SHERIFFDOM OF TAYSIDE, CENTRAL AND FIFE AT DUNDEE

[2021] FAI 1

DUN-B363-20

DETERMINATION

BY

SHERIFF GEORGE ALEXANDER WAY

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

into the death of

CHRISTOPHER IVAN BLACK

Dundee, 23 December 2020

DETERMINATION

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

1. Christopher Ivan Black ('Mr Black') was born on 10 May 1968 and that at the date of his death he was ordinarily resident in Falkirk.

2. In terms of section 26(2)(a), Mr Black died around 0053 hours on 25 November 2017 at Ninewells Hospital Dundee.

3. In terms of section 26(2)(b), an accident occurred sometime between 0900 and 0915 hours at Cotton of Turin Farm near Forfar.

4. In terms of section 26(2)(c), the cause of the death was a backwards fall from a trailer at a height of approximately four feet causing a head injury with blunt force trauma.

5. In terms of section 26(2)(d), there is insufficient evidence to establish the cause of the said accident which occurred.

6. In terms of section 26(2)(e), no precautions could reasonably have been taken which might realistically have resulted in the death being avoided.

7. In terms of section 26(2)(f), there were no defects in any system of working which contributed to the death.

8. In terms of section 26(2)(g), there were no other factors relevant to or which contributed towards the accident.

RECOMMENDATIONS

No recommendations are made.

NOTE

Introduction

[1] On 3 December 2020 at Dundee Sheriff Court a public inquiry was held under the 2016 Act into the death of the deceased Christopher Ivan Black.

[2] Preliminary hearings were held at Dundee Sheriff Court by teleconference on 12 and 25 November 2020.

[3] MR GAVIN CALLAGHAN Senior Procurator Fiscal Depute represented the Crown at the inquiry.

[4] MRS SUSAN DUFF Advocate represented Ian Murrie Haulage Limited at the inquiry.

[5] MR MARK DONALDSON Solicitor-Advocate represented D Ramsay and Son Farmers.

[6] MR ALLAN RAMSAY, farmer, gave evidence at the inquiry.

[7] MR IAN MURRIE, haulage contractor gave evidence at the inquiry.

[8] Ms MICHELLE GILLIES HM Inspector of Health and Safety gave evidence at the inquiry.

[9] Statements given contemporaneously by Mr Lyall Ramsay, now deceased, of D Ramsay and Sons were referred to and held as evidence that could be admitted as relevant to the inquiry.

[10] The Inquiry was held in terms of the Inquiries into Fatal Accidents and Sudden Deaths etc. (Scotland) Act 2016.

[11] The inquiry was governed by the Act of Sederunt (Fatal Accident Inquiry Rules) 2017.

[12] In terms of sections 1(3) and (4) of the 2016 Act, the purpose of the inquiry was to

(a) establish the circumstances of the death, and

(b) consider what steps (if any) might be taken to prevent other deaths in similar circumstances. The purpose of the inquiry was not to establish civil or criminal liability.

[13] In terms of sections 26(1), (2) and (4) of the 2016 Act, the sheriff must as soon as possible after the conclusion of the evidence and submissions in the inquiry, make a determination setting out:

(1) In terms of subsections (1)(a) and (2), in relation to the death to which the inquiry relates, the sheriff's findings as to (a) when and where the death occurred, (b) when and where any accident resulting in the death occurred, (c) the cause or causes of the death, (d) the cause or causes of any accident resulting in the death, (e) any precautions which (i) could reasonably have been taken, and (ii) had they been taken, might realistically have resulted in the death, or any accident resulting in the death, being avoided, (f) any defects in any system of working which contributed to the death or any accident resulting in the death, and (g) any other facts which are relevant to the circumstances of the death.

(2) In terms of subsections (1)(b) and (4), such recommendations (if any) as the sheriff considers appropriate as to (a) the taking of reasonable precautions, (b) the making of improvements to any system of working, (c) the introduction of a system of working, and (d) the taking of any other steps, which might realistically prevent other deaths in similar circumstances.

[14] The procurator fiscal depute represented the public interest at the inquiry.

[15] The inquiry was an inquisitorial process.

Summary

Agreed facts

[16] Parties entered into a joint minute agreeing the following facts:

1. Christopher Ivan Black ('Mr Black') was born on 10 May 1968 and that at the date of his death he was ordinarily resident in Falkirk.

2. Ian Murrie Haulage Limited ('IMHL') is a haulage company specialising in the haulage of livestock, and is also involved in the transporting of bales. Its registered office is at 2 Melville Street, Falkirk, FK1 1HZ and its main place of business is at Meadowfield Farm, Throsk, by Stirling.

3. In November 2017, IMHL had traded as a business for over 30 years, though the limited company was first incorporated in 2009. It had 7 employees, including Ian and Alan Murrie (who were father and son) and the Company Secretary.

4. Mr Black was, at the time of his death, employed by IMHL.

5. Mr Black was employed by IMHL during 2 separate periods. The first period lasted around 10 years, and ended in 2013. During that first period, Mr Black's duties had involved transporting livestock, but he left that employment due to problems with his knees, and his duties had involved crawling. Mr Black was a heavy smoker and found the work physically challenging. Mr Black returned to IMHL in March 2017. His duties during this second period, until his death, involved the transporting of straw and hay bales. This did not require crawling, and was less physically demanding.

6. IMHL's fleet, in November 2017, included 2 45ft trailers which were used for transporting bales. One of these trailers was a flat trailer, and the other was a stepped frame trailer. The latter was the preferred trailer as it was lower to the ground and thereby allowed more bales to be loaded on to it. This also kept the loads lower which was beneficial in travelling under bridges.

7. D Ramsay & Son ('DRS') is a farming partnership. In November 2017 the partners were Lyall Ramsay, his wife Helen Ramsay, and their son Alan Ramsay. Cotton of Turin Farm ('the Farm'), near Forfar, was then owned by Lyall Ramsay.

8. Lyall Ramsay died on 1 April 2019.

9. The Farm is located outside Montrose at Pitkennedy on unclassified road C44, which lies between the roads connecting Forfar and Montrose, and Aberlemno and Brechin respectively. The Farm comprises, inter alia, a yard area which has a concrete surface. On the north and south side of the yard are 2 modern warehouse type sheds with older stone sheds on the west side. The modern shed on the north side contained, in November 2017, numerous square and round strawbales, which were stacked.

10. Shortly after 0900 hours on 23 November 2017, during an operation to load strawbales using a telehandler, registered mark SP16 EBF belonging to DRS ('the Telehandler') onto a stepped framed trailer owned by IMHL, and while Mr Black was working in the course of his employment with IMHL, Mr Black fell from the bed of said trailer, and sustained an injury to his head.

11. Alan Ramsay, a trained First Aider and his wife, a nurse, assisted Mr Black pending the arrival of an ambulance. On arrival, Mr Black was treated by ambulance personnel. A further ambulance, and an Accident & Emergency medical practitioner, Andrew Reddick, attended.

12. Mr Black was subsequently conveyed to the Intensive Care Unit at Ninewells Hospital, Dundee, for treatment but life was pronounced extinct at 0053 hours on 25 November 2017 at Ninewells Hospital, Dundee.

13. Mr Black's body was subsequently taken to the Police Mortuary, Sir James Black Building, 9 Dudhope Crescent Road, Dundee, and was examined by Doctors Tamara McNamee and Helen Brownlow, Forensic Pathologists, on 30 November 2017. Crown Production 3 is a Post Mortem Examination Report, and contains a record of Doctors McNamee and Brownlow's findings. In said report it was noted inter alia that "There were no findings at post mortem examination to explain the exact mechanism of the fall i.e. whether he was directly struck by a bale of hay, tripped or lost his balance."

14. In terms of said post mortem report, the cause of Mr Black's death was

(a) Head Injury

(b) Blunt Force Trauma

(c) Backwards Fall from Trailer (4 feet)

15. Samples of inter alia Mr Black's blood were conveyed to Forensic Medicine and Science, University of Glasgow, where these were examined by Denise McKeown and Dr Fiona Wylie, both Forensic Toxicologists. Lignocaine,

an anaesthetic used in hospital setting was found to have been present in Mr Black's blood. No other drug was detected, nor was alcohol found. Crown Production 4 is a Toxicology Report, and contains a record of the examination of Mr Black's blood and serum and the findings arising therefrom.

16. Crown Production 5 was an Intimation of death in respect of Mr Black.

17. Crown Production 1 was a set of 47 photographs taken by Stephen Baillie, Scene Examiner, Scottish Police Authority, on 23 November 2017 at said Cotton of Turin Farm, said photographs showing various views of the aforesaid stepped framed trailer, and the Telehandler.

18. Crown Production 2 was a Book of Photographs taken by Stephen Baillie, Scene Examiner, Scottish Police Authority, on 23 November 2017 at said Cotton of Turin Farm, said photographs showing various views of the aforesaid stepped framed trailer, and the Telehandler.

19. Crown Production 6 was a photograph taken by Alan Ramsay of said stepped frame trailer loaded after the accident involving Mr Black.

20. Crown Productions 7 and 8 were photographs of said stepped frame trailer annotated by Alan Ramsay.

21. Crown Production 9 was a sketch of said stepped frame trailer showing the dimensions of same produced by Paul Radley, Detective Constable, on 1 December 2017.

22. Crown Productions 10-13 inclusive contain documents relating to qualifications held by Mr Black, and information relating to said qualifications.

23. Crown Production 14 was an IMHL payslip relating to Mr Black.

24. Crown Production 15 was a P45 relating to Mr Black, created by IMHL.

25. Crown Production 16 was an IMHL Employee Processing History, and contains a record of IMHL employees.

26. Crown Production 17 contains employee details for IMHL's employees.

27. Crown Productions 18 and 19 are invoices and timesheets issued to IMHL by Brendan McKay.

28. Crown Production 20 contained photographs shown to Ian Murrie, Managing Director of IMHL by Police Scotland during the investigation into Mr Black's death.

29. Crown Productions 26 and 27 were, respectively, the Partnership Agreement, and Minute of Agreement relating to said Partnership Agreement, in respect of the firm of D Ramsay & Son.

30. Crown Productions 28-34 inclusive contained documents relating to qualifications held by Alan Ramsay, and information relating to said qualifications.

31. Crown Productions 35 and 36 were a weighbridge ticket and Invoice.

32. Crown Production 38 was DRS document 'Rules for Lorries coming in for Straw', in draft.

33. Crown Productions 40 and 41 are, respectively, a service document and Thorough Examination Certificate relating to the Telehandler.

34. DRS has owned and operated telehandlers from the same manufacturer and supplied by the same local distribution agent for more than 20 years. They currently have two telehandlers which are the most used pieces of agricultural plant the partnership have. Alan Ramsay uses telehandlers on a daily basis to lift and transport straw bales and is extremely familiar with their operating characteristics as well as the type of operation ongoing at the time of the accident in general terms. Alan Ramsay is additionally a fully qualified and highly experienced agricultural engineer. Although Alan Ramsay had not received telehandler-specific operator training, he had extensive qualifications, including in relation to the operation of forklift trucks, and is considered to have been competent in the use of telehandlers.

35. The Telehandler in question was purchased from the manufacturers' local distribution agent in April 2016 and the square bale lifting attachment was purchased at the same time. The agents were familiar with the baler owned by the partnership from previous farm visits and aware it produces only quadrant sized square bales.

36. The Telehandler was examined by a specialist HSE mechanical inspector ('Specialist Inspector') working in conjunction with the manufacturers distribution agents Sellars after the accident. In considering the Telehandler and the circumstances of the accident, as understood, the Specialist Inspector noted that:

- The lifting capacity of the Telehandler was 3,000kg. There was no evidence it was overloaded at the time of the accident.
- No defect was identified in respect of the steering, acceleration or braking of the Telehandler, or in respect of the operation of the boom of the Telehandler.
- The yard at Cotton of Turin farm where the loading operation was being undertaken at the time of the accident was found to be surfaced with concrete which was in good condition with no potholes.
- A bale, of the type understood to have been being moved at the time of the accident, was measured and found to be: length 2616mm, width 1270mm, height 660mm.
- Published HSE guidance indicates that bales should not be carried on a telehandler such as to obscure the operator's vision.
- There was no good reason identified for Mr Black to have been on the bed of the stepped frame trailer during the loading operation.

37. DRS produce between 1200 and 1300 quadrant sized square bales (hereinafter referred to as square bales) each year and approximately three quarters of the total produced are used by the partnership themselves. The bales in question had been sold by DRS to a straw merchant. Only straw with a moisture content of less than 15% is used for the production of square bales. Square bales are made under pressure in sections and then further secured with

twine. The baler is set near the maximum level of 86 bar to ensure that the square bales are as solid and compact as possible for ease of storage.

38. There are various ways in which a load of bales being transported on a telehandler could be lost. This includes, but is not limited to, (1) the loss of a load as a result of an emergency (or sudden) braking manoeuvre; or, (2) the lowest bale being carried flexing or collapsing, which can render bales above it, if they are stacked vertically and held in place by friction and not secured (for example by additional tines or forks), becoming unstable and thereby falling from the telehandler.

39. Following the accident the DRS issued guidance to their straw merchants for onward transmission to haulage companies visiting to collect straw directing that drivers should remain in their vehicle cabs and that the partnership would decide the method to be adopted during loading. Alan Ramsay undertook formal telehandler training and passed same.

40. Following the accident IMHL undertook risk assessments and arranged for external training to be delivered to its workforce in relation to work at height of trailers. Access to the bed of trailers was task dependent. No measures were put in place to access trailers during the task to load bales as this was not necessary or expected by IMHL.

41. Crown Production 46 was HSE publication 'Safe working with bales in agriculture'.

42. Crown Production 47 was an HSE publication 'Workplace Transport Safety, A Brief Guide'.

43. Crown Production 48 was a Freight Transport Association publication 'Preventing Falls From Vehicles An Industry Guide'.

44. Crown Production 50 was a Police Notebook containing a statement given to the Police by Alan Ramsay.

45. Crown Productions 51-54 inclusive are statements given to the HSE by said Alan Ramsay.

46. Crown Production 55 was a statement given to the HSE by said Lyall Ramsay.

47. Crown Production 56 was a statement given to the Police by Ian Murrie.

48. Crown Production 57 was a statement given to the Police by Mrs Helen Black, now deceased.

49. Crown Production 58 was a statement given to the HSE by Alexander Simpson.

50. Crown Production 59 was a statement given to the HSE by James Gouck.

51. Crown Production 60 was a statement given to the HSE by John Murrie.

52. Crown Production 62 was a Police Notebook containing a statement given to the Police by Lyall Ramsay.

I make the following findings in fact based on the evidence of Mr Allan Ramsay at the inquiry that are not already established by virtue of the Joint Minute:

1. The deceased appeared to be an experienced agricultural worker and driver.

2. The deceased and Mr Ramsay discussed the way in which the bales of straw would be stacked upon the deceased's trailer. The method was not as Mr Ramsay would have chosen but it was agreed that it would maximise the number of bales carried.

3. Once the methodology was agreed the deceased returned to his vehicle. The witness believed he was in his cab or at least beside it at all times. This would place the deceased in a position where the vehicle was between him and the yard or shed where the bales were stored. This was, what was accepted by all parties as a "place of safety". The deceased had no part to play in the mechanical loading process. He would be responsible for securing the bales but only after the entire load was in place. The telehandler would be parked.

4. The position of the deceased would, equally, place the vehicle and trailer between him and the telehandler at all times. The bales were to be loaded from the offside of the vehicle and no manual handling of any kind was involved.

5. The bales were being loaded from the cab end. The telehandler was being manoeuvred to load more bales at the cab end. The telehandler would not, at that stage in the loading process be approaching the trailer end of the vehicle at all.

6. The witness believed that the deceased was in the cab of his own vehicle whilst the witness was driving the telehandler to load another bale at the cab end of the deceased's vehicle which involved reversing the machine towards the deceased's trailer and then turning to present the bale front on to the deceased's vehicle. The process of loading bales on to the trailer end of the vehicle had not commenced and the witness was in the cab. At no time did the witness see the deceased on the trailer.

7. The witness did see his late father, who until then was sitting in a separate vehicle, running in the direction of the deceased's trailer. This was such an unusual occurrence that he reacted to what he perceived as an emergency by halting his vehicle abruptly; the equivalent of an emergency stop. This caused the straw bale to come off the forks of the telehandler and this bale landed on the deceased's trailer.

8. The witness alighted from the telehandler and was only then aware of the accident that had befallen the deceased; who was lying on the ground at the driver side of the trailer. The witness was clear that he was still driving the telehandler with the straw bale still on its forks when he saw his father running. He reasonably inferred from this and discussions with his late father that the deceased had somehow fallen from the back of his trailer before he executed the "emergency stop" of the telehandler. There was no question of either the advance of the telehandler or the falling straw bale contributing in any way to the accident.

9. The witness did not see the deceased fall and could offer no explanation for the accident. The deceased had no part to play in the loading once planned. This is an entirely mechanical operation with no manual handling. The bales are far too heavy for human lifting. Any reason that the witness might offer would be pure speculation and there was no practical or logical reason for the deceased to be anywhere near the trailer end let alone seeking to climb up upon it.

I make the following findings in fact based on the evidence of Mr Ian Murrie at the inquiry that are not already established by virtue of the Joint Minute:

1. The deceased was a highly regarded and experienced agricultural worker. Mr Murrie had extensive experience of livestock and produce handing. He estimated that only 5% of his firm's business involved produce such as straw bales. The deceased was mainly involved with livestock handling and transport but was equally well versed in handling and loading straw bales. He was highly trained and had City and Guild and other certificates of appropriate and successful completion of training.

2. The witness confirmed that the deceased was aware that drivers should always be in a place of safety during mechanical loading and that the method of loading straw bales using a telehandler was not one that allowed for manual handling. The driver should have no involvement in the process until his vehicle is fully laden and the use of machinery has ended.

3. There was simply no explanation that the witness could offer, for the deceased climbing on the trailer at all or indeed, why he might have fallen. Speculation would be pointless as there was no logical explanation based upon experience of the loading operation in question.

I make the following findings in fact based on the evidence of Ms Michelle Gillies at the inquiry that are not already established by virtue of the Joint Minute:

1. The telehandler was not defective in any way.

2. No evidence could be found to explain why or how the accident to the deceased occurred. There was nothing to suggest any operational reason for the deceased to be in any way involved in the mechanical loading operation. There was no evidence that he was seeking to participate in that operation. The deceased's training and experience was appropriate and his employers' operational methods were appropriate. There was nothing to explain the accident beyond speculation for which there would be no factual or logical basis. It would nothing more than guesswork.

I make the following findings in fact based on the Statement of the late Mr Lyle Ramsay admitted as evidence at the inquiry that are not already established by virtue of the Joint Minute:

1. Mr Lyle Ramsay did not see the deceased on the trailer. He saw him lying on the ground at the driver side of the vehicle. Mr Lyle Ramsay ran to his assistance and that at time he did not know what was wrong.

This completes the narration of the evidence.

Submissions

1. Parties were agreed that I should make findings in terms of sections 26(1)(a) and (2)(a) and (c) of the 2016 Act relating to the date, place and cause of death.

2. They were agreed that no findings were required in terms of sections 26(1)(a) and (2)(b), (d), (e) and (f) of the 2016 Act, and that I should not make any recommendations in terms of sections 26(1)(b) and (4) of the Act.

3. They further agreed that there was insufficient evidence upon which I could find or establish how or why the accident occurred.

4. The learned senior procurator fiscal depute suggested however that I could make a finding in terms of sections 26 (2)(g) of the 2016 Act restricted to the need to ensure that drivers, such as the deceased, kept to appropriate places of safety, such as their vehicle cab, during mechanical loading operations. Mrs Duff and Mr Donaldson were neutral on this point.

Discussion

Cause of death

[17] I agree with the submissions of all parties that there is simply insufficient evidence to allow me to conclude how or why the fatal accident occurred. There was no failure of training or instructions on the part of his employers. He was, patently, a highly experienced agricultural worker and driver. He was popular and seemed to enjoy his work. Indeed he had a spell away in more commercial HGV driving, found it not to his taste and returned to work for his present employers. There was no failure in the planning or operation of the mechanical loading of the straw bales. The deceased was not struck by a straw bale. There is simply no explanation as to how or why the deceased sought to climb onto the trailer or how he came to fall backwards. No one saw this; the witnesses only came upon the aftermath. This was a tragic accident but one for which the Inquiry can find or indeed offer no explanation of any kind; even speculation would be groundless.

Recommendations

[18] I understand the concern of the Crown that drivers should be aware of the dangers of leaving places of safety during mechanical loading operations at their vehicles but I do not consider that this requires any formal finding. The deceased's employers were clear that they have reiterated such instructions to all their staff. Indeed, in the absence of any reasonable or logical theory as to the deceased's intentions

that day, it is impossible to conclude that any such guidance or indeed instructions contributed to the accident itself.

Conclusion

[19] I agree with all parties that the deceased's death was tragic and untimely. The fact that it remains unexplained must make the family's loss more keenly felt. I thank the parties for their assistance in conducting this inquiry. I wish to particularly commend them for the significant preparation and the efficient, sensitive manner in which they conducted the inquiry. I join with them in expressing sincere condolences to the family of the late Mr Black.