SHERIFFDOM OF GRAMPIAN HIGHLAND AND ISLANDS AT ABERDEEN

[2021] FAI 38

ABE-B58-20

DETERMINATION

BY

SHERIFF MORAG McLAUGHLIN

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

into the death of

JAMES GAULD GRANT

Aberdeen, 5 October 2020

DETERMINATION

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

1) James Gauld Grant, born 19 September 1942 residing at Strachan, Banchory, died there on 10 January 2019;

2) In terms of section 26(2)(a), Mr Grant's life was pronounced extinct at 16.55 hours on 10 January 2019 at his farm at Strachan, Banchory;

3) In terms of section 26(2)(b) the accident resulting in Mr Grant's death occurred at the cattle shed on his farm on 10 January 2019;

4) In terms of section 26(2)(c) the cause of Mr Grant's death was head injuries due to a fall from height;

5) In terms of section 26(2)(d) it would appear that the accident happened when Mr Grant was working on the roof of the cattle shed from which he fell. The precise cause could not be ascertained as there were no witnesses to the accident;

6) In terms of section 26(2)(e) having regard to the Health & Safety Executive (HSE) investigations, Mr Grant's death might have been avoided had he used a safer method of working on the roof and had regard to HSE Guidance in relation to working at height;

7) In relation to section 26(2)(f), in not using any safety equipment in order to carry out a job on the roof of the cattle shed, Mr Grant did not follow a safe system of working and this contributed directly to his death; and

8) I have no recommendations to make in relation to section 26(1)(b).

NOTE:

Introduction

[1] The inquiry was a mandatory inquiry in terms of section 2 of the Act, Mr Grant's death having occurred whilst he was acting in the course of his employment as a self-employed farmer on his farm at Strachan, Banchory.

[2] Mr Grant's death was reported to the procurator fiscal on 11 January 2019.

[3] A preliminary hearing was held on 4 March 2020 and the hearing proceeded on 9 March 2020.

[4] The procurator fiscal was represented at the inquiry by Mr Hanton. There were no other participants in the inquiry, although Mr Grant's niece had entered into a joint

minute of agreement with the procurator fiscal. Members of the Health & Safety Executive were in court as observers.

[5] No witnesses were led, all evidence led at the inquiry was contained in a joint minute of agreement.

[6] The inquiry was held under section 1 of the Inquiries into Fatal Accidents and Sudden Deaths Etc. (Scotland) Act 2016 and was governed by the Act of Sederunt (Fatal Accident Inquiry Rules) 2017/103.

[7] The purpose of the inquiry was to establish the circumstances of Mr Grant's death and to consider what steps (if any) might be taken to prevent other deaths in similar circumstances.

[8] The matter is to be covered in the Determination in terms of section 26 are as set out above.

[9] The procurator fiscal represents the public interest in conducting the inquiry, which is an inquisitorial process and it is not the purpose of such an inquiry to establish civil or criminal liability.

Summary

[10] The agreed facts, presented to the inquiry, were as follows:

1. That the body of James Gauld Grant (born 19 September 1942), residing at his farm at Strachan, Banchory was found at 16.15 hours on 10 January 2019 within a cattle shed at the said farm, with his life being pronounced extinct at 16.55 hours on the same day by a paramedic.

2. Mr Grant's death was reported to the procurator fiscal at Aberdeen on 11 January 2019.

3. Mr Grant was the sole owner of the said farm and operated it alone on a self-employed basis, with some assistance from family members on an *ad hoc* basis.

4. A post-mortem examination was conducted by Doctor Leighanne Margaret Deboys, senior lecturer in forensic medicine on 14 January 2019 at the Aberdeen Mortuary and it was her considered opinion that the deceased died of head injuries due to a fall from height. The full post-mortem report was produced in evidence.

5. On 15 January 2019, Doctor Duncan Stephen analysed various post-mortem specimens taken from Mr Grant and found no alcohol or illicit substance to be present.

6. Niall Miller, investigator with the HSE carried out an investigation into the circumstances of Mr Grant's death concluding that no further action required to be taken on the basis that Mr Grant was self-employed and working alone, with no one else responsible for supervising how he carried out his work. The full HSE report was produced as were a series of photographs obtained by SPA Scene Examiners on 10 and 11 January 2019.

7. From the HSE report referred to in evidence I note that the said Farm is a small business comprising a farmhouse and several farm buildings which are generally old and in various states of disrepair. As part of ongoing

maintenance during December 2018 and January 2019, Mr Grant undertook to repair the roof of the cattle court as it had developed a few leaks. He had access the roof on a number of occasions trying to use sealant paint to repair the leaks. He was known to access the roof without safety precaution in place and was known to "walk the purlins of the roof". "Walking the purlins" is a term used to indicate that a person walking on a roof which they believe to be fragile will walk above the supporting members of the roof structure to prevent falling through. According to Mr Grant's niece he would not use scaffolding or walking boards to prevent a fall through the roof surface.

8. On 10 January 2019 Mr Grant was seen by his niece working on the roof of the cattle shed when she returned to the farm after collecting her son from school. Shortly thereafter she and her son heard what was described as "the sound of something sliding off the roof". Mr Grant's niece asked her son to go and see what Mr Grant was doing and on approaching the cattle shed he observed Mr Grant lying on the ground having sustained a head injury. The emergency services were called and the police and ambulance personnel attended and found Mr Grant on the ground within the cattle court below a broken Perspex-type roof light with fragments of the roof light around his body.

9. Investigators were advised that Mr Grant took no precautions to prevent him from falling through the roof or from the roof. In the past work had

been carried out on the roof using boards and a telescopic handler but only when others were involved. When the deceased was working alone it was his habit not to use the safety equipment.

10. As a self-employed farmer with no employees, Mr Grant was not required to have formalised risk assessments and investigators were not able to establish what training he may have undertaken in this regard.

11. The conclusion of the Health & Safety investigation was that Mr Grant failed to work in a safe manner by not using equipment to either allow him to effect the repair without going on to the roof or to prevent him from falling from the roof or to mitigate the consequences of such a fall. They concluded that evidence supported a conclusion that he had some awareness of the risks associated with working on the roof and that he had some awareness of precautions that were required to be followed to prevent such an incident occurring.

12. The legislation covering Mr Grant as a self-employed person working in this capacity is section 3(2) of the Health & Safety at Work Etc. Act 1974, to the effect that "It shall be the duty of every self-employed person to conduct his undertaking in such a way as to ensure, so far as is reasonably practicable, that he and other persons (not being his employees) who may be affected thereby are not thereby exposed to risks to their health and safety".
Mr Grant thus had a duty to ensure his own safety and that of others present at the farm.

13. The Work at Height Regulations 2005, Regulation 3, 4, 6 and 9 placed a duty on him to plan for working at height (4), for avoiding work at height (6) and for fragile surfaces (9).

14. Regulation 4 requires that work at height is properly planned, appropriately supervised and carried out in a manner which is so far as reasonably practicable, safe. The conclusion of the HSE inspector was that the work at height undertaken by Mr Grant was not undertaken in a safe manner.

15. Regulation 6 requires that consideration is given to the need to work at height and that if it cannot be avoided, a hierarchy of control measures should be followed in order either to remove or to mitigate the risk of a person being injured. The regulations sets out control measures such as working from an existing safe place, using temporary working platforms and/or measures to mitigate the consequences of a fall such as the use of safety nets and the use of personal fall prevention/mitigation such as the use of a harness. Mr Grant employed no such measures.

16. Regulation 9 requires that where reasonably practicable no person at work passes across or near a fragile surface or works from or near it. Where not reasonably practicable it sets out control measures to prevent a person falling through a fragile surface including the use of boards, coverings and fall mitigation measures such as safety nets and harnesses. The investigation found that no such control measures had been deployed by Mr Grant.

Recommendations

[11] In light of the evidence agreed and presented to the Inquiry, including the terms of the ~HSE report, there are no recommendations that I can make in terms of section 26(1)(b).

[12] The medical cause of death is as noted above. It is clear that Mr Grant died as a result of head injuries because of his fall whilst he was accessing the roof, alone and without safety precautions, to effect repairs. The full Health and Safety Executive investigation disclosed the issues set out above.

Conclusion

[13] In all the circumstances, I was invited by the Procurator Fiscal to make the findings noted at paragraphs 1) to 8) above and I considered it appropriate to do so.

[14] The Court extends its sympathy to Mr Grant's family and loved ones.