SHERIFFDOM OF GRAMPIAN, HIGHLAND AND ISLANDS AT LOCHMADDY

[2019] FAI 48

Case ref: LMD-B16-19

DETERMINATION

BY

SHERIFF CHRISTOPHER DICKSON

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

into the death of

HECTOR MACKINNON MACLEOD

Lochmaddy, 6 November 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 Hector Mackinnon Macleod, born 24 December 1959, died at about 12.48 hours on 24 April 2018 within a cattle shed located at the apportionment of the common grazing ground pertaining to a croft at Berneray, North Uist, near to Borve Cemetery, Berneray, North Uist.

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 07.45 and 12.00 hours on 24 April 2018 within a cattle shed located at the apportionment of the common grazing ground pertaining to a croft at Berneray, North Uist, near to Borve Cemetery, Berneray, North Uist.

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

That the cause of death was:

I (a) Multiple injuries

due to (or as a consequence of):

(b) Crushed by cattle.

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

That the cause of the accident resulting in death was as follows:

(i) The single bull of the herd escaping from the bull pen within the cattle shed;

(ii) Mr Macleod entering the cattle shed to return the bull to its pen and being crushed by cattle when in the process of doing so.

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 or the accident resulting in 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):**

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

Recommendations

1. **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 Hector Mackinnon Macleod. Mr Macleod lived with his partner, Jayne Jackson, at their croft at Berneray, North Uist. About two and a half miles away from this croft was an area of common grazing land (known as the Machair) where Mr Macleod had successfully applied for an area of that common grazing land to be apportioned to his croft. This apportioned land was located near to Borve Cemetery, Berneray, North Uist and Mr Macleod had built a cattle shed and cattle pens upon it. Mr Macleod died on 24 April 2018 in the cattle shed on the apportioned land as a result of being crushed by cattle.

[2] The death of Mr Macleod was reported to the Procurator Fiscal (hereinafter referred to as "PF") on 25 April 2018. A preliminary hearing was not necessary and the inquiry took place over a single day on 9 October 2019. Mr Main, PF Depute, represented the Crown. Mr Seaton, Solicitor, represented Mr Macleod's partner, Ms Jackson.

[3] The Crown presented two affidavits and two witness statements. The first affidavit was from Dr Natasha Inglis, FRCPath, Consultant Pathologist, Raigmore Hospital, Inverness. The second affidavit was from Jennie Stafford, HM Inspector of Health and Safety, 3rd Floor Cornerstone, 107 West Regent Street, Glasgow. Dr Inglis had conducted the post mortem examination of Mr Macleod and Ms Stafford had considered whether there had been any defects in the system of working on the apportioned land. The witness statements were from Richard Frost, who was the first person at the scene of the accident, and Ms Jackson. I heard oral evidence from the following person:

1. PC Michelle Nelson, Police Service of Scotland, based at Lochboisdale; and
2. Ms Jackson.

PC Nelson was one of the first police officers to attend the apportioned land after the accident occurred and took various photographs of it. Ms Jackson was able to explain the layout of the apportioned land and what she found at the apportioned land when she attended with police after the accident occurred.

[4] Findings in fact 1 to 5, 7 to 8 and 14 are based on the evidence of Ms Jackson. Finding in fact 6 is based on a combination of the evidence of Ms Jackson taken with

the evidence in the affidavit of Ms Stafford, HM Inspector of Health and Safety. Finding in fact 17 is based on the evidence in the affidavit of Ms Stafford. Finding in fact 12 is based on the statement of Richard Frost. Finding in fact 13 is based on the evidence of PC Nelson. Findings in fact 15 and 16 are based on the evidence in the affidavit of Dr Inglis. Findings in fact 9 to 11 and 18 are based on the combination of the evidence of Ms Jackson, Mr Frost and Pc Nelson and the reasonable inferences that I took from that evidence.

The Legal Framework

[5] This inquiry was held in terms of section 1 of the 2016 Act. Mr Macleod 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 Crown represented the public interest.

[6] 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 Macleod 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).

[7] 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**

(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.

(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."

[8] In this Note I will, first, set out the summary of the facts that I have found proved. I will then set out a brief summary of the submissions made by the PF and the solicitor for Ms Jackson. Finally, I will consider the circumstances identified in section 26(2)(a) to (f) of the 2016 Act and explain, with reference to the evidence before the inquiry, the conclusions I have reached.

Summary

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

1. That Hector Mackinnon Macleod was born on 24 December 1959 and resided with his partner, Jayne Jackson, at their croft at Berneray, North Uist.
2. That Mr Macleod had, since moving back to Berneray in 2005, worked on and ran his croft and a number of other crofts on a self-employed basis.
   Ms Jackson assisted Mr Macleod in the running of his crofts.
3. That about two and half miles away from Mr Macleod's croft is an area of common grazing land (known as the Machair). Mr Macleod had successfully applied for an area of that common grazing land to be apportioned to his croft (hereinafter referred to as the "apportioned land"). This apportioned land was located near to Borve Cemetery, Berneray, North Uist.
4. That in 2017 Mr Macleod built a purpose built facility to handle a small herd of cattle upon the apportioned land. The facility included a cattle shed, cattle pens, a cattle race, a cattle crush and a fenced off area which the cattle were not permitted to enter. The facility was specifically designed to enable

Mr Macleod and his partner to safely look after and handle a small herd of cattle.

5. That the cattle shed was approximately 70 feet (21.3 metres) in length and 30 feet (9.1 metres) in width. The cattle shed was accessed by the cattle at an opening at one end of the cattle shed. At the other end of the cattle shed was a rectangular bull pen. A feeding fence ran along the length of the front of the cattle shed. The feeding fence had diagonal bars for the cows to feed through. The feeding fence of the bull pen had horizontal bars for the bull to feed through. The bull pen ran the width of the cattle shed with a metal fence running perpendicular from the feeding fence (and parallel to the side of the cattle shed) to the rear of the cattle shed. This metal fence separated the bull pen from the main part of the cattle shed (this metal fence is hereinafter referred to as "the separating fence") and contained a gate (which was within the cattle shed), which allowed access to the bull pen from the main part of the cattle shed. At the front of the feeding fence was a fenced field (hereinafter referred as "the front fenced field"). The front fenced field was used by Mr Macleod to safely lay out feed in front of the feeding fence. The cattle did not enter the front fenced field but could reach the feed through the feeding fence. At the rear of the cattle shed was a number of pens which were used for a variety of purposes when one or more of the cattle required to be isolated from the rest of the herd.

6. At the time of accident Mr Macleod had 19 cows and 1 bull. The bull was a Charolais and was about 8 years old. Mr Macleod had bred the bull and

looked after it since it was born. At the time of the accident seven cows were pregnant and six cows had calved. Mr Macleod had not previously experienced any signs of aggression from either the cows or the bull.

7. Mr Macleod tended to the cows and the bull every day. His usual routine was to: (i) leave his house between about 07.45 hours and 08.15 hours; (ii) check on his mother who lived next door; (iii) drive his tractor to collect a bale of hay; and (iv) then make his way to the cattle shed to feed the bale of hay to the cattle. When Mr Macleod arrived at the cattle shed he would then decide on the method he was going to use to feed the cattle. The first method was to drive the tractor within the front fenced field along the length of the feeding fence and use machinery on the back of the tractor to unroll the bale of hay so that it was distributed along the length of the feeding fence. The second method was to use the same method to unroll the bale of hay but to do that in the common grazing lands, near to the cattle shed, and allow the cows to feed on it in the open common grazing lands.

8. On 23 April 2018 the separating fence was intact and the bull was safely housed in the bull pen.

9. At some point either later on 23 April 2018 or during the morning of 24 April 2018 the bull crushed and flattened a part of the separating fence near to the rear of the cattle shed and escaped from the bull pen.

10. On 24 April 2018 Mr Macleod left his house at approximately 07.45 hours. At some point later he drove his tractor to collect a bale of hay and then drove to the cattle shed. Mr Macleod, at some point, drove his tractor into the front

fenced field and then drove the tractor along the length of the feeding fence whilst unrolling about half of the bale of hay along the entire length of the feeding fence (hay was laid in front of both the cow feeding fence and the bull feeding fence). At some point Mr Macleod noticed that a part of the separating fence had been crushed and flattened by the bull. Mr Macleod then effected a temporary repair to the damaged part of the separating fence. He did so by lashing a metal farm gate to the separating fence in the area where it had been crushed and flattened.

11. After the temporary repair had been effected to the separating fence Mr Macleod required to either to remain within the cattle shed or re-enter the cattle shed in order to return the bull to the bull pen via the gate in the separating fence. Whilst Mr Macleod was within the main part of the cattle shed and in the process of attempting to return the bull to the bull pen an accident occurred which resulted in Mr Macleod being crushed by cattle. At the time of the accident the gate to the bull pen was open.

12. About 12.00 hours on 24 April 2018 Mr Richard Frost attended at the apportioned land in order to see his friend, Mr Macleod. At that time: (i) Mr Macleod's tractor was within the front fenced field with the engine running; (ii) the cows were located within the cattle shed and were feeding through the feeding fence; and (iii) the bull was mixed with cows and had what appeared to be blood on its face, but was uninjured. Mr Frost found Mr Macleod lying in the main part of the cattle shed face down. He was not

moving and did not appear to be breathing. Mr Frost phoned for an ambulance and waited for the emergency services to arrive.

13. The emergency services subsequently arrived but attempts to revive Mr Macleod were unsuccessful. At 12.48 hours on 24 April 2018, at the apportioned land, Mr Macleod was pronounced deceased.

14. Later on 24 April 2018 Ms Jackson attended the apportioned land. At that time the cows and the bull were in the common grazing lands. Ms Jackson called the cows and they returned to the cattle shed. The bull came with the cows and neighbours returned the bull to bull pen without incident. The bull was subsequently euthanised.

15. That on 26 April 2018, Dr Natasha Inglis FRCPath, Consultant Pathologist, undertook a post mortem examination of Mr Macleod at Raigmore Hospital, Inverness and prepared a post mortem report. Dr Inglis' conclusion of said examination was that:

> "This man was found dead in a cattle pen which contained a bull. Post-mortem examination has revealed multiple injuries most notably to the head, chest and spine consistent with the deceased having been attacked by the bull. There was also evidence of severe single vessel coronary artery atheroma so there is the possibility that a cardiac event may have contributed to his death for example by causing him to collapse within the pen."

16. The medical certificate of cause of death was completed as follows:

> "I (a) Multiple injuries
> due to (or as a consequence of)
> (b) Crushed by cattle."

17. That the Health and Safety Executive have produced an Information Sheet entitled "Handling and housing cattle". That Information Sheet includes

guidance that every farm that handles cattle should have proper handling facilities which are well maintained and in good working order. The handling facilities on the apportioned land complied with that guidance.

18. That the cause of the accident resulting in death was: (i) the bull escaping from the bull ben within the cattle shed; and (ii) Mr Macleod entering the cattle shed to return the bull to its pen and being crushed by cattle when in the process of doing so.

Submissions

Submission for the Crown

[10] The Crown sought formal findings in respect of section 26(2)(a) to (c) of the 2016 Act. The findings sought were based on the uncontroversial evidence before the inquiry and my findings mirror those sought by the Crown.

[11] As regards section 26(2)(d) of the 2016 Act the Crown submitted that the cause of the accident was Mr Macleod coming into contact with, and being crushed by, cattle, most likely the bull, within the cattle shed. The Crown submitted that as a result of an absence of eye witness evidence, it was not possible to make more detailed findings about the circumstances of the accident. The Crown also contended that the significance of the pathologist finding evidence of severe single vessel coronary artery atheroma could not be established from the evidence before the inquiry.

[12] The Crown 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.

Submissions for Ms Jackson

[13] The solicitor for Ms Jackson explained the following. Mr Macleod was a native of Berneray. After completing his education he had served time in the merchant navy and had then joined the Royal Air Force (hereinafter referred to as "RAF"). Mr Macleod had served in the RAF with distinction and was part of the crew for the Nimrod aircraft during one of the gulf wars. During the course of his service with the RAF he had received medals for bravery. In 2005 Mr Macleod was given the opportunity to return to Berneray to take over the family croft.
Mr Macleod took up that challenge and had, since 2005, successfully run the family croft, acquired other crofts and built up a herd of cattle. Mr Macleod was a skilled crofter and his death had come as a huge shook to his mother, Ms Jackson and the rest of the local community.

[14] The solicitor for Ms Jackson agreed with formal findings sought by the Crown in respect of section 26(2)(a) to (c) of the 2016 Act. As regards section 26(2)(d) of the 2016 Act, it was submitted that a formal finding could made that Mr Macleod had been attacked by the bull. The bull had been found with blood on its face. In addition, Ms Jackson had explained that a calf had been born approximately 9 months after the accident, which suggested that the mother of the calf had been on heat and impregnated on or around the date of the accident. In the circumstances the bull had clearly flattened the separating fence to get to that cow and it could be inferred that when Mr Macleod tried to return the bull to the bull pen the bull's instinct had again been to get to that cow and had resulted in the bull attacking

Mr Macleod. The solicitor for Ms Jackson also submitted that Mr Macleod's heart condition may have caused him to have heart failure during the attack.

[15] The solicitor for Ms Jackson 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.

Discussion and Conclusions

Section 26(2)(a) of the 2016 Act (when and where the death occurred)

[16] In this inquiry there was no dispute as regards when and where the death occurred. PC Nelson confirmed that attempts by the emergency services at the cattle shed to revive Mr Macleod were, unfortunately, unsuccessful and that he was pronounced deceased at 12.48 hours on 24 April 2018.

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

[17] There was no dispute as regards where the accident resulting in death occurred. The only evidence as regards the time of the accident came from Ms Jackson and from the statement of Mr Frost. Ms Jackson explained that Mr Macleod had left home at 07.45 hours on the day of the accident and Mr Frost explained that he had found Mr Macleod within the cattle shed on the apportioned land at about 12.00 hours later that day. It was not clear from the evidence whether Mr Macleod went directly to the apportioned land or visited his mother first. In the circumstances I determined that the accident resulting in death took place between

07.45 and 12.00 hours on 24 April 2018 within a cattle shed located on the apportioned land.

Section 26(2)(c) of the 2016 Act (the cause or causes of death)

[18] There was no dispute as regards the cause or causes of death. The conclusion of Dr Natasha Inglis, Consultant Pathologist has been set out at finding in fact 15. That conclusion makes clear that Mr Macleod had multiple injuries which were consistent with being crushed by cattle. The medical certificate of the cause of death stated the cause to be multiple injuries due to, or as consequence of, being crushed by cattle. Dr Inglis also found evidence of severe single vessel coronary artery atheroma and highlighted the possibility that a cardiac event may have contributed to Mr Macleod's death. Whether or not Mr Macleod did suffer a cardiac event was unclear from the evidence and I did not consider that I could determine, on the evidence before the inquiry, that a cardiac event contributed to death, but it, of course, remained a possibility. In the circumstances I determined that the cause of death was as recorded in the medical certificate.

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

[19] The precise cause of the accident was difficult to determine due to the absence of any eye witnesses. Ms Jackson, who gave her evidence with great dignity, very helpfully explained the lay out on the apportioned land (see finding in fact 5) and the usual feeding methods followed by Mr Macleod (see finding in fact 7).

Ms Jackson then went on to explain her theory of how the accident had occurred. Ms Jackson explained that the gestation period for cows was nine months and that one of the cows in the herd had given birth to a calf almost nine months to the day after the accident. Ms Jackson explained her theory was as follows: (i) that the cow, who had given birth 9 months after the accident, was on heat on the day of the accident; (ii) that the bull had sensed this and had burst out of the bull pen, through the separating fence, to get to that cow; (iii) that Mr Macleod had then arrived in the morning and found the separating fence flattened and the bull out of the bull pen, mixed with cows on the common grazing land; (iv) that Mr Macleod had then fixed the separating fence by lashing a farm gate to it; (v) that Mr Macleod had then tried to lure the cows and the bull back to the cow shed by laying out half of the bale of hay in front of the feeding fence; (vi) that after luring the cows and the bull back to the cattle shed, Mr Macleod had attempted to put the bull in the bull pen; and (vii) that as Mr Macleod was attempting to put the bull back into the bull pen, the bull had wanted to get the cow on heat and had attacked Mr Macleod in order to so. Ms Jackson explained that it was her clear belief that the bull attacked Mr Macleod.

[20] I carefully considered Ms Jackson's theory and considered it to be a plausible theory. However, I did not consider that there was sufficient evidence to prove that the accident had occurred in the manner described by Ms Jackson. Ms Jackson explained that the separating fence had been intact on the day before the accident. Pc Nelson arrived at the apportioned land shortly after 12.40 hours on the day of the accident and noticed that there was damage to the separating fence. When Ms Jackson attended the apportioned land later that day she saw that part of

separating fence had been crushed and flattened and that a temporary repair had been effected to the damaged part of the separating fence by lashing a metal farm gate to it. I considered that the only inference that could be drawn from that evidence was that: (i) at some point between the separating fence last being seen to be intact on 23 April 2018 (the day before the accident) and the morning of 24 April 2018 (the day of the accident), the bull had crashed through and flattened part of the separating fence near to the rear of the cattle shed, enabling it to escape from the bull pen; and (ii) at some point after Mr Macleod attended the apportioned land on 24 April 2018 he discovered the damage to the separating fence and had effected a temporary repair to it by lashing a farm gate to it (the repair to the separating fence can be seen in the photographs taken by PC Nelson on the day of the accident).

[21] The reason why the bull crashed through and flattened a part of separating fence was not known but it could possibly have been to get to a cow on heat. Mr Macleod was found in the main part of the cattle shed by Mr Frost at about 12.00 hours. Mr Frost saw that the bull had what appeared to be blood on its face, but was uninjured. Ms Jackson confirmed that the gate to the bull pen was open when she attended later in the day and the police photographs also show the gate open. In the circumstances I considered that a reasonable inference from the evidence before the inquiry was that Mr Macleod had, after effecting the temporary repair to the separating fence, either remained within the cattle shed or later re-entered the cattle shed, in order to return the bull to the bull pen (Mr Macleod required to enter the cattle shed to open and close the gate to the bull pen). What then occurred in the cattle shed is unknown. Mr Macleod's injuries are entirely consistent with being

crushed by cattle but it is not known how these injuries were sustained. Mr Macleod may have been attacked by the bull and the blood on the bull's face may provide some support for that assertion. However, it is not clear what caused the blood to be deposited on the bull's face. It may have resulted from the bull attacking Mr Macleod but there could have been another reason why the blood came to be on the bull's face (such as Mr Macleod being accidently crushed by the bull or another cow in close proximity to the bull or the bull coming into contact with Mr Macleod after he sustained his injuries). In the circumstances, and given the lack of any eye witness to the accident, I considered that I could only determine that whilst Mr Macleod was within the main part of the cattle shed and in the process of attempting to return to the bull to the bull pen an accident had occurred which resulted in Mr Macleod being crushed by cattle.

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)

[22] The inquiry did not hear any evidence which suggested that a precaution could have reasonably been taken which might have realistically resulted in the death or accident resulting in death being avoided.

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)

[23] The affidavit of Ms Stafford, HM Inspector of Health and Safety identified that the Health and Safety Executive had produced an Information Sheet entitled "Handling and housing cattle". That Information Sheet included guidance that every farm that handles cattle should have proper handling facilities which are well maintained and in good working order. Ms Stafford confirmed that the purpose built handling facilities on the apportioned land complied with the guidance set out in the Information Sheet. Ms Jackson explained that Mr Macleod was safety conscious and the facility on the apportioned land had been purpose built to safely handle cattle. There was no information before the inquiry to suggest that Mr Macleod operated anything other than a safe system for handling the cattle. There was no information before the inquiry to suggest that the separating fence, prior to being crushed and flattened, was defective in any way.

[24] In the circumstances there was nothing to suggest that there were any defects in any system of working which contributed to the death or the accident resulting in death.

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

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

Recommendations

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)

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

Postscript

[27] At the outset of the inquiry I extended my condolences to Mr Macleod's family and to his partner, Ms Jackson. I was joined in those condolences by the other parties. I wish to formally repeat my condolences to Mr Macleod's family and Ms Jackson in this determination.