SHERIFFDOM OF TAYSIDE, CENTRAL AND FIFE AT PERTH

[2022] FAI 32

PER-B209-21

DETERMINATION

BY

SUMMARY SHERIFF FRANCIS GILL

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

into the death of

CHRISTOPHER NICHOLLS

Perth, 24 August 2022

The Summary Sheriff, having considered the evidence and information presented at the Inquiry, determines in terms of Section 26 of the Inquiries into Fatal Accidents and Sudden Deaths etc. (Scotland) Act 2016 (hereinafter "the Act"), that:

Findings

(1) In terms of Section 26(2)(a), of the Act (when and where the death occurred).

Christopher Nicholls, born on 14 July 1976, died in the garden of a property in Longforgan, Perth and Kinross on 22 December 2020. Life was pronounced extinct at 13.35 hours.

(2) In terms of Section 26(2)(b), of the Act (when and where any accident resulting in death occurred).

Mr Nicholls died as a result of serious injuries sustained in an accident which occurred at sometime between 11.30 hours and 12.51 hours on 22 December 2020 in the garden of a property in Longforgan, Perth and Kinross.

(3) In terms of section 26(2)(c), of the Act (the cause or causes of death).

The cause of Mr Nicholls' death was electrocution from overhead electrical power lines.

(4) In terms of Section 26(2)(d), of the Act (the cause of any accident resulting in the death).

The accident was caused when Mr Nicholls came into contact with the overhead power lines. The precise mechanism of the accident was not established.

(5) In terms of Section 26(2)(e), of the Act (the taking of precautions).

Had a formal risk assessment been carried out, an exclusion zone should have been created under the overhead power lines. Such an exclusion zone would have identified the risk of working near to the power lines and acted as a reminder of their presence.

(6) In terms of Section 26(2)(f) of the Act (defects in any system of working).

The failure to conduct a site specific risk assessment and thereafter to create and observe an exclusion zone was a defect in a system of working which contributed to the death of Mr Nicholls.

(7) In terms of Section 26(2)(g) of the Act (any other facts relevant to the circumstances of the death).

There are no other facts or circumstances relevant to the cause of death.

Recommendations

The Summary Sheriff having considered the evidence and information presented to the Inquiry, makes no recommendations in terms of Section 26(1)(b) of the Act.

Note

Procedure

[1] This was a mandatory Inquiry held in terms of Section 2(3) of the 2016 Act because Mr Nicholls died while acting in the course of his employment as a self-employed gardener in Scotland. The homeowner of the locus was not Mr Nicholls' employer.

[2] Preliminary Hearings were held on 10 December 2021 and 10 February 2022. The Inquiry itself was held on 10 March 2022. All hearings took place via WebEx.

[3] At the Inquiry, Ms Lixia Sun, procurator fiscal depute, represented the Crown. Mr David B. Bell, solicitor, represented Mr Nicholls' mother (Mrs Deirdre Nicholls). Mrs Gemma Macmillan, solicitor, represented Scottish Hydro Electric Power Distribution ("SHEPD"). SHEPD is the owner and operator of the power lines which run overhead above the garden at the locus.

[4] Shortly before the Inquiry hearing, the parties lodged a Joint Minute agreeing a number of factual matters. The Joint Minute was read into evidence by the Procurator Fiscal at the start of the Inquiry.

[5] At the conclusion of the evidence on 10 March 2022, I ordered parties to lodge written submissions by 31 March 2022. Each party did so. On 4 April (and unprompted), Mr Bell lodged a further written submission. In response, Mrs Macmillan lodged a further written submission on 14 April 2022. On 21 April 2022, the Procurator Fiscal confirmed that she would not be lodging a further written submission and so on 22 April 2022 I made *avizandum*.

[6] The following witnesses gave evidence to the Inquiry:

i. DL (the owner of the property where the accident took place).

ii. Michelle Gillies (HM Inspector of Health & Safety).

iii. Andrew Seager (HM Principal Specialist Inspector in Electrical Engineering).

iv. Ian Crawley (Head of Operational Safety at SSE).

The legal framework

[7] The Inquiry was held under section 1 of the Act and the procedure was governed by the Act of Sederunt (Fatal Accident Inquiry Rules) 2017.

[8] Section 1(3) of the Act sets out that the purpose of a Fatal Accident Inquiry is to establish the circumstances of the death and consider what steps (if any) might be taken to prevent other deaths in similar circumstances. The Inquiry is an inquisitorial process and it is not the purpose of an Inquiry to establish civil or criminal liability.

Background facts and circumstances

[9] The facts set out in this section of the Determination accord with the terms of the Joint Minute.

[10] Mr Christopher Nicholls ("Mr Nicholls") was born on 14 July 1976 and resided at 1 Somerville Place, Dundee.

[11] At the time of his death, Mr Nicholls worked as a self-employed gardener trading under the name of "Russell Landscapes".

[12] Over the last five years, Mr Nicholls had been carrying out regular garden maintenance work at the locus. His tasks included grass cutting, weeding and keeping the hedges neat and tidy. Mr Nicholls would usually work at the locus on two days each week. He was reliable and punctual.

[13] The garden at the locus is surrounded by hedging on all sides. Power lines run overhead across the garden.

[14] Prior to the accident, the said power lines were last inspected in August 2019 by SHEPD. That inspection included checks of the surrounding land and vegetation, including the hedge where the accident occurred. The clearance between the hedge and the power lines complied with the Electricity Safety, Quality and Continuity Regulations 2002 ("the 2002 Regulations").

[15] The poles on either side of the span of the said power lines have yellow warning signs in terms of Regulation 19(2) and Schedule 1 of the 2002 Regulations.

[16] A three wire 11 kV power line runs above an area of yew hedge in the garden on the east boundary. Due to the proximity of the overhead power lines to the top of the

hedge and for the last three years Mr Nicholls was instructed by DL not to cut the hedge in this area. Prior to the accident this instruction had always been followed.

[17] Arrangements had been made between DL and SHEPD to cut the hedge which is underneath the power line. Prior to the accident, the relevant section of the hedge at the locus was cut by SHEPD on 25 May 2019. The cut was requested by DL. Also at DL's request, SHEPD arranged to cut the hedge every two years as opposed to the company's usual four year tree cutting/maintenance cycle. This was because clearance achieved by a cut was deemed insufficient to last the standard 4 year interval between cuts.

[18] At approximately 07.15 hours on 22 December 2020, Mr Nicholls attended at the locus by prior arrangement. He spoke with DL who advised Mr Nicholls of the jobs he wished to be carried out that day. One of those jobs was to cut the hedge on the eastern border of the property.

[19] At about 11.30 hours, while cutting a section of the east hedge, Mr Nicholls and DL had a brief conversation. Mr Nicholls appeared to be fine.

[20] At some time before 13.00 hours, DL went to look for Mr Nicholls. He saw a ladder propped up against the hedge below the power line and found Mr Nicholls lying at the bottom of the ladder on his left side. At this point, Mr Nicholls was unresponsive and his lips and face were blue.

[21] Paramedics from the Scottish Ambulance Service were tasked to attend the locus at 12.51 hours and arrived at the locus at 13.04 hours. They were guided to Mr Nicholls and established that he had no vital signs. Medical treatment including advanced life support was given for approximately 20 minutes without any signs of life apparent. The

paramedics observed a small wound on Mr Nicholls right hand and detected a burning smell. Mr Nicholls' life was pronounced extinct at 13.35 hours on 22 December 2020.

[22] A post mortem examination of Mr Nicholls was carried out by Dr Alan Farnworth on 24 December 2020. It revealed that Mr Nicholls had suffered multiple electrical burns. Dr Farnworth concluded that Mr Nicholls' death was attributed to electrocution due to contact with overhead power lines.

[23] The formal cause of death was recorded as:

1(a) Electrocution (Overhead Powerlines, Gardener).

[24] Officers from Police Scotland attended the locus in the afternoon of 20 December 2020 and examined the scene. They observed a ladder leaning against the hedge with what appeared to be a hedge trimmer on top of the hedge. One of the officers noted that Mr Nicholls had a small black mark on his right hand in between the thumb and index finger. There were no other visible injuries although there was a strong smell of burning coming from Mr Nicholls. A right hand glove which had been used by Mr Nicholls had a small burn mark in between the thumb and index finger.

[25] A police officer measured the ladder and hedge trimmer which had been used by Mr Nicholls. The ladder at its height in place was 4.8 metres and the length of the hedge trimmer on the pole was 2.3 metres.

[26] After the accident the power line at the locus was checked by SHEPD. No fault was found and no other issues affecting the SHEPD electricity network in the area were reported.

[27] On 13 January 2021, Michelle Gillies an Inspector from the Health and Safety Executive who had initially attended at the locus on 23 December 2020, revisited the locus along with Kenneth Morton, then HM Principal Specialist Inspector in Electrical Engineering and two linesmen from SHEPD. An inspection of the overhead power lines was carried out and the heights of the overhead power lines were measured. The heights were measured as outer left 6.59m, middle 6.37m and outer right 6.39m. The height of the hedge at the approximate position of the ladder was 4.87m and the height of the hedge at the cut level was 4.57m.

[28] On 13 January 2021 Ms Gillies and Mr Morton attended at Perth Police Station to examine the ladder and hedge trimmer which had been used by Mr Nicholls. There were no obvious marks on the ladder or hedge trimmer. The hedge trimmer was 2.3 metres in overall length and 1.62m from top to the operator handle

[29] Following the conclusion of her investigation, Ms Gillies produced a report with her findings. That report is Crown Production 6 and it was admitted into evidence.

[30] Following the conclusion of his investigation, Mr Morton produced a report with his findings. That report is Crown Production 7 and it was admitted into evidence. Mr Morton noted that in terms of the 2002 Regulations, for a power line carrying up to 33 kV and crossing locations other than roads, the minimum line height is 5.2m. The height of the line above the ground at its lowest point of 6.37m at the hedge therefore exceeded the minimum clearance required by the 2002 Regulations.

[31] Andrew Seager, HM Principal Specialist Inspector in Electrical Engineering was instructed by the Crown in November 2021 to provide a report into the accident and

comment on the risks associated with contact with overhead power lines. That report is Crown Production 11 and was admitted into evidence. In his report, Mr Seager noted that there was a clearance of 1.8m between the hedge and the overhead power lines.

The witnesses at the Inquiry

DL

[32] DL was the homeowner of the property at the locus. He is 84 years of age and has lived at the locus for over 50 years. He had given a statement to the police on the day of the accident. This was lodged with the Inquiry and formed part of his evidence. DL explained that prior to the accident he had engaged the services of Mr Nicholls for about five years. He described him as being a very private person whom he had not go to know well, but that he had always got on well with him. He described Mr Nicholls as always being very punctual and reliable and that he always carried out the work instructed satisfactorily.

[33] DL explained that Mr Nicholls would carry out general gardening duties, hedge and log cutting and general landscaping. He was paid an agreed hourly rate and would issue DL with an invoice at the end of each month which was paid by cheque. DL said that Mr Nicholls was very familiar with the layout of the locus. The total size of the garden at his property is three acres, much of which is grass.

[34] Mr Nicholls arrived at the locus on 22 December 2020 around 07.20 hours. DL's evidence was that as was his normal practice, he went over with Mr Nicholls the jobs he wished him to carry out that day and provided him with a written list. The jobs were to

take logs into the house, cut the small hedge at the oil tank, clean some plant pots and then cut the hedge where the accident happened. In respect of that hedge, his instructions were clear that Mr Nicholls was not to cut the top of the hedge and was to stop cutting two metres below the top of it because of the presence of the overhead power lines. DL was in no doubt that he had made it clear to Mr Nicholls previously that he was not to cut the top of the hedge and that he had given that instruction twice on the day of the accident. DL's evidence was that Mr Nicholls clearly understood his instructions. DL was also clear that he had discussed the safety issues in regard to the overhead power lines with Mr Nicholls on previous occasions and he confirmed that Mr Nicholls was aware of the existence and position of the power lines.

[35] DL explained that he had an agreement with SHEPD for that company to cut the top of the hedge on a planned basis. His recollection was that the last time that SHEPD had cut the top of the hedge was in 2019 and he was clear that Mr Nicholls was aware of the cutting arrangements which had been agreed with SHEPD.

[36] DL was asked why, once the hedge had been cut to a safe height by SHEPD, he did not simply allow Mr Nicholls to cut and maintain the hedge to that safe height. DL's evidence was that for safety reasons even once the hedge had been cut to a safe height, he still only wished SHEPD and not Mr Nicholls to cut the top of the hedge. It was put to DL that in fact he had not given specific instructions to Mr Nicholls at approximately 07:30 hours and then again at 11.30 hours on the day of the accident that he was not to cut the top of the hedge. DL was resolute that he had. He was asked why Mr Nicholls would disregard his longstanding instruction and his specific instructions on the day not

to cut the top of the hedge. DL's best explanation was that Mr Nicholls was simply trying to do him a good turn.

[37] I considered that DL was doing his best to tell the truth and to assist the Inquiry, but he was at times unreliable. In particular, I did not accept his evidence that he had given Mr Nicholls two reminders on the day of the accident rather than just one, not to cut the top of the hedge. There was also some confusion as to the precise dates on which SHEPD had cut the hedge under the power lines, but otherwise I considered DL's evidence to be reliable.

Michelle Gillies

[38] Ms Michelle Gillies is employed by the Health and Safety Executive ("HSE") as an Inspector of Health and Safety. She has held this post for 22 years and has conducted numerous investigations into fatal accidents. She has a postgraduate diploma in Occupational Health and Safety. Following the accident, Ms Gillies produced a report.

[39] Ms Gillies' evidence was that the circumstances of the accident indicated that it can be assumed that Mr Nicholls either touched one of the power lines with the trimmer or the trimmer has come within close enough proximity for the power line to arc across to the trimmer. She had viewed the police photographs. In her report she noted that some of the photographs show evidence of the hedge below the power lines having being trimmed on the day of the accident.

[40] Ms Gillies confirmed that Mr Nicholls was self-employed. The homeowners were not his employers under the terms of the Health & Safety at Work Act 1974.

Accordingly the homeowners had no duties towards Mr Nicholls under that legislation. Ms Gillies also confirmed that under Section 3 of the same Act, that Mr Nicholls had a duty to take care of his own health and safety and in her view he had not discharged that duty.

[41] In respect of that latter aspect, she explained that it was Mr Nicholl's duty and his alone, to carry out a risk assessment of the tasks he was to undertake. Ms Gillies' evidence was that based on what she had found at the locus, Mr Nicholls had not carried out such a risk assessment and had not followed guidance from the HSE. In particular he had not followed HSE Guidance Note GS6 (Fourth Edition) – "Avoiding danger from overhead power lines" (Crown Production 12). She noted that no formal risk assessment had been found. Ms Gillies' evidence was that had a risk assessment been carried out in advance of cutting the top of the hedge, it would have concluded that such as task was not safe due to the proximity of the overhead power lines.

[42] She confirmed that the danger was working in the proximity of the power lines and not just the coming into contact with them. Ms Gillies agreed that even if Mr Nicholls' had been asked to cut the top of the hedge by DL, it would still have been his responsibility to carry out a risk assessment before going ahead. She also advised that the Electricity at Work Regulations 1989 would have applied to Mr Nicholls but again he did not appear to have followed these. She confirmed that there are various guidance notes (including GS6) which would assist individuals such as Mr Nicholls and which can be accessed and downloaded freely from the HSE website. Some of these

guidance notes are sector specific, for example, there is special guidance for agricultural workers.

[43] Ms Gillies was a credible and reliable witness.

Andrew Seager

[44] Andrew Seager is employed by the HSE as a Specialist Principal Inspector in Electrical Engineering. In this role he has investigated around 20 fatal incidents and has previously given evidence to Fatal Accident Inquiries and also at Inquests in England. The Crown instructed Mr Seager to prepare a report for the purpose of this Inquiry. He did not visit the locus. He too confirmed that guidance documents about working near overhead power lines are freely available on the HSE website.

[45] In his report, Mr Seager concluded that if Mr Nicholls had followed the guidance in GS6, then it is likely he would have identified the risks associated with the overhead power lines at the property and taken steps to ensure that neither he nor his equipment came into close proximity to, or made contact with them. These steps would have avoided the circumstances in which he received a fatal electric shock. The guidance in GS6 is that the most effective way to prevent contact with overhead power lines is simply not to carry out work where there is a risk of contact with them. If that is not possible then an exclusion zone of 3m should be set up around the lines or other control mechanisms should be put in place. The purpose of an exclusion zone is to prevent the risk of people carrying out work which would bring them into close proximity of power lines.

[46] Mr Seager was clear that Mr Nicholls should have carried out a risk assessment of all risks before starting work and that it was his responsibility to do so. This would have involved looking at the area around him for hazards at ground level, for example ponds, as well as for any hazards above him. If he was unsure he should have investigated what any overhead wires were for. The assessment should have taken into account the nature of the work he was going to do. As he was using a hedge trimmer, Mr Nicholls should have ensured that the trimmer stayed well clear of the overhead power lines.

[47] In his opinion, the overhead power lines at the locus met the requirements of the 2002 Regulations in terms of height, clearance, and signage at the time of the accident.

[48] Mr Seager's evidence was that Mr Nicholls had either touched the power lines directly, a tool he had been using touched the power lines or that there had been arcing. Arcing is where two conductive surfaces are so close together that the electrical current jumps from the conductor with the higher voltage to the other. For arcing to have occurred, either Mr Nicholls or the tip of the hedge trimmer would have to have been extremely close to the power lines. Mr Seager thought that Mr Nicholls or the hedge trimmer could have been as close as 1cm to the overhead power lines. He explained that when electrocution happens the muscles usually contract, so had Mr Nicholls been holding the trimmer when electrocution occurred, he would have expected the trimmer to have fallen to the ground with him. In fact, at the locus the hedge trimmer was found on the top of the hedge. Therefore, in Mr Seager's view, it was slightly more probable that the cause of the electrocution was Mr Nicholls touching the power line directly.

[49] Mr Seager was asked about the adequacy of the "Danger of Death" warning signs which are affixed to electricity poles and in particular to those at the locus. Photographs of these poles and the signs were included in Appendix A of his report. In Mr Seager's view the clear purpose of the sign is to warn people to keep off the pole and to alert them to the danger of electricity being carried by the overhead power lines. Anyone carrying out a risk assessment should note the sign. There was also barbed wire around the pole which he explained is an anti-climbing measure. Mr Seager confirmed that the signage on the poles at the locus complied with the 2002 Regulations. In his view, the sign is the universally recognised symbol for the presence of dangerous voltage.

[50] In his view it is a matter for the electricity company to carry out a risk assessment to see if any other warning information should be included on particular poles. He accepted that the standard sign does not given any explicit warning of the danger of coming into contact with power lines. He also accepted that there is scope to include additional text on these signs in terms of the 2002 Regulations and in some instances that is done, for example, where there is recreational fishing near power lines, but in his view the standard sign was sufficient for an electricity pole in a domestic setting and for the poles at the locus.

[51] Mr Seager was a credible and reliable witness.

Ian Crawley

[52] Mr Ian Crawley was called as a witness by SHEPD. He is the Head of Operational Safety at SSE and at the time of the accident was their Operational Safety Manager. He explained that SHEPD provides guidance on Health and Safety matters relating to the dangers of electricity to members of the public and businesses by publishing guidance and information on its website. An example was an information sheet called "Safety and Overhead Power Lines: Look Out, Look Up!" (SHEPD production 6). This was guidance specifically about safety when working close to overhead power lines. That guidance has a specific section on maintenance and advises that when in the vicinity of overhead power lines, work such as hedge cutting when using a power tool should be carefully planned.

[53] Mr Crawley explained that SHEPD offer a free service to check the type and condition of an overhead power line prior to any work being started and could discuss options and alternatives with an individual or company to make the proposed work safer. According to SHEPD's records, Mr Nicholls had not made any contact with SHEPD prior to the accident. Had Mr Nicholls contacted SHEPD, the advice would have been not to cut the hedge and they would have considered a site visit to discuss with him alternatives. These would have included SHEPD offering to carry out the cut or as a last resort switching the line off to allow Mr Nicholls to carry out the work.

[54] Along with the guidance on SHEPD's own website, Mr Crawley confirmed that there are a number of guidance notes on the Health and Safety Executive's website as well as guidance being more generally available on the internet. The Forest Industry

Safety Accord is further example of safety guidance which is publicly available. In Mr Crawley's view the common themes of the available guidance are: keep a safe distance from any power lines, contact the electricity company in advance for guidance and conduct a risk assessment before starting any work. There was no evidence that Mr Nicholls had carried out a risk assessment.

[55] Mr Crawley explained that SHEPD has a policy of working to a four year cycle for cutting hedges and trees on private property which are close to its power lines to make sure they do not interfere with the power lines. The cycle can be varied depending on the species of tree and growth rates. The SHEPD staff who carry out tree and hedge cutting are all qualified to do so. SHEPD tries to work in harmony with the landowner. In respect of the locus Mr Crawley confirmed that there was an agreement in place with DL to carry out a cut every two years.

[56] Mr Crawley was asked about the adequacy of the warning signs on the electricity poles. In his view the warning sign on the poles at the locus was sufficient and complied with the 2002 Regulations. In his view it is clear that the sign alerts the public to the risk of the presence of electricity rather than it simply being a warning not to climb the pole. SHEPD own thousands of electricity poles each of which is assessed for the risk of vandalism or climbing and whether other particular safety measures are required. In some high risk areas, for example, where members of the public are fishing, additional wording is placed on the warning sign. The poles at the locus had barbed wire attached to them because they were part of an "H pole" structure which supports a transformer unit. The poles had been assessed as low risk which was usual for a

domestic setting and he would not have expected the signs on them to have required any additional wording.

[57] Mr Crawley was asked whether additional wording on the warning sign regarding the need for an exclusion zone would have been useful and reasonable. He considered that the risks of working near electricity were generally well known and in particular by individuals such as Mr Nicholls whose work placed them in that environment. It was put to him that some people would not think to look at a website for guidance because they had no reason to consider that being in the vicinity of power lines (as distinct from coming into direct contact with the power lines) would put them in danger. Mr Crawley disagreed. In his view anyone working near power lines should be concerned about the risks to their safety. He also disagreed that expecting sole traders such as Mr Nicholls to be aware of the available guidance and carry out a risk assessment as recommended in that guidance was expecting too much of them. He accepted that while in principle there was scope for putting additional wording on the warning sign, he was clear that it was not necessary generally and not in respect of the poles at the locus. He confirmed that he was aware of four deaths in the last five years of self-employed individuals (including that of Mr Nicholls) who had died after coming into contact with power lines. Mr Crawley explained that breaching an exclusion zone would not always be dangerous and would depend on the type of work being carried out, for example, cutting grass would not necessarily be dangerous.

[58] Mr Crawley was a credible and reliable witness.

[59] Towards the end of Mr Crawley's evidence, I was invited to consider the Determination by Sheriff W M Wood following the Fatal Accident Inquiry into the death of Martin Buchan[1] and a copy was thereafter sent to the Court by the Crown.

Written Submissions for the Parties

The Crown

[60] The Crown proposed findings in terms of Section 26 of the Act which accord with those that I have made.

[61] In respect of the submissions on changes to the signage on electricity poles made on behalf of Mrs Nicholls (see paragraph [65] below), the Crown's submission was that the current "Danger of Death" sign is a universally recognised sign which provides warning of the danger of electricity. The content of the current version of the sign is adequate for this purpose. In the Crown's view there is no genuine public concern about the sign such that it is necessary for the Court to make a recommendation in terms of Section 26(1)(b) of the Act.

[62] The Crown's view was that Section 3(2) of the Health and Safety at Work Etc. Act 1974 leaves no doubt that the duty to make his working environment as safe as possible lay with Mr Nicholls.

[1] [2019] FAI 38

Mrs Deirdre Nicholls

[63] There were three main points in Mr Bell's written submissions: (i) DL was not a reliable witness; (ii) the court should make a recommendation in respect of changes to the warning signs which are placed on electricity poles found in domestic settings such as at the locus and (iii) it was unrealistic to expect individuals such as Mr Nicholls to be aware of the guidance referred to by the witnesses and therefore unrealistic to expect them to carry out a risk assessment of the type described in the guidance.

[64] Mr Bell doubted whether DL had given Mr Nicholls two specific instructions on the morning of the accident not to cut the top of the hedge. Mr Bell did however make clear that he did not contend that DL was liable for the accident and he was not suggesting that Mr Nicholls was given any specific instructions to cut the top of the hedge.

[65] Mr Bell invited the Court to make a recommendation that the Danger of Death signs placed on electricity poles situated in or around domestic premises should convey more information than they do at present. His position was that the present sign does not adequately alert anyone to the dangers associated with coming too close to the overhead power lines but only warns them to keep off the pole and not climb it. In his view the danger from breaching a recommended exclusion zone was a reasonably foreseeable one as set out in Regulation 19(2) of the 2002 Regulations. Therefore the sign should warn people that they or any equipment they are using should not come within the 3m exclusion zone referred to in GS6. The sign should make it clear that the danger is not just of touching the lines but of working close to them. The sign could also direct

the reader to contact the electricity operator for further specific advice and include web addresses of sites with links to the publications such as Crown Production 12 and SHEPD Production 6 discussed above.

[66] The submissions also made reference to the deaths of three individuals apart from Mr Nicholls within the last five years which were a result of contact with overhead power lines while at work. In Mr Bell's view if a change to the warning sign had been made in the past, those deaths would have been prevented.

[67] Mr Bell submitted that expecting self-employed individuals such as Mr Nicholls to be aware of their legal duties and the steps needed to discharge those duties would mean the Court taking a legalistic and unrealistic view of matters. In particular asking self-employed gardeners to be aware of and to take into account the guidance about the need to undertake a risk assessment would be seeking what he called a doctrine of perfection.

SHEPD

[68] The primary submission for SHEPD was that Mr Nicholls was aware of the location of the overhead power lines and that for reasons unknown, he acted contrary to DL's express instructions not to cut the top of the hedge. This was the cause of the accident.

[69] Mr Nicholls' death was the result of his failures to comply with the relevant health and safety legislation, to consider and follow the publicly available guidance regarding working near overhead power lines and his failure to carry out a risk

assessment. Had he completed a suitable risk assessment or had in place an appropriate system of work, the accident would not have occurred.

[70] It was important to understand that the act of encroaching into an exclusion zone does not in and of itself automatically place someone in danger. The purpose of the exclusion zone is to ensure that an individual and any equipment they are using is kept at a safe distance such that contact cannot be made with the power lines or to stop the individual getting so close to them that arcing occurs. So in this case even if Mr Nicholls had breached the exclusion zone by working 2.5m rather than 3m away from the power lines, he would not have been electrocuted.

[71] SHEPD considered that the submissions by Mr Bell in respect of the signage on the electricity poles at the locus were irrelevant matters for this Inquiry. This was because the accident did not involve an electricity pole. No evidence had been led that Mr Nicholls would have been in the vicinity of the poles closest to the site of the accident on the day in question or that he would have in fact seen the warning signs while working at the hedge that day. In any event the purpose of the warning signs on an electricity pole is to warn that there is a danger from overhead power lines and were a person may not otherwise be aware of the presence of the power lines. Mr Nicholls on the other hand already knew the overhead lines were there, yet knowingly opted to work underneath them on the day of the accident. A warning on the sign about establishing an exclusion zone would not have prevented this accident. The cause of Mr Nicholls' death was not simply that he had breached the recommended exclusion

zone, but that he was working so close to an 11kV power line that he made direct contact with it or that he came so close to it that arcing occurred.

[72] There have in fact been particular situations in which SHEPD have included additional information on warning signs where locations have been deemed a higher risk following the completion of a risk assessment. The focus on the signage on the poles was also misplaced as it fails to take into account the fact that many properties will simply have over-sailing electricity conductors and no poles on the property. As such any change to pole signage to include site specific exclusion zones would not serve any benefit to individuals working at those properties.

Discussion and conclusions

[73] From all the evidence that I have heard and considered, it is clear that the accident occurred because of the decision by Mr Nicholls to cut the top of the hedge below the overhead power lines. As there were no eye witnesses, we will never know why Mr Nicholls chose to do so. It is clear that he did not follow the available guidance in respect of risk assessments and exclusion zones.

[74] I make the following comments in respect of Mr Bell's submissions. I have already commented on certain aspects of DL's evidence at paragraph 37 above. I consider the reasons for his confusion to be a combination of the passage of time since the accident and the stress of giving evidence rather than anything more sinister. In any event this issue has had no bearing on my findings.

[75] I have not made the recommendation sought by Mr Bell in respect of changes to the Danger of Death sign, for the following reasons. The evidence of Mr Seager and Mr Crawley was clear that the signs at the locus met the requirements of the 2002 Regulations. There was no evidence led that the terms of the sign in any way caused or contributed to the accident or that additional information on the sign would have prevented it. The accident did not involve any of the electricity poles at the locus. Although I was directed to the FAI into the death of Martin Buchan, there was no evidence led about the circumstances of that case or the other two fatalities to which I was referred. In particular there was no evidence led before this Inquiry about whether the cause of those deaths had anything to do with the signs on electricity poles. It is important to note that Mr Nicholls' death was not caused simply because he breached the recommended exclusion zone.

[76] The evidence and information presented at the Inquiry was that both the HSE and SHEPD make safety guidance freely and publicly available. However, I am not certain that sole traders will always look at the HSE's website or indeed SHEPD's website and consider the guidance that is available there. Both organisations may therefore wish to consider whether there is anything more they can do to publicise the existence of their guidance notes to sole traders whose working environment takes them close to electricity power lines. I stress this is an observation rather than a recommendation.

[77] Broadly the same issue was recognised at paragraph 30 of the Determination into the death of Martin Buchan. I respectfully agree with the point made there by Sheriff

Wood and I hope that the holding of this Inquiry will of itself also assist in publicising the guidance which is available.

[78] Mrs Deirdre Nicholls attended the Hearings on 10 December 2021, 10 February and 10 March 2022. She conducted herself with a quiet dignity on each occasion. As I did at the first Preliminary Hearing and at the conclusion of the Inquiry, I offer my sincere condolences to her as well as to Mr Nicholls' wider family and his friends for their loss.