SHERIFFDOM OF TAYSIDE CENTRAL AND FIFE AT STIRLING

[2018] FAI 18

STI-B22/19

DETERMINATION

BY

SHERIFF S G COLLINS QC

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

into the death of

ANDREW MORTON

Stirling, 30 April 2019

Determination

The sheriff, having considered the 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 referred to as "the 2016 Act"):

1. In terms of section 26(2)(a) of the 2016 Act (when and where the death occurred):

   That the late Andrew Morton, date of birth 21 December 1931, was pronounced dead at 0934 hours on 8 September 2016 at Stoney Inch Field, Lochend Farm, Denny.

2. In terms of section 26(2)(b) of the 2016 Act (when and where any accident resulting in death occurred):

That the accident resulting in death took place between about 0730 and 0830 hours on 8 September 2016 at the said Stoney Inch Field.

3. In terms of section 26(2)(c) of the 2016 Act (the cause or causes of death):

That the cause of death was an all-terrain vehicle accident leading to positional and mechanical asphyxiation.

4. In terms of section 26(2)(d) of the 2016 Act (the cause or causes of any accident resulting in death):

Mr Morton was driving a quad bike along a rough track at Stoney Inch Field. For reasons unknown he drove off this track and down a gentle slope to a point around 12 to 15 metres from the track. He then stopped, put the quad bike into reverse gear, and reversed back up the slope for a few metres. In so doing the rear near side wheel came into contact with a large stone, partially concealed in the grass of the field. This caused the quad bike to overturn, trapping Mr Morton underneath and restricting his breathing causing his death.

5. In terms of section 26(2)(e) of the 2016 Act (any precautions which (i) could reasonably have been taken, and (ii) had they been taken, might realistically have resulted in death, or any accident resulting in death, being avoided):

There are no precautions which could reasonably have been taken that might realistically have resulted in the death, or accident resulting in death, being avoided.

6. In terms of section 26(2)(f) of the 2016 Act (any defects in any system of working which contributed to the death or the accident resulting in death):

There were no defects in any system of working which contributed to the death.

7. In terms of section 26(2)(g) of the 2016 Act (any other facts which are relevant to the circumstances of the death):

That there are no other facts relevant to the circumstances of the death.

Recommendations

In terms of section 26(1)(b) of the 2016 Act (recommendations (if any) 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, (d) the taking of any other steps, which might realistically prevent other deaths in similar circumstances):

There are no recommendations made.

NOTE

Introduction

[1] This inquiry was held into the death of Andrew Morton. Mr Morton died on 8 September 2016 after the quad bike which he was driving in the course of his employment as a farmer overturned in a field, trapping him underneath. The death of Mr Morton was reported to the Procurator Fiscal (hereinafter referred to as "PF") on the same day. A preliminary hearing was held on 29 March 2019. The inquiry took place over a single day on 26 April 2019. Miss Daly, PF Depute, represented the Crown. No

other parties were represented. Mr Morton's widow and son were, however, present throughout the inquiry, and provided helpful contributions on a number of matters.

[2] The PF had prepared a substantial Notice to Admit which contained evidence that I was satisfied was uncontroversial. There were no objections to the Notice to Admit. I accepted the facts set out in the Notice to Admit. Also before the inquiry was an affidavit dated 14 March 2019 and a report dated 2 November 2019 from Dr Ian Wilkinson, FRCPath, Consultant Forensic Pathologist.

[3] The combination of the Notice to Admit together with the affidavit and report from Dr Wilkinson resulted in the need for oral evidence to be significantly reduced. I heard oral evidence from the following two witnesses:

a. PC Alan Russell

b. Garry Miller, HM Inspector of Health and Safety.

Garry Miller had prepared a report dated 26 January 2017 the terms of which he confirmed and spoke to in oral evidence.

The Legal Framework

[4] This inquiry was held in terms of section 1 of the 2016 Act. Mr Morton died in the course of his employment or occupation, and, therefore, the inquiry was a mandatory inquiry held in terms of section 2 of the 2016 Act. The inquiry was governed by the Act of Sederunt (Fatal Accident Inquiry Rules) 2017 (hereinafter "the 2017 Rules") and was an inquisitorial process. The PF represented the public interest.

[5] The purpose of the inquiry was, in terms of section 1(3) of the 2016 Act, to establish the circumstances of the death of Mr Morton and to consider what steps (if any) might be taken to prevent other deaths in similar circumstances. It was not the purpose of the inquiry to establish civil or criminal liability (see section 1(4) of the 2016 Act). The manner in which evidence is presented to an inquiry is not restricted. Information may be presented to an inquiry in any manner and the court is entitled to reach conclusions based on that information (see Rule 4.1 of the 2017 Rules).

[6] Section 26 of the 2016 Act sets out what must be determined by the inquiry. Section 26 of the 2016 Act is in the following terms:

> "26 The sheriff's determination
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> (1) As soon as possible after the conclusion of the evidence and submissions in an inquiry, the sheriff must make a determination setting out—
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> (a) in relation to the death to which the inquiry relates, the sheriff's findings as to the circumstances mentioned in subsection (2), and
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> (b) such recommendations (if any) as to any of the matters mentioned in subsection (4) as the sheriff considers appropriate.
>
> (2) The circumstances referred to in subsection (1)(a) are—
>
> (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,

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

(3) For the purposes of subsection (2)(e) and (f), it does not matter whether it was foreseeable before the death or accident that the death or accident might occur—

(a) if the precautions were not taken, or
(b) as the case may be, as a result of the defects.

(4) The matters referred to in subsection (1)(b) are—

(a) the taking of reasonable precautions,
(b) the making of improvements to any system of working,
(c) the introduction of a system of working,
(d) the taking of any other steps,

which might realistically prevent other deaths in similar circumstances.

(5) A recommendation under subsection (1)(b) may (but need not) be addressed to—

(a) a participant in the inquiry,
(b) a body or office-holder appearing to the sheriff to have an interest in the prevention of deaths in similar circumstances.

(6) A determination is not admissible in evidence, and may not be founded on, in any judicial proceedings of any nature."

Summary

[7] I found the following facts admitted or proved:

a. Andrew Morton, born 21 December 1931, and aged 84 years, was married to Jean Morton since May 1961 and had a son and a daughter.

b. Mr Morton was a self-employed partner in the farming business trading as the "firm of Andrew Morton". The other partners in the business are his wife and son. The farm is a cattle and sheep farm consisting of Lochend and

Townfoot Farms, Denny, with the main activities based at the Lochend Farm steading.

c. Mr Morton was semi-retired but still carried out a number of tasks including checking the cows and sheep each morning using a quad bike. This activity falls within the scope of the Health and Safety at Work etc. Act 1974.

d. Mr Morton had undiagnosed minimal coronary heart disease. He generally kept good health, but suffered from arthritis in his wrists and knee, upset stomachs and a minor prostate problem.

e. On 8 September 2016 Mr Morton got up at about 06:30 hours and had breakfast with his wife. He did not complain of feeling unwell.

f. At about 07:30 hours Mr Morton got onto the quad bike and went to check on the cows. This check would normally take him about an hour to complete. The weather was dry.

g. The quad bike used by Mr Morton was a red Suzuki king quad 4x4 500AXi registered number SN65 AFK. This bike was in generally good condition with the steering, brakes and body work sound. All tyres were severely worn, with little remaining tread, however the tyre pressures were appropriate. It had a weight of around 300 kg. Purpose-built water tanks were fitted to the front and rear carriers of the quad bike. Both tanks had capacity of 80 litres.

h. Around 08:30 hours Mr Morton was returning to Lochend farm steading. He was about 1 mile east of the farm steading, riding the quad bike through Stoney Inch field ("the field").

i. Mr Morton was travelling in a roughly westward direction following a rough track leading to a gate at the end of the field. On his left hand side, to the south, the ground fell away gently for about 10 to 20 metres, and then started dropping away more steeply to the gully of the nearby Carron River.

j. The field is generally covered with rough and tussocky grass. Growth of soft rush begins as the slope steepens into the said gully.

k. For reasons that are unknown Mr Morton drove the quad bike off the rough track and took a curving route down towards the gully, to a point roughly 12 – 15 metres from the line of the track. In doing so he passed a large stone on his left hand side, roughly pyramidal in shape, and standing around a foot to a foot and half proud of the ground. This stone was partially concealed in the grass.

l. Again for reasons unknown, Mr Morton then stopped the quad bike, put it into reverse gear, and began reversing slowly up the slope. As he did so the rear nearside wheel of the quad bike came into contact with the said stone which he had passed a few moments earlier. This caused the quad bike to overturn, to its left side, trapping Mr Morton underneath and restricting his breathing.

m. At the time of the accident the front water tank on the quad bike had about 35 litres of liquid in it. The rear tank had 15 litres of liquid in it. The resulting weight, particularly at the front, was at the limit of the safe loading capacity for the bike. When the bike became unbalanced, as a result of coming into contact with the stone, the weight of the tanks and their contents may have accentuated its overturn.

n. Between about 08:45 and 09:00 hours, when Mr Morton had not returned, his son, Andrew Morton Jr, sent his son, also named Andrew Morton, to look for him.

o. When found by his grandson shortly thereafter, Mr Morton was lying face down with the quad bike on top of him. The engine was not running, but the ignition lights were on.

p. The quad bike's engine stopped running because, as the bike was upside down following the overturn, the fuel from the fuel tank stopped flowing to the engine.

q. Mr Morton's grandson telephoned his father and told him to phone 999, which he did. He thought that Mr Morton was dead because his skin was white and his lips and eyelids were blue.

r. Mr Morton's grandson pushed the quad bike off him, rotating it over on its left side, down the slope, so that it again stood upright on its tyres.

s. Mr Morton's grandson received a telephone call from the health services, and he was told to start CPR on Mr Morton. He did so.

t. Jack McLaren, a paramedic, arrived at the scene shortly afterwards. He assessed Mr Morton and pronounced life extinct at 09:34 hours.

u. Police officers, including PC Alan Russell, attended as well and carried out investigations at the site. By this time the weather had deteriorated. It was windy and raining, and the underfoot conditions were wet and muddy.

v. Mr Morton was then removed and taken to Edinburgh City Mortuary.

w. Garry Miller, HM Inspector of Health and Safety, HSE, attended the site with a colleague later the same afternoon. In due course he prepared an investigation report dated 26 January 2017, now Crown Production 3.

x. On 13 September 2016, at Edinburgh city mortuary, Dr Ian Wilkinson carried out a post-mortem examination on the body of Andrew Morton. The findings of the examination are in Crown Production 1, a post-mortem report dated 2 November 2016.

y. The post mortem examination did not identify any external injuries to Mr Morton to suggest that trauma directly resulted in his death. He had a number of rib fractures, but these were consistent with the CPR carried out by Mr Morton's grandson.

z. Although Mr Morton's previously undiagnosed heart disease was discovered on post mortem examination, there was no evidence that he had suffered an acute myocardial infarction. Mr Morton would have been predisposed to a cardiac event such as an arrhythmia, but there was no pathology to establish that this had in fact occurred.

aa. Mr Morton's death was due to the restriction of his breathing caused by the weight of the quad bike after it overturned, trapping him underneath.

Submissions

[8] The PF sought formal findings in respect of section 26(2)(a) and (b) of the 2016 Act. The findings sought were based on the uncontroversial evidence and my findings closely mirror those sought by the PF.

[9] As regards section 26(2)(c) Dr Wilkinson had given the cause of death in his report as being "All terrain vehicle incident and cardiac enlargement associated with ischaemic heart disease." The post-mortem examination did indeed reveal that Mr Morton had such disease. However there was no evidence that he had had a heart attack. Nor was there any pathology to establish that he had had an arrhythmia, contributing to the death. Dr Wilkinson had noted Mr Morton's unexplained diversion from the rough track and reasoned that this might be due to his losing control of the vehicle due to a cardiac event such as an arrhythmia.

[10] Initially this was the PF's position too. However Dr Wilkinson does not appear to have been made aware that the quad bike was in reverse gear when found by Mr Morton's grandson. As was made clear in evidence, this could not have happened by accident. Mr Morton himself must have deliberately put the bike into reverse gear, shortly before the accident, and at a point when he must have been around 12 to 15 metres away from the line of the rough track. Had the divergence from the track been due to a loss of control resulting from an arrhythmia, and this been the cause of Mr

Morton's death, it seems unlikely that he would have been able to put the bike into reverse gear at the point he did.

[11] In the light of this, the PF lodged a supplementary written submission, shortly after the hearing, in which it was submitted that the cardiac issue was likely to be less significant and that positional and mechanical asphyxiation played a more significant role in causing Mr Morton's death.

[12] As regards section 26(2)(d) of the 2016 Act the PF submitted that the exact course of events could not be determined as there were a number of possibilities. Based on the available evidence, it was submitted that the most likely conclusion was that Mr Morton had, for some reason, left the rough track, come to a stop, put the quad bike into reverse, and collided with a stone whereby the bike overturned and trapped him underneath it.

[13] The PF did not seek findings in relation to section 26(2)(e) to (f) of the 2016 Act and did not invite the inquiry to make any recommendations. The PF did not submit that there were any other facts which are relevant to the circumstances of the death in terms of section 26(2)(g).

Discussion and Conclusions

[14] Section 26(2)(a) of the 2016 Act (when and where the death occurred):

> In this inquiry there was no dispute as regards when and where the death occurred. It is clear from the undisputed evidence that Andrew Morton was pronounced dead at 0934 hours on 8 September 2016 at Stoney Inch Field, Lochend Farm, Denny.

[15] Section 26(2)(b) of the 2016 Act (when and where any accident resulting in death occurred):

> There was no significant dispute as regards when and where the accident resulting in death occurred. In my view the accident resulting in death took place between about 0730 and 0830 hours on 8 September 2016 at the said Stoney Inch Field. I put this timeframe on it because it was apparent that Mr Morton left the farm about 0730 hours, that his round normally took about an hour, and that he was on his way back to the farm, and about a mile and a half away, when the accident happened.

[16] Section 26(2)(c) of the 2016 Act (the cause or causes of death):

> For the reasons recognised by the PF, and discussed above, I was not satisfied that it had been established that Mr Morton's undiagnosed cardiac condition had any part to play in his death. He was found by his grandson trapped under a heavy quad bike which had overturned onto him. There were no external injuries suggesting that trauma directly resulted in his death. The most likely mechanism of death was therefore positional and mechanical impairment of Mr Morton's respiratory functions.

[17] Section 26(2)(d) of the 2016 Act (the cause or causes of any accident resulting in death):

a. It is apparent that Mr Morton turned off the track on the quad bike and travelled the short distance down the slope towards the gully. Why he did so

is unclear. It is possible that he was going slightly further down the slope simply to check whether any cattle were down by the river.

b. The quad bike was in reasonably good condition, with sound steering, brakes and body work. The tyres were very worn, but it was not established that this had any part to play in the accident, particularly given that it became clear that the weather was dry at the time, the rain only coming on later in the day when the police and HSE were conducting their inquiries.

c. The critical piece of evidence, as became apparent at the enquiry, was the fact that the quad bike was found in reverse gear. The evidence on this matter satisfied me that it could not have got into reverse gear by accident. Therefore Mr Morton must have driven off the line of the rough track and down the slope, in forward gear, then stopped the bike, then put it into reverse gear himself. At this stage he must have been in control of the bike, suggesting that his initial divergence from the rough track was unlikely to have been inadvertent, due to loss of control resulting from a cardiac event. The fact of the bike being found in reverse gear strongly suggests that Mr Morton was in control of the bike, and reversing, immediately before the accident.

d. Mr Miller, in his clear and helpful evidence, explained that the positioning of the quad bike when found was consistent with Mr Morton having driven forward a short distance past a large stone partially concealed in the grass, then inadvertently come into contact with that stone when reversing at slow

speed, causing the overturn. I was satisfied that this was the most likely cause of the accident.

e. Mr Miller did express some concern about the weight of the water in the tanks on the front and rear of the quad bike, and potentially destabilising effect that this could have had. However he did not suggest that the bike was dangerously overloaded or unstable as a result, even given the gradient of the slope, and nor was he in a position to say that but for the amount of water in the tanks the bike would not have overturned once it came into contact with the stone. It is possible that once the bike started to topple over, the weight of the water in the tanks accentuated this event, but the evidence does not amount to a probability. Overall, I was not satisfied that it was established that the presence of the water tanks made a material contribution to the accident and so to Mr Morton's death.

[18] Section 26(2)(e) of the 2016 Act (any precautions which (i) could reasonably have been taken, and (ii) had they been taken, might realistically have resulted in death, or any accident resulting in death, being avoided):

The evidence heard at the inquiry did not identify any precaution which could reasonably have been taken which might realistically have resulted in the death, or the accident resulting in death, being avoided.

[19] Section 26(2)(f) of the 2016 Act (any defects in any system of working which contributed to the death or the accident resulting in death):

The evidence heard at the inquiry did not identify any defects in any system of working which contributed to the death or the accident resulting in death.

[20] Section 26(2)(g) of the 2016 Act (any other facts which are relevant to the circumstances of the death):

The evidence heard at the inquiry did not identify any other factors which were relevant to the circumstances of the death.

Recommendations

[21] Section 26(1)(b) of the 2016 Act (recommendations (if any) 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, (d) the taking of any other steps, which might realistically prevent other deaths in similar circumstances):

The inquiry did not identify any matter which necessitated the making of a recommendation.

Postscript

[22] Like the PF, I offer my condolences to Mr Morton's family in this determination. I was grateful to his widow and son for their attendance at and participation in this inquiry.