SHERIFFDOM OF GRAMPIAN, HIGHLAND AND ISLANDS

2022 FAI 20

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DETERMINATION

BY

SHERIFF ROBERT FRAZER

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

into the death of

CAROLINE RENNIE

Banff, 31 May 2022

Determination

The Sheriff, having considered the information and evidence 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 Act") the following:

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

   That Caroline Rennie, born 6 January 2000 died on 3 April 2021 within an agricultural field adjacent to the A947 road near the Hatton Estate, Turriff, Aberdeenshire.

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

That the death of Caroline Rennie resulted from an accident within the field at the locus specified above at approximately 1720 hours on 3 April 2021.

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

That the cause of death was multiple injuries sustained when Caroline Rennie slipped and fell from to a moving tractor and thereafter under a power harrow being pulled by it.

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

That the cause of the accident was that Caroline Rennie attempted to jump on to a moving tractor being driven by GC who had not seen her and had not stopped. As a result, Caroline Rennie lost her footing, fell against the guard of the rear offside tyre and thereafter fell under the power harrow which was being pulled by the tractor whilst in the process of ploughing the field.

5. In terms of section 26(2)(e) of the 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):

That there are no precautions which could reasonably have been taken that might realistically have resulted in the death being avoided.

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

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

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

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

Note

[1] This inquiry was held into the death of Caroline Rennie on 5 May 2022 at Banff Sheriff Court. Mr Sadiq, Procurator Fiscal Depute, represented the Crown and Mr Donaldson, Solicitor Advocate, represented Miss Rennie's immediate family.

[2] At the time of the accident Miss Rennie was an agricultural student in the fourth year of her University degree. She was also employed by John Rennie & Sons (Farmers) Ltd, an agricultural farming business ("the company"), run by her father, AR, who was the main director.

[3] The locus of the accident was an agricultural field close to the A974 road near the Hatton Estate, Turriff, Aberdeenshire. The company was contracted by the land owners, DS Contractors, to plough the field and sow barley seed.

[4] On 3 April 2021 GC, an employee of the company and BE, a self-employed general farm worker contracted to the company, were working together in the field, each driving a tractor. BE had a metal rollers attached to the back of his tractor which allowed the ground to be flattened in front of the tractor being driven by GC, who had a seed hopper attached it. Barley seeds were then passed by way of a hydraulic system to a power harrow attached to the back of GC's tractor. The harrow was 4 metres in width and made up of 17 intertwined rotars. The harrow rotovated the ground which led to

barley seed then being deposited into the rotovated ground the seed hopper. The harrow was attached to the tractor by way of a power take-off shaft (PTO). The harrow and rotor blades were powered by the tractor's engine and would continue to operate until the engine was turned off.

[5] No oral evidence was presented to the inquiry. Parties had entered into a comprehensive joint minute of agreement in advance of the hearing. This contained, *inter alia*, the following agreed facts in relation to the accident:

(i) Around 1530 hours, on 3 April 2021, GC and BE arrived at the locus to carry out their duties in order to rotovate the field and sew barley seed.

(ii) Around 1545 hours AR arrived at the locus with Caroline in order to ensure the job was being carried out satisfactorily. On their arrival GC was at one side of the field in tractor SW19 OJO with BE on the opposite side within tractor SV17 LYJ. Both drove towards the other in order to pass in parallel to each other in the middle of the field. AR positioned himself closer to the roadside whilst Caroline moved further towards a section of field between the two tractors where there was sufficiently safe space and ground on which to stand.

(iii) As GC continued to drive he looked over his right shoulder in order to have sight of AR to ensure he was not too close to the tractor and machinery. At this time witness BE drove towards the centre of the field where he was to pass parallel to GC's tractor. Because GC looking towards where AR was standing he

did not have sight of Caroline who had positioned herself on the opposite side of the tractor.

(iv) BE saw Caroline, suddenly and without warning, run towards the tractor being driven by GC. On reaching the tractor she attempted to jump on to the steps which accessed the driver's cab. However, in doing so, she missed the steps causing her to slip and start to fall.

(v) Caroline attempted to grab a handle attached to the door of the cab but was unable to reach it. She then attempted to catch hold of the plastic mudguard surrounding the rear tyre but also failed to do so.

(vi) Caroline made a further attempt to take hold of the rear tractor tyre but was unable to do so. Her legs then became caught within the machinery of the power harrow attached to the rear of the tractor.

(vii) Due to the rotor blades continuing to rotate as a result of the PTO being attached to the tractor's running engine Caroline was pulled into the blades and so sustained fatal injury.

(viii) GC, who was within the cab, heard the noise of the mudguard being struck which resulted in him bringing the tractor to a stop. As Caroline was in GC's blind spot immediately before she started to run towards the tractor he did not see her and had no knowledge of her attempts to board the moving tractor.

(ix) BE immediately turned his vehicle and stopped beside GC's tractor. AR was still in the same position in the field and was aware of what had occurred.

(x) It was apparent to all witnesses that Caroline had suffered fatal injuries. Police Scotland were immediately contacted by AR.

(xi) As a result, police officers immediately attended the locus where they pronounced life to be extinct at 1720 hours.

(xii) Caroline was thereafter taken by the duty undertaker to Queen Street Public Mortuary, Aberdeen.

[6] A post-mortem examination was carried out on 8 April 2021 by Dr Tamara McNamee and Dr Paul Brown. The injuries were entirely consistent with the accident as detailed above. The cause of death was recorded as "multiple injuries (incident on farm)". The report confirmed that death would have been instantaneous.

[7] The following productions were lodged by the Crown and referred to within the joint minute:

Crown Production 1 – Post-mortem examination report

Crown Production 2 – Toxicology report

Crown Production 3 – Death certificate

Crown Production 4 – Book of photographs of Caroline Rennie

Crown Production 5 – Book of photographs of locus

Crown Production 7 – Profile of employer

Crown Production 8 – Health & Safety policy (for employer)

Crown Production 9 – Employer Risk Assessment (specific to tractors)

Crown Production 10 – Health & Safety Executive report

Crown Production 11 – Training certificates (for AR)

Crown Production 12 – Training certificates (for Caroline Rennie)

Crown Production 13 – Certificate of appointment of NFU Mutual

Crown Production 14 – Witness statement of GC

Crown Production 15 – Witness statement of BE

Crown Productions 16 & 17 – Witness statements of AR

[8] All documentary productions referred to above were agreed by parties to be true and accurate.

[9] In addition, the following witness statements were lodged by the Crown and referred to in the joint minute:

Crown Production 14 – Witness statement of GC

Crown Production 15 – Witness statement of BE

Crown Productions 16 & 17 – Witness statements of AR

[10] Likewise these statements were agreed by parties as evidence to be considered as equivalent to the parole evidence for each witness.

Legal Framework

[11] This inquiry was held in Crown represents the public interest.

[12] The purpose of the inquiry, with reference to section 1(3) of the Act, is to establish the circumstances surrounding Caroline's death and to consider what steps, if any, might be taken to prevent other deaths in similar circumstances. It is not the purpose of the inquiry to establish either civil or criminal liability. The manner in which evidence and other information is presented to the inquiry is unrestricted and it is for

the inquiry to find its conclusions based on such evidence and other information (Rule 4.1).

[13] Section 26 (1) and (2) of the Act sets out the requirements for the Sheriff's written determination following the inquiry:

> "(1) As soon as possible after the conclusion of the evidence and submissions in an inquiry, the sheriff must make a determination setting out —
>
> (a) in relation to the death to which the inquiry relates, the sheriff's findings as to the circumstances mentioned in subsection (2), and
>
> (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."

[14] Accordingly, I will set out the facts I have found to be admitted and proved and then explain why I consider it appropriate to make formal findings in terms of section 26(2)(a), (b), (c) and (d) of the Act (*supra*).

Summary

[15] I found the following facts to be admitted/proved:

1. That Caroline Rennie was employed by the company as part of the family's farming business.

2. That on 3 April 2021 Caroline Rennie was assisting her father together with witnesses GC and BE within the field at the locus for the purpose of sewing barley seeds.

3. That witness GC was driving a tractor, registration SW19 OJO, to which was attached a power harrow, 4 metres in breadth, with 17 rotor blades attached to its underside.

4. That, in turn, the power harrow was attached to the tractor by way of a PTO (power take-off shaft) which was powered through the tractor's engine. Accordingly, the machinery would run until the tractor's engine was switched off.

5. That at 1545 hours Caroline Rennie and her father, AR, entered the field at the locus to check the progress of GC and BE who were each operating their respective tractors. AR remained closer to the roadside whilst Caroline moved to a part of the field where she positioned herself at a safe distance between the two moving tractors.

6. That suddenly and without warning, Caroline ran towards the tractor being driven by GC. She attempted to jump onto the steps which accessed the driver's cab whilst it continued to move.

7. That witness GC was unaware of Caroline's movements as she had run from his blind spot towards the tractor. Accordingly he had not seen her.

8. That Caroline misjudged her jump whereby she was unable to place her foot on the steps so causing her to slip and start to fall. Caroline attempted to grab hold of the handle attached to the driver's door but was unable to do so. She then attempted to grab hold of the plastic mudguard surrounding the tractor's rear tyre but was, again, unable to do so.

9. That, as a result, Caroline became caught in the machinery of the power harrow and rotor blades which continued to operate as the tractor was still moving with its engine running.

10. That on hearing a noise on the mudguard GC stopped the tractor. BE turned and stopped his tractor next to that of GC.

11. That on becoming aware of what had happened AR immediately contacted emergency services.

12. That police officers thereafter attended at the locus and pronounced Caroline's life as extinct at 17.20 hours.

13. That a post mortem examination was carried out on 8 April 2021 and concluded that Caroline had died of multiple injuries, entirely consistent with the accident on 3 April 2021.

14. That Crown Production 10 (Health & Safety Report) concluded that, (i) there were no defects to the relevant machinery; (ii) that the tractor and machinery were appropriately guarded; (iii) that Caroline had received

appropriate training in operating agricultural machinery and was aware of the risks involved in jumping/climbing onto a moving tractor and; (iv) there was no breach or contravention of Health & Safety Law.

15. That Crown Production 12 (Caroline's training and degree qualification certificates) confirmed that Caroline was highly experienced in agricultural farming techniques, including the use of large items of agricultural machinery. She had passed her driving test at 17 years of age and had operated tractors with appropriate supervision since she was 15 years old. Caroline was described in the report as an "extremely competent and careful equipment operator".

Submissions

[16] Parties accepted that Caroline died of her injuries at the locus in the circumstances described and, therefore simply sought formal findings in respect of section 26(2)(a), (b), (c) and (d) of the Act. They did not seek any findings in respect of the remaining parts of the sub-section.

Discussion

[17] From the agreed evidence it was clear that Caroline died from her injuries at the locus as a direct result of attempting to jump on to a moving tractor driven by GC.

[18] GC was unable to see Caroline from his position within the tractor cab as she was, at that point in time, in his blind spot. He was therefore completely unaware of her actions for which he was not to blame.

[19] Caroline was a highly experienced agricultural worker as evidenced by her training certificates and studies for her agricultural degree. She had worked on the family farm for a number of years and had learned to drive tractors at the age of 15. She was a valued member of the business who was implicitly trusted by her father, AR, the main director.

[20] In addition, it is quite clear that all machinery was working satisfactorily and that all appropriate steps had been taken by the company to comply with Health & Safety legislation. Accordingly, there are no recommendations to make in terms of section 26(2)(e), (f) and (g) of the Act (supra).

[21] I am therefore satisfied that the cause of Caroline's tragic death was as a direct result of her unilateral decision to attempt to jump on to a moving tractor whilst the field was being ploughed and sewn for barley seed. She did not give any indication or warning to any of the witnesses for her actions which took AR, GC and BE completely by surprise. There is no rational explanation which can be given for her actions which were clearly out of character for a woman who, despite her relatively young age, was highly experienced, reliable and very well regarded by all concerned.

[22] I am also satisfied that, based on all of the above, Caroline's death was due solely to the circumstances, as described above and as recorded in the death certificate.

[23] In all these circumstances I consider that the appropriate findings are formal ones in terms of section 26(2)(a), (b), (c) and (d) of the Act. This is as reflected in the findings-in fact at the start of this determination (*supra*) which, hopefully, are self-explanatory.

[24] Finally, I must finish by joining with the Crown and Mr Donaldson in expressing my sincere condolences to Caroline's family, friends and colleagues for their very sad loss in these most tragic of circumstances. In particular I would like to record my thanks and admiration to Caroline's parents and sister for their attendance at this inquiry and the dignified manner in which they conducted themselves throughout. It is testament to them that they sought to thank the police, emergency services and the Crown for their work and involvement in the matter. I hope, in some small way, this process has helped in assisting them in coming to terms with their undoubted grief and loss of a beloved daughter and sibling.

Sheriff RW Frazer

Banff Sheriff Court
May 2022