INQUIRY UNDER THE FATAL ACCIDENTS AND INQUIRY (SCOTLAND) ACT INTO THE SUDDEN DEATH OF KENNETH JOHN BISSET

SHERIFFDOM OF GRAMPIAN, HIGHLAND AND ISLANDS AT INVERNESS

Fatal Accidents and Sudden Deaths Inquiry (Scotland) Act 1976

Inquiry into the circumstances of the death of Kenneth John Bisset

Determination

by

Sheriff Principal Sir Stephen S T Young Bt QC

Inverness, July 2007

The sheriff principal, having resumed consideration of the evidence and submissions thereon, determines as follows:-

1. The late Kenneth John Bisset, aged 56 years, 8 Waterfurrows, Fortrose died in an accident in the course of his employment at Harbro Feed Mill, Harbour Road, Inverness at about 8.48 am on 24th November 2006.

2. The cause of Mr Bisset's death was traumatic asphyxia.

3. At the material time Mr Bisset had been discharging a load of grain pellets from a lorry into an intake at the mill. He had raised the tipper on the lorry to an angle of about 30° from the horizontal and the grain pellets were being discharged from the tipper through a grain sock which had been affixed to the grain hatch in the tailgate of the vehicle. Suddenly the tailgate itself burst open discharging a large quantity of pellets on top of Mr Bisset who at the time was standing within the intake in the vicinity of the tailgate.

4. In ordinary circumstances the tailgate ought to have been held securely closed by a turnbuckle on either side of it and a locking bar along its foot. At each end of the locking bar there was a vertical arm which was normally held in position by a slip ring.

5. On this particular vehicle there were also two further turnbuckles which had been fitted at the foot of the tailgate at some stage after the manufacture of the vehicle. The purpose of these was to keep the tailgate especially tightly secured when finer loads such as rapeseed were being carried. But so long as the turnbuckles at each side and the locking bar along the foot were fastened it was not necessary to secure

the two turnbuckles along the foot as well in order to keep the tailgate securely closed.

6. At the time of the accident the two side turnbuckles, and also the two along the foot, had been undone and the slip ring on the vertical arm of the locking bar on the offside of the vehicle had been released. In these circumstances the downward pressure of the load of pellets within the tipper overcame the restraining effect of the locking bar so that the tailgate burst open.

7. There were two reasonable precautions whereby the accident and Mr Bisset's resulting death might have been avoided, namely

(a) while the tipper of the vehicle was raised the tailgate could have been kept securely closed by fastening the turnbuckles at either side of it and also the slip rings on the vertical arms at either end of the locking bar; and

(b) Mr Bisset could have refrained from standing within the intake, or indeed anywhere else, behind or in the immediate vicinity of the tailgate of the vehicle while the tipper was raised.

Note

[1] At the outset of this note it may be of assistance to set out the terms of sub-section 6(1) of the Fatal Accidents and Sudden Deaths Inquiry (Scotland) Act 1976 which prescribes the matters which should be the subject of the sheriff's determination following an inquiry such as this. The sub-section reads:

6(1) At the conclusion of the evidence and any submissions thereon, or as soon as possible thereafter, the sheriff shall make a determination setting out the following circumstances of the death so far as they have been established to his satisfaction -

(a) where and when the death and any accident resulting in the death took place;

(b) the cause or causes of such death and any accident resulting in the death;

(c) the reasonable precautions, if any, whereby the death and any accident resulting in the death might have been avoided;

(d) the defects, if any, in any system of working which contributed to the death or any accident resulting in the death; and

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

It will be seen that in this case I have confined my determination to the matters referred to in paragraphs (a), (b) and (c) of the sub-section.

[2] I have not thought it necessary or appropriate to make detailed findings in fact about the circumstances which led up to Mr Bisset's death. The evidence has all been recorded and this and the documents which were referred to by the witnesses during the inquiry all speak for themselves. I would refer here in particular to Crown

production 4, namely the report by Dr Stewart Arnold, which has a full account of the results of his investigation into the accident and of which I understand Mr Bisset's family have a copy. I am happy to record that, judging by their respective demeanours, I saw no reason to doubt the credibility or the reliability of any of the witnesses at the inquiry.

[3] It is impossible to say from the evidence precisely how or when the turnbuckles at either side of the tailgate and the slip ring on the vertical arm at the offside end of the locking bar came to be released. Plainly they ought not to have been while the tipper was raised. Indeed it is one of the unhappy features of this case that there ought to have been no need at any stage of the unloading process to open the tailgate since the vehicle was equipped with both an auger and a blower to remove the quantity of grain pellets that remained in the tipper once the simple force of gravity had removed the bulk of the load through the open grain hatch in the tailgate.

[4] Again, it is not clear on the evidence why Mr Bisset should have been standing at the material time within the intake in the immediate vicinity of the tailgate of the vehicle. It is not uncommon in my experience of fatal accident inquiries to find that vital questions remain unanswered, and this was one such inquiry. The sad truth is that no one will ever know exactly what happened in this case, and there is nothing to be gained by my speculating on these unanswered questions.