simple fall would not have caused the injuries she found. Something powerful with weight must have hit him to the front of his head. In so concluding, she departed from paragraph 2 of the conclusions of her report in which she had then concluded that the initial impact point of blunt force trauma was at the back of his head. That change of view was reached after this fatal accident inquiry process had commenced and was due to queries being raised with her concerning her report by the Crown (following discussion of various matters as the preliminary hearing) resulting in her re-examining her findings and discussing matters once more with her colleague before now coming to the conclusion that she has expressed in evidence.

[36] In her opinion, the injury could have been caused by the gate which could have struck Mr Wilson on the front of his head at the same time as his legs or the injuries to his legs could have happened after the initial injury to the front of his head. The weight of the gate, being 120 kg, is also consistent with the injury which she thought might produce a similar force to other cases where injuries have resulted from an applied

force such as the so-called 'one punch manslaughter' cases. The injury to the rear of his head is more likely to have been caused by a fall to tarmac than a fall onto grass. It could have resulted from a fall from a kerb if there was also acceleration.

[37] She did not believe that the injuries were consistent with having been struck by a car door. If it were a car door, Mr Wilson would have had to have been crouching or bending down and therefore there would not have been sufficient force to have caused the injuries to the back of the head. She accepted that the injuries she saw were potentially the result of an assault but there was nothing pathological to indicate assault. If there had been a punch to Mr Wilson, she would have expected a more localised injury and not the large bruise on the underside of the scalp above the eye which is what she found on Mr Wilson. Therefore, in her view the gate was more likely than a punch. She could not rule out the use of a weapon but there was no external evidence of that. If there had been a weapon used on Mr Wilson one would have expected to have seen the shape of the weapon in the injury which was not the case here. The injuries found to Mr Wilson's shins and ankles did not assist her in her opinion one way or the other.

[38] The only other possible explanation she could think of was that the wind had blown something hitting Mr Wilson in the face but in her view the gate theory was the most plausible. In expressing these views, she did not defer to Dr Campbell except as regards that witness' opinion on clinical matters. While she accepted that fatalities could result from falls, from her experience and that of her colleagues, falls would usually require to have a degree of acceleration before death would result.

Furthermore, the quantity of contusions found in the brain indicate an accelerated fall. She did not defer to Dr Campbell as regards the likely mechanism of injury: that is part of her field. She thought it highly unlikely that a simple fall could have produced the injuries she found. The impact to the front of the head would require quite a force and weight. She could not however quantify exactly what that power and weight would be but it would need to be something not dissimilar to the sort of power and force that one has seen in 'one punch manslaughter' cases in England. If the gate was responsible, it would likely have moved some distance and taken him by surprise but she could not say how far. It is less likely that the injury could have been caused by a gate striking Mr Wilson if he was close to it at the time.

[39] *Graham Higgins.* He was formerly a mechanic with the Company until 2015 and had been employed there for about 10 years. He had limited experience of opening the gates when it was windy and probably did so with Mr Wilson and possibly with Mr Mathieson. The gates were easy to open if it was not windy but was worse if it was windy and the gates might pull you away. When securing the gate they would have to put the pin in the cradle to stop it swinging back again and in windy conditions the gate would have swung back if not secured; he had seen that happen. You would need to watch what you were doing if it was windy. It would be possible for the gates to break away from you in the wind. If you were pushing the pin down it was possible to miss the cradle on a windy day; he would hold the gate with one hand and try to drop the pin in with the other. Sometimes he missed but he would realise that in seconds. The only person he could remember talking about opening gates in the winds was

George Gray who said the gates were a pig to deal with when it was windy. However, no one suggested mentioning this to management and he had not done so. The gates when opened would always be pinned open.

[40] He saw Mr Wilson on the morning of 15 January 2015 at about 07.45 or so when Mr Wilson was in his car. He spoke to Mr Wilson but Mr Wilson was not making much sense; talking about finding his keys as if he did not know where he was. He could smell vomit and there was saliva and blood by the door sill. Mr Wilson was a grey/white colour. Mr Wilson was wearing a black jacket, shirt and tie and black trousers. He did not notice that Mr Wilson was dirty. He thought Mr Wilson had taken a stroke. He did not see Mr Wilson's glasses. Later, Mr Tweedie said he had found Mr Wilson's glasses in Mr Wilson's jacket. Mr Wilson always wore glasses.

[41] *DS Alex Clark.* He is a detective sergeant with Police Scotland with 16 years' service. Following the death of Mr Wilson, he made enquiries into his death. He went to the Company premises and took statements from a number of persons. He looked unsuccessfully for traces of blood. He found nothing untoward on inspection of Mr Wilson's car. He examined the garage door at the home of Mr Wilson are found nothing unusual or untoward there. He looked at the possibility of criminality as a possible cause of Mr Wilson's injury and examined police records for the 24 hours around the time of Mr Wilson having been discovered on 15 January 2015. Criminality was ruled out. A road traffic accident was ruled out, again from records and also from an examination of his car. He examined the external gates. His view, taking into account the gates and the elimination of other possible causes of the injuries to Mr Wilson and

all other known circumstances including the question of timing, the location where Mr Wilson was first found, the statements, his examination of the gates, is that the most likely cause of Mr Wilson's head injuries was a strike by the gate. He formed this view without however having been aware of the post-mortem report or having seen Mr Wilson's medical reports.

[42] *DC Iain Hughes.* This detective constable has 18 years' service in the police force. He visited the locus on 25 January 2015. He participated in the investigation of Mr Wilson's death. On first visiting the Company premises, and discussing matters with employees there and Mr Tweedie, the theory advanced in conversation was that Mr Wilson suffered his injuries after being struck by one of the external gates. He examined the gates. A check on other possibilities was made to see whether some form of criminality might have caused the injuries but that investigation was negative. Attempts were made to interrogate Mr Wilson's iPhone but without success. CCTV footage did not cover the gates but did cover other parts of the premises. The footage was examined but nothing untoward was seen.

[43] *James Tweedie*. He is the managing director of the Company and has been since 1988. The Company imports coaches to the United Kingdom repairs them and supplies parts. He has long and regular experience with both sets of gates, both opening and closing them. He has never experienced difficulties in opening and closing the gates. In windy weather he would be more cautious but it was not arduous. In windy weather he would stand to the side of the gate and pull it so that if there was a gust of wind which caught the gate he was not in the way. He had not ever discussed this with

colleagues. He did not believe that there was any significant risk opening the gates in windy weather. It was just a matter of common sense. Mr Wilson had never mentioned any difficulties to him with opening the gates and neither had he made any jokes to him about that. However, he might occasionally say that he 'was swinging on the gate today' or if it was wet he would say he 'had got drowned this morning'. It was simply his way of saying it was wet or windy. He had a sense of humour. His comments did not cause any concern about the gates. He never asked Mr Wilson to elaborate. It was just part of everyday chat. No risk assessment had been done on the external gates before 2015.

[44] On 15 January 2015, he saw Mr Wilson when Mr Wilson was in his car parked in the car park. He saw an injury on the back of Mr Wilson's head as he helped him out of the car. He drove him to Monklands Hospital. Mr Wilson was confused. He walked into the hospital. After examining Mr Wilson, a doctor came out and asked him if Mr Wilson had been attacked. He said no and that he had been seen parked between the gates. He did not tell the hospital that the gates were responsible for the injury although it is possible he did mention the gates in the context of the injury. Mr Wilson did not tell the doctors what had happened. Mr Tweedie then left and returned to the workplace. He looked at the gates and looked for blood and found nothing. He completed the accident book and recorded that the external gates were suspected as being the cause of the injury. He did that on his return from hospital. He thought the gates might have been responsible because of where Mr Wilson had first been seen. He still however is

not sure about what he thinks happened to Mr Wilson. He did not believe that there was any problem with the external gates.

[45] However, after the incident, he gave an instruction that the external gates were to be kept open pending further investigation. After much consideration, he instructed that new gates be made to substitute for the existing gates. The new gates are made of tubular steel. Each gate is 20 kg lighter. Each gate presents much less wind resistance as the slats are rounded and are ¾ inch in diameter as compared to the 2½ inch slats in the original gates. The new gates fit the same gateposts. They cost £4,000. He guessed they would be about 25% easier to open because they were lighter and presented less wind resistance. There was no risk assessment performed on the new gates. He did not think it was possible to risk assess the new gates. It would not be practicable to have a standing rule that two employees must always be present to open or close the gates. Even if there was such a rule, he himself would not obey it. He is quite a big man being 6′2″ high, weighing 15 stone. He saw Mr Wilson's glasses when he was in hospital after leaving him there. They were on the table when he removed Mr Wilson's wallet to put on the table. He told Mrs Wilson that day that he thought Mr Wilson's injuries were connected with the gates. He thought the gates might be a plausible explanation for Mr Wilson's injuries which is why he also put that in the accident book. An electric or hydraulic gate would not be practical for logistical reasons.

[46] *Elizabeth Gray*. She is the senior environmental health officer for the local authority being North Lanarkshire Council. Her department is responsible for investigating certain accidents at the workplace including this one. 15 January 2015 was

an unusually windy and gusty morning. She first went to the Company premises on 28 January 2015 which was the date when she was first notified by the HSE of the incident and death of Mr Wilson. She spoke to Mr Tweedie and inspected the gates. The gates were well-maintained and were typical for this kind of premises. On opening them, she could feel wind resistance where the wind was from the north-west. She thought the injury suffered by Mr Wilson could have been the result of being hit by the gates but it might also have been a result of a strike by a car door. However she had not seen any medical reports or the post-mortem report and therefore was not able to offer a definitive opinion.

[47] She wrote to Mr Tweedie and suggested he consider reviewing the operation of the gates to see if matters could be improved. She did not issue any type of official notice. She could not instruct the Company how to comply with health and safety legislation, only that they must. She therefore did not instruct new gates to be put in place. The new gates were put in by the Company at the instance of Mr Tweedie. They are safer because they have less wind resistance and also they are lighter and easier to move. She would not expect manual gates to be risk assessed. Only powered gates would be assessed. She was not aware of any light-hearted remarks having been made by Mr Wilson about the gates. Such comments would not indicate the gates were out of control. In retrospect only could one have expected the management to have done something about them.

[48] *Jim Tassell.* He is an independent consultant in occupational health and safety. He had prepared a report at the instance of the Crown. He had not however inspected

the original gates. He had not visited the locus. He had not inspected the new gates. He prepared a report based on photographs of the gates and the dimensions of the gate and other material provided to him. His initial view was that he would not have expected the gates to have been risk assessed. On reflection and on being pressed, he thought that perhaps if certain information had come to the attention of the management concerning difficulties in opening the gates in windy weather, some thought should have been given by the management to the gates, perhaps resulting in a memo or a notice on a noticeboard. The design of the new gates presents less area to the wind which he would expect to reduce wind pressure on the gate and hence the force against the gate.

[49] He accepted that so far as risk assessments are concerned there was no definition of what was meant by a suitable sufficient assessment and that different people have different views of what risks are presented by any given situation. He accepted that given his experience, he might reasonably take a different view from management as regards a particular risk. When preparing a risk assessment, one is looking at foreseeable risks and in doing that one is also looking to the past to see whether or not problems have occurred. So far as gates are concerned, he had researched the point and he had not found anything in the literature with regard to the need for risk assessment concerning opening and closing manually operated gates. He accepted that the question of risk assessment of these particular gates was somewhere in a grey area being a borderline case and he also accepted it was not possible to risk assess every activity and that people’s perceptions of what is foreseeable reasonably

differ. When assessing risks and policies in the workplace, there is a balancing exercise to be done concerning safety and business efficiency but that should be balanced in favour of the employee. But there does come a point when an incremental improvement is not justified.

**Joint Minutes**

[50] I should also note that the parties agreed two joint minutes, both of which I have taken account of in full in reaching my determination. I make reference to their contents where appropriate below.

**Submissions**

[51] Following the conclusion of evidence, I asked for written submissions to be lodged in advance by the parties and fixed a hearing to consider them. I am grateful to the parties for doing so timeously and for the helpful content of those submissions. Given that those submissions are lodged in process, there is no need for me to rehearse them. I have taken them fully into account and I will refer to them below where appropriate when I discuss the reasons for my Determination.

**Reasons for Findings in Fact**

[52] I have reached the findings in fact noted above on consideration of all the evidence including the documentary evidence, oral evidence and joint minutes. Below, under each of the statutory headings, I discuss that evidence in more detail when

explaining how I reached my conclusions including where necessary my assessments of the credibility and reliability of the witnesses.

**Section 6(1)(a): Date and Place of Death and Any Accident**

[53] In my view, the findings to be made under section 6(1)(a) are both as to the time and place of death *and* the time and place of any accident implicated in the death. That view is contrary to the submissions advanced on behalf of the Company to the effect that it is only the time and place of death that is required in the findings. I disagree with that contention on a straightforward construction of the statutory language. In any event, it is inevitable that where an accident is implicated in the death of a person, a finding in fact as regards the circumstances of that would have to be made, if there is evidence for that. In my view, there is in this case.

[54] As regards the date and place of death, that is uncontroversial. It was agreed in the joint minute and that finding forms part of my formal Determination and a finding in fact.

[55] As regards the time and place of any accident, this matter was highly controversial in that while the Crown and Mrs Wilson contended that there was an accident causing the deaths, being Mr Wilson having been struck by one of the external gates, the robustly stated position of the Company was that there was insufficient evidence to justify any findings that was an accident at all, still less a finding that the cause of the head injuries (undoubtedly suffered by Mr Wilson) was a strike from one of the external gates. In the next part of this note, when dealing with my findings under

section 6(1)(b), I explained why it is that I have come to the conclusion that the injuries were the result of an accident involving the external gates. That reasoning is relevant to my findings here under section 6(1)(a) as to the time and place of the accident. My conclusion as regards that matter derives from the conclusions as regards the cause of the injury.

**Section 6(1)(b): the Cause of the Accident**

[56] The antecedent controversial question here is how Mr Wilson came to suffer from the injuries that he undoubtedly did. This was a core part of the enquiry. On the one hand, the Crown and Mrs Wilson invited the enquiry to conclude that the most likely cause of the injuries was Mr Wilson having been struck by one of the external gates while opening the gate in very windy weather. On the other hand, the Company invited the enquiry to conclude that it was an open question as to how the injuries occurred, that one could not conclude whether any accident had occurred and therefore that the Inquiry should not make any finding under this heading.

[57] One significant difficulty in determining this question is the fact that there were no eyewitnesses to the events leading to Mr Wilson suffering the injury. Neither was there any recording of the events. Accordingly, in determining this question, it has been necessary to examine the facts surrounding the incident, drawing inferences where appropriate, to see if it was possible to determine the most likely cause of the injuries, applying the usual civil standard. Once done, the Inquiry can determine the question of an accident. I do not accept, contrary to some submissions made to the Inquiry, that in

the absence of direct evidence on the cause of the injuries, it is not possible to make a determination that the gates were involved or that an accident occurred. Evidence of circumstances and reasonable inferences from those is a normal, legitimate manner of finding facts. In my view there is ample evidence in this case entitling the Inquiry to conclude, as it has done, that the injuries were due to Mr Wilson having been struck by an external gate.

[58] The principal sources of evidence leading to that conclusion are as follows. First, it was undisputed that the gates were large and heavy. There was ample evidence that in windy weather, the gates could be difficult to open. Evidence to that effect was given by George Gray and Graham Higgins. That evidence was supported to some extent by Elizabeth Gray and Jim Tweedie. I preferred the evidence of George Gray and Graham Higgins to that of Iain Brown and Terrence Hill on that question since neither Mr Brown nor Mr Hill had much experience in opening the gates in windy weather. I regret to say, I did not find Mr Mathieson's evidence entirely credible or reliable as regards the characteristics of the external gates. In considering the potential difficulty of opening the gates in windy weather, I took account of height and weight comparing Mr Wilson, who was relatively light and of slight build with that of the other witnesses. I think it reasonable to infer it is likely that Mr Wilson would have encountered greater difficulties in opening and controlling gates in windy weather than others of a bigger build and greater strength. I also considered the evidence as regards the nature of the pin and cradle securing device given by various witnesses and the difficulty of securing the gate in windy weather (particularly that of Graham Higgins) was significant in

considering the contribution which the gate might have made to the injury suffered by Mr Wilson. In short, the gates were big and heavy and were more difficult to open, control and secure in windy weather, all the more so where the employee was relatively slightly built. That difficulty would have been increased in winter when there would be no natural light at 7 a.m. and the only source of artificial light would be car headlights or a smartphone (I did not accept Mr Mathieson's evidence concerning a lamppost on the public street: that was not supported by any other evidence and was inconsistent with the location of the external gates).

[59] Next, I considered the weather conditions at the time that Mr Wilson was found sitting in his car in a confused state at 07.15 on 15 January 2015. The parties agreed the wind conditions which were obtained from the meteorological data. All witnesses were unanimous as regards the exceptional nature of the windy weather that day and if anything, it is possible that the findings in fact understate the extent of the windy weather. That finding contributes to a conclusion that Mr Wilson is likely on that date to have had difficulties in opening the external gate.

[60] Next I considered the evidence as regards the circumstances in which Mr Gray found Mr Wilson that morning. Normally Mr Wilson would have arrived at the entrance to the Company premises at around 7 a.m. (Mrs Wilson's evidence which I accept) and would have opened both the external set of gates and the internal set of gates before driving down the private roadway to the Company car park. In my view, it is reasonable to assume that if he had arrived at the external set of gates by 7 a.m., he would have opened and secured both the external and internal gates and arrived at the

car park before 07.15. According to George Gray's evidence, which I accept, at 07.15 the external gates were open and secured properly and Mr Wilson was in his car stationary in front of the internal gates, which had not been opened. That strongly suggests that Mr Wilson was responsible for opening and securing the external gates, as he would normally do. Further, the fact that he had not then gone on to open and secure the internal gates points to some event having occurred before, during, or after the opening of the external gates and that event had happened sometime in the 15 minutes before the arrival of George Gray at the locus.

[61] I then considered the evidence relating to Mr Wilson's behaviour from that time onwards. It is quite obvious that by the time Mr Wilson had arrived in the car park, he was in a rather confused state. In my view, the description by Mr Gray of Mr Wilson in his car when he was stationary outside the internal gates points to Mr Wilson having been at that point in a confused state. His being in a confused state could account for his failure to open the internal gates. That again points to some event having occurred before 07.15 in the vicinity of the gates which caused him confusion.

[62] As regards injuries, the injuries to the back of Mr Wilson's head and there being blood on the driver's seat and blood coming from Mr Wilson's left ear were discovered before around 07.45. He could not have suffered those injuries while driving from the internal gates to the car park so the injuries occurred before he set off for the car park. I accept Mrs Wilson's evidence that he was uninjured the day before. After investigation, it was found that there was nothing to suggest that his injuries were caused that morning at his home, his garage or when driving to work. The police evidence is that

there were no reports of any events such as road traffic accidents or criminality, that morning which Mr Wilson might have been involved in which might have led to his injuries. There was no sign at the location where Mr Wilson was first found that any other person had been there or, not involving the gates, that Mr Wilson had been involved in some event which might have accounted for his injuries. There is no reason at all to implicate any employee of the Company as being responsible somehow for inflicting the injuries. All that points to the injuries having been suffered at some point from his arrival at the external gates, at 07.00 and 07.15 when Mr Gray arrived.

[63] I then considered the medical evidence. In this regard, I much preferred the evidence of the consultant forensic pathologist, Dr Kemp to that of Dr Campbell as regards the question of causation. That is because in my view the question of causation of the injuries suffered by Mr Wilson is very much a matter which lies more firmly within the field of a forensic pathologist than that of a clinician. Whilst Dr Kemp properly and fairly accepted that she would defer to the opinion of Dr Campbell on clinical questions, she did not do so as regards the question of causation. In my view, she was right to do so. Her opinion on this question, which was shared by the co-author of the post-mortem report, was that the most likely cause of the head injuries was due to Mr Wilson having been struck with a heavy blow to the front of the head causing an accelerated fall to the ground whereupon he suffered further injury to the back of the head leading in turn to massive brain injury and thus to eventual death. She expressly refuted the proposition put to her at some length that the injuries could equally likely be accounted for by a simple fall from the vertical or that they might be due to Mr

Wilson having been hit by a car door blown against him by the wind causing him to fall over. She considered both of those propositions unlikely and believed that her interpretation was much more likely than any other.

[64] She also said that the posited heavy blow to the front of the head could well have come from a heavy gate causing Mr Wilson to accelerate to the ground whereupon his head forcefully struck the ground. Although she also suggested that it was possible that the blow to the front of the head could possibly have been due to an object being blown against Mr Wilson, rather than the gate, that possibility was not advanced with any degree of confidence. Moreover, there is no other evidence which might support such a theory: the locus was carefully searched soon after the incident and nothing was found to support such a theory and that possibility was not pursued by any of the parties at the Inquiry. While that possibility cannot be entirely ruled out, that scenario is on the evidence highly unlikely.

[65] I found Dr Kemp's evidence on this matter to be cogent, persuasive and consistent with the known facts and accepted that evidence preferring, as I say, that evidence to that of Dr Campbell where they differed.

[66] I accepted the evidence of Dr Campbell that despite the fact that Mr Wilson had suffered what turned out to be fatal brain injury, he would have been capable soon after the injury was inflicted of opening and securing the gates and thereafter driving his car. Indeed, the evidence of Mr Gray is that Mr Wilson did drive along the access road after Mr Gray had opened the internal gates. The type of injuries suffered by Mr Wilson produced a gradual but inevitable deterioration in brain function and the medical

evidence as to injury and consequence is quite consistent with a narrative describing Mr Wilson having completed the operation of opening and securing the gates even after having been struck by a gate.

[67] I also took note of the other injuries suffered by Mr Wilson, notably those to his shins and ankles, which on the medical evidence is consistent with those injuries having been also caused by one or more gates striking Mr Wilson in that area of his body at the same time as his head was struck or afterwards.

[68] In addition, I think it significant that Mr Tweedie, the managing director, who knew the gates well (and the locus of course), who arrived at the locus before 8 a.m., took Mr Wilson to hospital and saw his injuries, believed that the gates were implicated, told hospital staff so, and said so when he completed the Accident Book later on 15 January 2015.

[69] Taking account then of all the circumstances, including in particular the matters that I have referred to above, when considering what is the most likely cause of the injuries suffered by Mr Wilson, I find the most likely way in which Mr Wilson came to suffer his injuries was an accidental strike from one of the two external gates at some point when he was engaged in the opening and securing operation. While I agree with Ms Anderson that such a conclusion is not certain and that in the absence of direct evidence on the matter, there must always remain some room for doubt, nonetheless, determining the matter on the balance of probabilities as I must, it seems to me that by far and away the most likely cause of his injuries was having been struck in some fashion by a gate in an accident.

[70] However, when I come to consider whether it is possible to reach a more detailed view as to the precise mechanism of the strike and fall, I regret that on the evidence it is in my view not possible to do so. A number of possible scenarios were aired during the course of the Inquiry including a gate being blown into Mr Wilson's head whilst in the process of opening one gate or his being caught by a gate after mistakenly having thought he had secured the gate. In my view, those scenarios have some evidence to support them. There are other scenarios which one could plausibly envisage involving the interaction of one or either or both of the gates, the high winds and the use of the pins and cradle with variations depending on the position of Mr Wilson at the point at which he is struck. One can speculate as to exactly how Mr Wilson came to suffer the injuries on his shins and ankle and the mechanism whereby he suffered those injuries as well as the injuries to his head. However, in my view all such attempts to pin down with greater precision the mechanism would depend to a greater or lesser degree on speculation. Therefore, I cannot and do not go any further than the conclusion I have just reached. That inability to posit a more precise mechanism has consequences for the other findings that I go on to make in this Inquiry.

**Section 6(1)(c) of the Act: Reasonable Precautions**

[71] I turn now to consider questions arising under section 6(1)(c) of the Act: were there any reasonable precautions whereby the death and the accident resulting in the death might have been avoided. In considering this question I remind myself of the precise terms of section 6(1)(c), the way that this has been interpreted and the

authorities that I refer to at paragraphs [10] to [12] above. In particular, it should be remembered that this exercise requires a causal link between any such precautions identified, the accident and resulting death; although of course, the use of the word "might" indicates only that there be established a "real or lively possibility" that the accident and death might have been avoided. Further, it is very much an exercise in hindsight and is quite different from the sort of tests typically applied in civil cases.

[72] The additional difficulty that one encounters when considering findings under this heading is that while I have been able to establish the likely cause of Mr Wilson's injuries, my inability to determine the precise mechanism means that it is more difficult to determine what precautions, if any, might have prevented the accident and the resulting death.

[73] Nonetheless, in my view there is sufficient evidence which even on the more limited finding I have been able to make concerning causation, to enable me to posit two precautions which *might* have prevented the accident and therefore Mr Wilson's demise.

[74] The first is quite simply that if there had been two employees operating each gate, it is in my view less likely that control of the gate would have been lost by Mr Wilson. It is I think common sense that in windy conditions if two men rather than one man are engaged in the gate opening and securing exercise (so for example one man might hold the gate steady whilst the other engages the pin in the cradle or two men push the gate against the wind) they are likely to have greater control of the gate, the gate is less likely to be controlled by the wind and the operation is more likely to be

carried out successfully and safely. In reaching that finding, I have had regard to the evidence as a whole . In making that finding, I emphasise that I do not say that the Company was at fault in not ensuring that there were two men available to open the gate on that day. Rather, it does seem to me to be a measure, with the benefit of hindsight, which if it had been in place *might* have prevented the accident. I cannot go further than that without a better understanding of the mechanism of the accident, which has not been possible to achieve.

[75] The other precaution which might have prevented the accident is if the gate had been of a different design. There was in the Inquiry plentiful evidence as regards the large size of the gates and the tendency of the gates to catch the wind thus increasing the difficulty in manoeuvring the gate at least in windy weather. The evidence also is that the replacement gates were noticeably easier to open in windy weather because they offered less wind resistance and were smaller and lighter: Mr Tweedie, Mr Mathieson and Mrs Gray. I take account also of Mr Wilson's relatively slight build. Therefore, even though one cannot be sure as to the precise mechanism, I find that if the gates that were installed after the accident had been in place at the time of the accident, it is possible that the accident *might* have been avoided in the sense that there is a lively possibility that Mr Wilson would have been able to manoeuvre the gates more easily and control them more easily in the very windy weather.

**Section 6(1)(d): Defects in System of Working**

[76] I now turn to the evidence relevant to consideration of section 6(1)(d): the

defects, if any, in any system of working which contributed to the death or any accident resulting in death. In doing so, I am conscious that it is not for this Inquiry to determine fault in a civil or criminal sense.

[77] The contentions of the parties were diverse. In brief, I was invited on behalf of the Company to make no findings on this heading, a position consistent with their submissions on the preceding issue. The Crown invited me to find that there was a defect in working in that if a risk assessment had been carried out on the gates, some form of action might have been taken by the Company which might have led in some way to the accident being prevented. On behalf of Mrs Wilson, the submission was the defect in the system of working was that there was no system, there ought to have been one and that carrying out a risk assessment would have established a work system. It was further said that no risk assessment had been made of the external gates, that such a risk assessment ought to have been done, standing what had been known of the difficulties of opening the gates in windy weather and that if such a risk assessment had been made, then measures would have been put in place including a Company rule requiring two workers to open the gates in windy weather, which would have prevented the accident and therefore the death of Mr Wilson.

[78] In my view, it is not appropriate to make any finding on this heading. As I have noted above in relation to my understanding of the law in this area at paragraph [13], in order to make a finding, there must be defects in a system of working (including an absence of a system) which contributed to the death and for that I require evidence that there was a particular defect and that the defect in question did in fact cause or

contribute to the death. In other words, there must be a causal link proven on the balance of probabilities between the defect and the death.

[79] In my view, there are two principal reasons why it is inappropriate to make a finding on this ground. The first concerns the contentions of the Crown and Mrs Wilson that on the material known to the Company prior to the accident, the Company was put on notice that there was a potential risk posed by the external gates when operating them in high wind which ought then to have prompted a risk assessment which then would have prompted changes in the system of work which then would have prevented the accident leading to Mr Wilsons death.

[80] It is essential to the arguments of those parties that such a risk assessment ought to have been carried out. I am unpersuaded that the state of knowledge of the Company was such that a risk assessment ought to have been carried out. I reach that view for the following reasons. First, I find that in the 20 years in which the gates were in operation, at no time did any employee make any complaint to the management, whether formally or informally that the operation of the gates in windy weather posed a risk to the safety of any worker. In that regard, I do not accept that the jovial remarks made by Mr Wilson on a few occasions amounted to such a complaint. I accept the evidence of Mr Tweedie and others to the effect that such comments were not intended to amount to a complaint, even a veiled or cloaked complaint, as to the safety of the gates. I accept that they, knowing Mr Wilson as well as they did, had no reason to believe that some sort of complaint or warning was being given by Mr Wilson. That conclusion I believe is buttressed by the evidence of Mrs Wilson, who had a particularly

close relationship with her husband, who stated that he had never made any remarks to her at any time with regard to the safety of the gates in windy weather. On her evidence, I believe that if he had had any such concerns, he would at least have mentioned those concerns to her. The fact he did not strongly suggests that he did not see that there was a risk and therefore supports the contention that when making his jovial remarks to his colleagues, he did not intend that those comments should be taken as some sort of reflection on the safety of the operation of the gates.

[81] Further, I am unpersuaded by the evidence of Mr Tassell with regard to whether a risk assessment should have been carried out on the gates. His initial position was that no risk assessment would normally be done on such gates. On being pressed, he tended to a more equivocal view before concluding that it was a grey area. That tentative opinion is not in my view an adequate basis on which one can conclude that a risk assessment ought to have been made. Furthermore, I note that he at no time examined the gates in question, the replacement gates or the locus. That somewhat undermines the strength, such as it is, of his views in that regard. Further, I do accept his evidence with regard to his research into the literature to the effect that there was nothing in the literature with regard to the need for risk assessments to be made regarding opening, securing and closing of manually operated gates. I also accepted the evidence of Elizabeth Gray that she would not expect manual gates to be risk assessed. She also was of the view that the comments made by Mr Wilson about the gates would not indicate that the gates were out of control and that it was only in retrospect that one could have expected the management to have done anything.

[82] Furthermore, in the 20 years or so of the gates operation, there had never been any reports of any incident or injury or danger resulting from either the opening or the closing of the gates. Therefore there was nothing in that regard which would have put the Company on notice.

[83] I conclude therefore that in not making a risk assessment of the external gates, no defect in working was thereby constituted. I conclude also that there was no defect in a system of work. It follows from that that I can make no finding on this heading.

[84] I should also add, for the sake of completeness, that even if a risk assessment ought to have been carried out, it is not possible to say what that risk assessment would have concluded and whether any measures would have been taken to vary the usual operation of the gates. One can only speculate as to what the content and result of any such risk assessment would have been especially in the light of there not being any accepted standards with regard to risk assessment of large manually operated gates of this type and the absence of reports of danger or accidents. If one can only speculate as to that question, it is impossible to assign a causal relationship between the absence of a risk assessment and the death of Mr Wilson.

**Section 6(1)(e); any Other Facts Relevant to the Circumstances of Death**

[85] I now turn to deal with section 6(1)(e) of Act and decide whether to make any finding under this heading. I was not invited to make any findings under this heading and looking at all matters, I do not believe it is necessary to do so.

[86] I have nothing to add.