SHERIFFDOM OF TAYSIDE CENTRAL AND FIFE AT PERTH

[2019] FAI 42

PER-B143-19

DETERMINATION

BY

SHERIFF LINDSAY DAVID ROBERTSON FOULIS

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

into the death of

GRAHAM STEWART SHAW

Perth, 1 October 2019

The Sheriff, having considered all the evidence adduced, Determines:

1. In terms of section 26(2)(a) of the Inquiries into Fatal Accidents and Sudden Deaths etc (Scotland) Act 2016, that Graham Stewart Shaw (hereinafter referred to as the deceased) died at 12.30pm on 29 April 2018 in a barn at Peattie Farm, Coupar Angus, Perthshire, PH13 9LH.

2. In terms of section 26(2)(b) of the said Act, that the accident which resulted in the said death took place within a barn at Peattie Farm, Coupar Angus between 10.30am and 12.30pm on 29 April 2018.

3. In terms of section 26(2)(c) of the said Act, that the cause of the said death was traumatic asphyxia caused by the entrapment of the deceased between the wall of the barn and a piece of farm machinery, namely a Caterpillar TH336 Telescopic Handler.

4. In terms of section 26(2)(d) of the said Act, that the cause of said accident which resulted in said death was that the deceased exited the cab of said telescopic handler whilst the engine was running and without applying the handbrake. In the course of exiting the said cab, he accidentally struck the gear lever in said cab resulting in a forward gear being engaged thus causing said telescopic handler to move forward trapping the deceased between it and the wall of the barn.

5. In terms of section 26(2)(e) of the said Act that a precaution which could reasonably have been taken and might realistically have resulted in the said accident being avoided was the deceased applying the handbrake of said telescopic handler prior to his exiting the said cab.

6. In terms of section 26(2)(g) of the said Act, another fact which is relevant to the circumstances of the death of the deceased is that a revision of the "Safe Stop" section of the Health and Safety Executive document "Working safely with Agricultural Machinery" should be undertaken to remove any ambiguity as to the circumstances in which "Safe Stop" procedure should be adopted by extending its operation to any situation in which an operator of agricultural machinery vacates the driver's seat/operating position.

NOTE

[1] Evidence in this Fatal Accident Inquiry into the tragic death of Mr Graham Shaw was led on 29 July 2019. The Crown was represented by Mr Richard Brown, Procurator Fiscal depute. He led evidence from Messrs Donald Hynd, Gary Wood, Peter Dodd,

and Police Constable Kevin Wilkie. In addition, the Crown presented evidence in the form of deposition from Police Sergeant Lindsay Armstrong, Mrs Kay Shaw, and Mr Garry Miller. No other party was represented at the inquiry. The Crown further lodged a Notice to Admit information and I shall comment upon the use of this notice later in this note. The Crown's submissions at the conclusion of the Inquiry were largely as set out in the written submissions they provided me. These are appended to this note. The only additional matter upon which comment was made by the Crown was whether the problem with the handbrake of the telescopic handler was a defect or another fact relevant to the circumstances of the accident resulting in the death of the deceased. There was also an issue relating to whether some observations should be made about possible Government policy on the policing of the inspection and maintenance of agricultural machinery.

[2] No person actually witnessed the accident occurring. Mr Hynd was the first person on the scene. He had been working at Peattie Farm with the deceased. The deceased left him and did not return when expected. He tried to contact the deceased by telephone but there was no reply. He went up to the sheds and at around 12.30pm discovered the deceased trapped between the wall of a barn and the telescopic handler. The engine in the telescopic handler was still running. Mr Hynd managed to gain access to the cab of the telescopic handler and switched off the engine. The hand brake had also not been applied. Mr Hynd said that the deceased generally did not apply the hand brake. By the time Mr Hynd arrived at the shed, the deceased had passed away. Mr Hynd called the emergency services. The point regarding non application of the

hand brake was spoken to by Mrs Kay Shaw in her deposition. She detailed that the deceased did not always apply the hand brake when driving a car or pick up and was in the habit of leaving them in gear. Indeed, she later commented in her deposition that he usually did not apply a handbrake and referred to entering vehicles after the deceased had used them to find the vehicle in gear and the handbrake not always applied.

[3] The telescopic handler had four forward gears and four reverse gears. The gear lever was situated on the left of the steering wheel. Little force was required to move the gear from neutral to engage forward or reverse gear. If the handbrake of the handler was applied, it was not possible to engage a gear inadvertently to enable it to move. The brake of the telescopic handler was not in efficient working order. The floor of the barn was virtually level.

[4] The deceased had returned to the barn to collect bags of fertiliser. These bags each weighed 500 kilograms. They were stacked on top of each other. To lift a bag from the stack, the forks of the handler were inserted through the loops of the bags. These loops tended to lie flat as a consequence of the bags being stored one on top of the other. This necessitated someone lifting the loops up as shown in photograph 14 of Crown production number 1 before the forks could be inserted.

[5] The first person to attend from the emergency services was Mr Wood, a firefighter. He attended at 12.45pm just over 10 minutes after the services were called. His impression on arrival was that the deceased had been crushed and had passed away. Police Constable Wilkie attended in the afternoon. He confirmed that the hand brake of the telescopic handler had not been applied. When he turned on the ignition of

the telescopic handler, the instrument panel indicated that the vehicle was in second forward gear. He also applied the hand brake and confirmed that the brake handle had to be pulled up half way before the warning light illuminated on the instrument panel. The hand brake was loose at this point.

[6] Mr Peter Dodd was a health and safety inspector with the Health and Safety Executive. He had been in that role for over 20 years. He attended the farm and inspected the telescopic handler on 1 May 2018. He had prepared a report after his inspection, Crown production number 7. The cab of the handler was situated to one side of the vehicle and the door to the cab opened backwards. He confirmed that the handler had four forward and four reverse gears and these were selected by rotating the gear lever, which was positioned on the left of the steering wheel, attached to the steering column. He confirmed that when he turned on the ignition the instrument panel showed that the handler was in second forward gear. The engine, however, could only be started if the handler was in neutral. The hand brake had to be pulled up fully to a near vertical position to enable the parking brake to the handler to be applied. Testing the handler on a 6 degree slope established that the full application of the brake did not prevent it moving on such a slope. He considered that the hand brake had not been working efficiently for a number of months. Applying the hand brake resulted in the handler automatically engaging neutral gear. This was a safety feature. Once the hand brake was disengaged, a gear then had to be selected before the handler moved. Accordingly, if the hand brake was not applied, it was possible accidentally to engage a forward or reverse gear. To engage forward gear the gear stick was moved forward and

then rotated to select the gear. To engage reverse gear, the stick was moved in the opposite direction. Once the gear was engaged the handler moved at a fairly fast walking pace.

[7] In light of these investigations, Mr Dodd concluded that the most likely explanation for the accident which resulted in the deceased's tragic demise was that he had left the cab of the handler to lift the loops on the fertiliser bags without applying the handbrake. The handler had been in neutral, with the engine still running. Unfortunately he accidentally knocked the gear lever as he left the cab. Because the cab door of the handler opened by swinging backwards, forward gear was engaged. The gear engaged would be the same one the handler had been in immediately before the deceased engaged neutral gear before exiting the cab, namely the second forward gear. As a result the handler moved forward trapping the deceased between the wall of the barn and the advancing handler. This resulted in his being crushed. He concluded that he could not envisage any other explanation for the accident and I agree with this conclusion. There was no challenge to his conclusion and it was consistent with the other evidence led in this inquiry. There was nothing in the evidence presented, including the contents of the depositions, that caused me to question this conclusion. As a consequence I can make the determinations one to four above. As was recorded by Mr Dodd, if the parking brake had been applied by the deceased before he left the cab, the handler would automatically have gone into neutral gear. The floor of the shed was flat and, although the handbrake was not working efficiently, the handler would not have moved. The handbrake would have had to be disengaged before a gear could have

been selected. Accordingly, even if the deceased had knocked the gear lever as he exited the cab, the application of the handbrake would have prevented the handler engaging a forward gear. As a consequence, I consider I can make a fifth determination.

[8] Turning to the remaining matters which require to be considered in terms of section 26(2), Crown production number 8 was a Health and Safety Executive publication relating to working safely with agricultural machinery and was available on the website of the Executive. This provided advice relating to "Safe Stop". It provided a clear warning that it was extremely dangerous to undertake any work on an agricultural machine whilst it was under power. Thus the handbrake should be applied, the machine put in neutral, the engine switched off, and the ignition key removed. Persons were implored to follow this procedure before leaving the driver's seat/operating position.

[9] The opening comment in the "Safe Stop" section refers to it being extremely dangerous to undertake any work on a machine whilst it is under power. Whilst later on in the section there are three bullet points under the instruction as to when "Safe Stop" should be followed, the first of which being "before leaving the driver's seat/operating position", the opening comment to this section can suggest that the advice is directed towards scenarios involving the working on a machine. Reference is made to carrying out any maintenance or adjustments including dealing with a blockage or other problem. Comments regarding clearing blockages, trying to correct faults and similar situations are again made further on in the section. It does not strictly cover the circumstances which arose in the present instance. Accordingly, it seems to me that the

advice regarding "Safe Stop" should be revised to make it clear that such procedures should be adopted on any occasion that an operator leaves the driver's seat/operating position. I have accordingly made a further determination to cover this.

[10] Mr Dodd indicated that accidents involving agricultural machinery were common and the consequences of such accidents could be serious. The dimensions and weight of agricultural machinery tended to be considerable. In his experience, persons working in an agricultural setting were more likely to compromise on their own safety. He thought that any servicing for the handler was likely to be no more than annual. Mrs Shaw in her deposition gave the impression that servicing of the handler might have been a little haphazard. There was no real policing of the maintenance of such machinery to ensure that it was in an acceptable working condition. He considered that it was unlikely that there would be resources to police such servicing.

[11] The recommendations of Mr Dodd's report referred to the inspection and adjustment of the handbrake on the telehandler and thereafter periodic inspection and adjustment in accordance with the manufacturer's instructions to maintain the effective operation of the brake. There was no dispute that the handbrake was not operating efficiently. I have not made any determination directly addressing this matter for a number of reasons. The first is that if the handbrake had been applied, irrespective of its effectiveness, the accident would not have occurred. Thus this was not a defect which contributed to the accident. In any event, the evidence pointed to the deceased sadly having a tendency of not applying handbrakes. Accordingly, even if the handbrake had been in efficient working order, it was just as likely that he would not have applied it.

[12] Whilst still on the theme of inspection and maintenance of machinery, the introduction of Crown production number 8 referred to many agricultural machines having potentially dangerous moving parts capable of causing serious, if not fatal, injury. It refers to the possibility of complacency on the part of operators and a lack of awareness. In his evidence, Mr Dodd confirmed these matters. The content of the deposition from Mrs Shaw pointed to the servicing of the handler possibly being haphazard, albeit this had now been addressed.

[13] If a component on a piece of machinery is not operating as it should, it may encourage an operator to ignore its use whilst operating the machinery. Whilst the evidence points to the deceased's non application of the handbrake in the instant case not having been influenced by its not working efficiently, a different operator might have a different attitude. As I have noted there is no real policing of the inspection and maintenance of agricultural machinery and Mr Dodd doubted whether there would be resources to enable such policing to take place. It was not something really investigated in evidence and is not directly relevant to the circumstances of the present inquiry. However, it seems to me that it would be worthwhile for the appropriate government department to consider whether some sort of inspection and maintenance regime could realistically be introduced, in effect the equivalent of an MOT for agricultural machinery.

[14] The issue of training for the use of agricultural machinery was raised in the deposition of Mrs Shaw. She was unaware whether the deceased had been on a training course for the operation of the telescopic handler. For reasons already given, it is

unlikely that such training would have effected a change in the deceased's apparent tendency not to apply a handbrake. However, if he was ignorant of the safety implications of not applying the handbrake, one cannot be sure. It is clear from the deposition that training is now being undertaken. Advice regarding being suitably trained to use agricultural machinery is covered in Crown production number 8 under the paragraphs headed "Before you start" and "Is the machine operator competent to do the job safely". I do not consider anything further requires to be covered regarding this issue in light of the evidence in this inquiry.

[15] Finally there is a matter of practice which I wish to comment upon. The only party represented in the inquiry was the Crown. This was the second Fatal Accident Inquiry over which I have presided since the introduction of the Inquiries into Fatal Accidents and Sudden Deaths etc (Scotland) Act 2016. As I noted in the determination in the Inquiry into the death of Darrell Kerr Smith it is anticipated that considerable efforts will be made to agree matters which are non-contentious at an inquiry in terms of this legislation. Section 18 of the Act refers to agreement of facts before the inquiry and a number of paragraphs in the subsequent Act of Sederunt (Fatal Accident Inquiry Rules) 2017 are directed towards such agreement with reference to joint minutes, duties on participants to agree information, and notices to admit information as examples. In this inquiry a notice to admit information was produced by the Crown. Provision for the use of such a notice is made in rule 4.12 of the Act of Sederunt (Fatal Accident Inquiry Rules) 2017. That rule firstly provides that the sheriff orders the intimation of such notices. No such order was made in this inquiry. I would question whether the

use of such a notice was accordingly appropriate. I have already referred to a number of witness statements. Rule 4.13 covers the use of such statements. Again, I can find no interlocutor which apparently is envisaged in terms of the rule.

[16] In the present inquiry the fact that these provisions were not complied with was of no real consequence, although I have reservations as to whether there was specific evidence as to the medical cause of the death of the deceased. It does have to be accepted that having regard to the evidence which was led as to the positions in which the deceased and the telescopic handler were discovered in the barn, it was clear that he had been crushed and thus it requires no great leap to determine that the cause of death was traumatic asphyxia. However in different circumstances, it might well have been of some significance. Parties should not forget that a deceased's family are likely to have an interest in the inquiry and be in attendance, albeit the evidence at the inquiry may cause distress. Any unnecessary procedural hiccup may well exacerbate such distress. It may at least prolong it. Well intentioned attempts to focus the evidence to be led are to be encouraged but it is important that the provisions which allow this to be undertaken are followed or the legal equivalent of "more haste less speed" may be the consequence!

[17] Finally I close by offering my belated condolences to the family of the deceased.

Submissions
by
Procurator Fiscal Depute for the Crown
in the
Inquiry into the death of Graham Stewart Shaw

Overview

The Crown would wish to commence these submissions by iterating its sincere condolences to the family of Mr Shaw. Mr Shaw was a man whose life was cut short in tragic circumstances.

At approximately 1230 hours on Sunday 29 April 2018 Mr Shaw was found by Donald Hynd pinned to the wall of a barn by a telehandler. The barn in question was on the farm run by Mr Shaw: Peattie Farm in Coupar Angus, Perthshire.

The emergency services were contacted and attended at the farm however it was clear that even by the time Mr Shaw was initially discovered by Mr Hynd he had passed away. From the evidence we have heard today it appears that Mr Shaw had left the telehandler with the ignition running and with the parking brake not applied. He has then climbed backwards out of the operator's cab and in doing so has accidentally knocked the vehicle into forward gear.

The accident was subsequently investigated by Police Scotland and the Health and Safety Executive ("HSE"). As Mr Shaw died in the course of his employment a fatal accident inquiry was mandatory under section 2 of the Fatal Accidents and Sudden Deaths etc (Scotland) Act 2016.

The First Notice was lodged on 15 May 2019 with your lordship's clerk and your lordship then granted the first order dated 16 May 2019 ordering a preliminary hearing on 8 July 2019 and the Inquiry itself which took place today, 29 July 2019.

Evidence

Evidence in this Inquiry came from four witnesses who provided an account to the court; a Notice to Admit Information; three affidavits; and seventeen productions.

I do not intend to rehearse the evidence heard - it is in short compass and it is no doubt fresh in your Lordship's memory.

Legal Framework

The determination to be produced by your Lordship must address those matters set out in section 26(2) of the Inquiries into Fatal Accidents and Sudden Death etc (Scotland) Act 2016 ("the 2016 Act").

In terms of section 26 of the 2016 Act the Crown would respectfully invite your Lordship to make findings in the following terms:

Section 26(2)(a) - when and where the death occurred

Graham Stewart Shaw, born 3 February 1964, died at 1300 hours on 29 April 2018 at Peattie Farm, Coupar Angus, Perthshire, PH13 9LH.

Section 26(2)(b) - when and where any accident resulting in the death occurred

The accident resulting in the death took place within a barn at Peattie Farm at some point between 1030 and 1230 hours on 29 April 2018.

Section 26(2)(c) - the cause or causes of the death

Following post mortem examination on 2 May 2018 the cause of death was certified by Dr Helen Brownlow as 1a) traumatic asphyxia; 1b) entrapment between barn wall and farm machinery.

Section 26(2)(d) - the cause or causes of any accident resulting in the death

It is submitted that the cause of the accident was that Mr Shaw had climbed out of the telehandler cab having left the engine running and without having applied the parking brake. Whilst exiting the cab it is believed he has accidentally struck the gear lever which has caused the telehandler to begin moving forward. The telehandler has then moved forward and pinned Mr Shaw to the wall of the barn resulting in his death.

Section 26(2)(f) - any defects in any system of working which contributed to the death

It is submitted that there are no apparent system defects which contributed to the death of Mr Shaw.

Section 26(2)(g) - any other facts which are relevant to the circumstances of the death

It is submitted that there are no other facts which are considered to be relevant in this case.

Conclusions

The Crown would like to thank the witnesses for their attendance and assistance in this inquiry and also express gratitude to your Lordship for the pragmatic approach adopted.

Richard Brown
Procurator Fiscal Depute
Health and Safety Investigation Unit
29 July 2019