

SHERIFFDOM OF LoTHIAN AND BORDERS AT Livingston

DETERMINATION

By

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Inquiry into the circumstances of the death of

WILLIAM WATT

In terms of section 6 of the Fatal Accidents and
Sudden Deaths Inquiry (Scotland) Act 1976

PART I: INTRODUCTION AND LEGAL FRAMEWORK

[1] This is an Inquiry under the Fatal Accidents and Sudden Deaths Inquiry (Scotland) Act 1976 (the “Act”) into the circumstances of the death of William Watt who died at Lincroft Farm, Avonbridge, West Lothian, on 20 October 2011.

[2] Mr Robertson, Procurator Fiscal Depute, appeared in the public interest. Mr Watt's employer, Landtrac Agricultural Engineers Ltd, was represented by James Varney, Solicitor.

There was no representation on behalf of Mr Watt's family although members of his family were in attendance throughout the Inquiry and his son and daughter gave evidence.

[3] The Inquiry heard evidence and submissions over the course of 27, 28 and 29 November and 19 December 2013. The Crown led ten witnesses. The parties entered into a joint minute of agreement which covered much of the more formal evidence.

Legal Framework

[4] Section 1(1) (a) (i) of the Act provides that a Public Inquiry should be held into the death of a person if -

“... it appears that the death has resulted from an accident occurring in Scotland while the person who has died, being an employee, was in the course of his employment or, being an employer or self-employed person, was engaged in his occupation as such;”

[5] The purpose of the Inquiry is for the Sheriff to make a determination setting out the following circumstances of the death so far as they have been established to the Sheriff's 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 may have been avoided;
- (d) the defect, if any, in the system of working which contributed to the death or any accident resulting in the death;
- (e) any other facts which are relevant to the circumstances of the death.

[6] The court proceeds on the basis of the evidence placed before it. Although described as an inquiry the sheriff's powers do not go beyond making a determination in relation to the circumstances established to his or her satisfaction by such evidence led following investigation by the procurator fiscal and any other party, if so advised.

PART II: DETERMINATION AS TO THE CIRCUMSTANCES OF THE DEATH

[7] The Sheriff having considered all the evidence adduced FINDS AND DETERMINES in terms of Section 6(1) of the Act:

(1) In terms of section 6 (1) (a) that William Watt, who was born on 31 October 1949 and late of 31 Glenburn Gardens, Whitburn, EH47 3NL, was pronounced dead at 1233 hours on 20 October 2011 within the garage at Lincroft Farm, Avonbridge, West Lothian.

(2) In terms of section 6 (1) (b) the cause of death was (a) compression of the chest and (b) crush injury due to the weight of a vehicle.

(3) In terms of section 6 (1) (c) there was a reasonable precaution whereby the death might have been avoided, specifically the precaution of not entering under the vehicle when it was supported only by individual blocks of wood which had been placed in a haphazard fashion.

(4) In terms of section 6 (1) (d) working under an inadequately secured vehicle was a system of working that was defective and that defect contributed to Mr Watt's death or the accident resulting in his death.

(5) In terms of section 6 (1) (e) the employer's director's failure to have regard to Mr Watt's health and safety, arising out of her failure to recognise her responsibilities as employer, was a fact relevant to the circumstances of the death.

PART III: FINDINGS IN FACT

[8] As at 20 October 2011 William Watt was 61 years of age. He was an agricultural engineer and was employed by Landtrac Agricultural Engineers Ltd ("Landtrac").

[9] Mr Watt was an experienced agricultural engineer. He was highly regarded by his colleagues and commanded respect within the industry.

[10] Mr Watt had a close and supportive family with whom he would discuss, inter alia, issues or concerns arising from or connected with his employment.

[11] Landtrac was incorporated on 6 January 2009 and dissolved on 29 March 2013. It had one director, Alison Young, and, as at 20 October 2011, only one employee, Mr Watt.

[12] Mr Watt had previously been employed by R H Young Engineering Ltd ("RHY"). It had been incorporated on 20 October 2003 and was dissolved on 17 October 2008.

[13] One of the directors of RHY, Robert Young, is the husband of Alison Young. Mrs Young had been an employee of RHY throughout its existence.

[14] Prior to its incorporation RHY had traded as a partnership between Alison Young and Robert Young albeit that Mrs Young's role was principally that of carrying out administrative duties for the partnership.

[15] Prior to its dissolution part of the undertaking of RHY comprised the provision of agricultural engineering work. Landtrac was established with the specific purpose of continuing to carry on providing the agricultural engineering works that had been provided by RHY.

[16] Landtrac did not issue Mr Watt a contract of employment.

[17] Landtrac carried on its business from premises at Lincroft Farm, Avonbridge, West Lothian, the home of Alison and Robert Young.

[18] In addition to the house where Mr and Mrs Young lived, there are a number of agricultural buildings within Lincroft Farm. While Mr Watt had access to, and use of, all the buildings other than the house, he principally carried out his duties from one of the sheds, referred to by Mrs Young and Mr Young as "Willie's shed" or "Willie's workshop".

[19] There were a variety of tools and equipment in the various buildings including vehicle jacks and a vehicle stand.

[20] There was a close working relationship between Mr Watt and Mrs Young. Mrs Young would issue Mr Watt with instructions about which customer he was to visit but otherwise leave it entirely to Mr Watt to determine what work was required and how it should be carried out. Mr Watt would report to her with details of the work carried out and she would arrange to issue invoices to customers.

[21] Given their prior association there was also a close relationship between Mr Watt and Mr Young. There was little attempt to provide Mr Watt with a clear demarcation between instructions issued to him by Mrs Young in her capacity as director of Landtrac and his employer and any instructions given to Mr Watt by Mr Young.

[22] Mr Watt's duties included the maintenance and repair of vehicles owned by Landtrac. He was sufficiently skilled as an engineer to be able to fix most defects in those vehicles.

[23] At around 8 am on 20 October 2011 Mr Watt arrived at work at Lincroft Farm. At around 8.10 am Mr Young spoke to Mr Watt and told him that there appeared to be a fault in one of the vehicles belonging to Landtrac, a Corsa van registration number SO02 FFU.

[24] Mr Young told Mr Watt that the van was not starting. Mr Young understood and appreciated that Mr Watt would treat that as an instruction that, as part of his employment

duties with Landtrac, he was to inspect the vehicle to try to identify the defect and, if possible, fix it.

[25] Mr Watt set about inspecting the vehicle. At some point between 8.10 am and around 12.15 pm, in keeping with a practice sometimes used in agricultural engineering, Mr Watt placed a number of wooden blocks of varying sizes under the vehicle. Initially at least these lifted the front wheels of the vehicle off the ground sufficiently to enable Mr Watt to go underneath. He went underneath to carry out work.

[26] At some point after lifting the vehicle up sufficiently for him to go underneath but prior to Mr Watt's death Mr Young had been in the yard again and had seen Mr Watt underneath the vehicle.

[27] No other equipment was used to support the vehicle. The rear wheels were not chocked.

[28] The system of wooden blocks laid on top of one another to form a tower was inherently unstable and ought not to have been used as the only support for the vehicle while Mr Watt was working underneath it. Should the blocks move there was nothing to prevent the vehicle coming to rest on the ground. There was not sufficient clearance between the ground and the underside of the vehicle to accommodate Mr Watt should the vehicle come down.

[29] While he was under the vehicle it moved off the blocks and came to rest on top of Mr Watt's chest. He died as a result of the compression of his chest and the crush injury caused by the weight of the vehicle.

[30] At around 12.15 pm Mrs Young came out in to the yard. She saw Mr Watt's lying under the vehicle with his legs protruding out from under it. She called the emergency services. They attended and Mr Watt's life was pronounced extinct at 12.33 pm on 20 October 2011.

PART IV: SUBMISSIONS

Crown

[31] The Crown invited me to make determinations in terms of section 6(1) (c), (d) and (e). I was invited to make general recommendations which it was suggested would act by way of reminder of the risks involved in carrying out work of the sort carried out by Mr Watt.

[32] It was Mr Robertson's submission that the tower of blocks Mr Watt used to lift the vehicle was an inherently unsafe system. There were reasonable precautions which could

have been taken, submitted Mr Robertson, as well there being as defects in that system. There was compelling evidence that the lack of a proper system of work had had a causative effect, he said, contributing to the accident that caused Mr Watt's death.

[33] Mr Robertson drew to my attention those passages of the evidence he submitted supported the determinations sought. He commended the evidence given by Mr Taylor, an experienced HSE inspector, as well as by Mr Watt's son and daughter. They had been excellent witnesses, said Mr Robertson, and should be preferred in matters of conflict to the evidence given by Mrs Young and Mr Young. Mr Robertson was especially critical of Mrs Young's evidence which, he submitted, should give pause when considering issues of credibility and reliability.

[34] In relation to section 6 (1) (c) Mr Robertson submitted that I should find that there were reasonable precautions which could have been taken and for which there was a real or lively possibility that the death and the accident resulting in the death might have been avoided. There were, he said, various safe (or safer) systems of lifting the van and they could have prevented the accident. Such safe systems were reasonable precautions, said Mr Robertson, and death might have been avoided if they had been used.

[35] Mr Roberson invited me to determine that a system for the safe lifting of vehicles and working safely under vehicles would involve training in Health and Safety, supervision, a company policy about the lifting of vehicles and inspection of equipment. All of those were reasonable steps, he said. Whether individually or taken together as a whole, these were precautions for which there was real possibility they might have resulted in safer work practice and which might have avoided the resulting accident.

[36] In relation to section 6 (1) (d) Mr Robertson invited me to determine that there were defects in the system of working which contributed to the death or the accident that had resulted in Mr Watt's death. On the evidence there clearly were defects in the system of working in relation to the lifting of vehicles, said Mr Robertson, but accepted that the more difficult question was whether they contributed to the accident resulting in Mr Watt's death. A determination under subsection (1) (d) required a higher standard of proof than under 6(1) (c), he said.

[37] It was Mr Robertson position that there was ample evidence of various failings on the part of Landtrac. He pointed to an absence of a Health and Safety at Work policy, and the lack of training / supervision / safety inspections / familiarity with HSE guidance. There was, as he put it, a "culture of indifference". Any of those failings, individually or cumulatively, might properly be regarded as a contributory factor to the fatal accident, argued Mr Robertson.

[38] In any event there should be a determination in terms of section 6 (1) (e), Mr Robertson submitted. There were wider lessons to learn in the public interest, he said, including that even an excellent employee – as Mr Watt undoubtedly was – who was able to work well, work alone and work independently - still required monitoring and support to ensure access to safety advice and awareness of risks. While it was not suggested that there was any intention to cause harm to Mr Watt the risk of such harm could not be ignored, but was. The absence of a system of work meant that Mr Watt had to devise his own, said Mr Robertson, and while it was he who took the decision to use the tower of blocks nevertheless it was Landtrac's duty to monitor and ensure compliance with health and safety. It was the employer's action - or inaction – that caused Mr Watt to act as he did and final responsibility for management of the system of work rested with it, said Mr Robertson.

Landtrac

[39] For Landtrac, it was Mr Varney's submission that in terms of the Act the Inquiry's remit was clear. There was no power or obligation to apportion blame. It was an exercise in fact finding, he said, armed with the benefit of hindsight, expert opinion and the evidence available more than two years after the accident. The purpose of the Inquiry was to make determinations to prevent recurrence in the future, he said, and the Inquiry might bear in mind that Landtrac was dissolved.

[40] While the evidence raised question marks about the acts or omissions of the employer company, and individuals involved, that had to be understood against the background to that employment relationship, said Mr Varney.

[41] Any potential determination under subsection (1) (c) must refer to the past and not the future, submitted Mr Varney. It must consider whether a precaution was reasonable and was one that might have prevented the death. There should be no connotations of negligence or breaches of statutory or common law obligations, he said.

[42] In relation to a determination under section 6 (1) (d) contribution was central to that matter, submitted Mr Varney. If there was a determination that there was a defect in any system of working it must have caused or materially contributed to the death, he said.

[43] As the test was not one of foreseeability the Inquiry need not have regard to the state of knowledge at the time of death, submitted Mr Varney. Nor did the Inquiry require to be satisfied that a proposed precaution would in fact have avoided Mr Watt's death, he said, only that it might have done. However a determination in terms of section 6 (1) (d) required that the Inquiry be satisfied that the defect in question did in fact cause or contribute to the death, argued Mr Varney.

[44] The Inquiry should assess the evidence in the usual way, submitted Mr Varney. The onus rests on the Crown and all essential facts fall to be proved on the balance of probabilities, he said. In considering that evidence it should be borne in mind that more than two years had passed since the accident and the passage of time will have had an impact on the quality of the evidence, he said. It was Mr Varney's position that Mrs Young had been doing her best to give assistance to the Inquiry; she and Mr Watt were close friends and had a longstanding working relationship and any issues that might have arisen with her evidence should be seen in that light.

[45] It was Mr Varney's position that he was not asking the Inquiry to make any findings in relation to Sections 6 (1) (c) to (e).

[46] The Inquiry should resist the temptation to speculate about what Mr Watt did, or did not do, and to base its findings only on the evidence, said Mr Varney.

PART V: NOTE ON EVIDENCE AND CONCLUSIONS

[47] It was clear from the evidence of all of the witnesses who knew Mr Watt that he was held in high regard, both professionally and personally. I heard from his son, Graham Watt, and his daughter, Lyndsay Watt, both of whom I found to be impressive witnesses who gave their evidence with commendable dignity and composure. I had no difficulty in finding that they had a close relationship with their father and that he would, when the need arose, discuss with each of them, although more frequently with Ms Watt, concerns and apprehensions he had about his employment. Equally I had no difficulty in finding that Mr Watt had voiced with them his reservations about the situation in which he found himself following the collapse of RHY and his transfer to Landtrac's employment.

[48] The evidence which they give about the conditions generally at Landtrac had the essential ring of truth and was consistent with much of the other evidence which I heard including, to an extent at least and subject to my observations below, by Mr Young and Mrs Young.

[49] It was clear from the evidence that whatever the reasons for the collapse of RHY and the precise status of the ownership of the assets (both tangible and intangible) of that company that Mr Watt's employment transferred seamlessly and without interruption from RHY to Landtrac. The mechanism for that transfer or the legal consequences of it are beyond the scope of this Inquiry but it was clear from the evidence that from Mr Watt's perspective there was little if any difference in his day to day activities following his transfer to Landtrac.

[50] Why that is relevant to the Inquiry is that it provided context to the somewhat unusual working arrangements that pertained at the time of Mr Watt's death. He had gone from a situation where he was employed by a larger organisation operated and run by those with experience in the field of agricultural engineering to being employed by a company whose sole director's experience was confined to that of an administrator. While that is not to denigrate Mrs Young it was clear from the evidence that her area of expertise was on the paperwork side of the business and that she had nothing to offer to the engineering side. Nor for that matter did she have experience as an employer as opposed to being an employed person. There was some evidence that she had been a partner in RHY's predecessor but it was clear that she had only ever carried out administrative duties in that partnership. In consequence she appeared to have no knowledge or understanding of her wider responsibilities to Mr Watt *qua* employer beyond providing him with work to carry out and paying him his salary.

[51] Mr Varney urged me not to be critical of Mrs Young's evidence, ascribing her memory difficulties to her state of health and the passage of time. However while that might explain some of the inconsistencies between her evidence and the rest, including that of Mr Watt's children, I was not satisfied that it explained it all. Notwithstanding Mrs Young's evident distress while giving evidence I am bound to observe that in certain respects I found that evidence somewhat lacking in candour nor was I satisfied that it was wholly credible.

[52] In contrast Mr Young impressed as rather more candid in his evidence accepting, for what appeared to be the first time, that on the day of his death he (Mr Young) had seen Mr Watt working underneath the Corsa van. That was not what was contained in his statement to the HSE. While accepting that one account differed from the other Mr Varney suggested that as I could not be certain which account was truthful that I should, in effect, make no findings in fact about the matter other than an observation that there was a conflict in evidence.

[53] I am not persuaded that that is the correct approach. Mr Young was giving evidence to the Inquiry on oath. In that passage of his evidence – i.e. the passage concerning seeing Mr Watt under the Corsa van on the day he died – Mr Young impressed as being truthful and honest. Whatever were the reasons for his having given a different account on an earlier occasion I was satisfied that the account which he gave to the Inquiry was truthful as far as that matter went.

[54] I had no difficulties in relation to the evidence which I heard from any of the other witnesses who I find to be credible and reliable.

[55] Turning then to the conclusions of the Inquiry I was satisfied that I could make a finding in terms of section 6 (1) (a) that Mr Watt was pronounced dead at 1233 hours on 20 October 2011 within the garage at Lincroft Farm, Avonbridge, West Lothian.

[56] I was also satisfied that I could make a finding in terms of section 6 (1) (b) that the cause of death was (a) compression of the chest and (b) crush injury due to the weight of a vehicle.

[57] Turning then to the question of determinations in terms of subsections (1) (c) to (e) I considered these having regard to the matters referred to in submissions and the different approaches required under each subsection.

[58] In terms of section 6 (1) (c) I accept that the correct approach is for me to consider whether I am satisfied that there was a real or lively possibility that Mr Watt's death and the accident resulting in his death may have been avoided by precautions which were reasonable. On the evidence before me I am satisfied that there was such a precaution, specifically the precaution of not entering under the vehicle when it was supported only by individual blocks of wood placed in a haphazard fashion. It was the entering under the vehicle that caused the risk of death and therefore it is reasonable that that is the precaution that may have avoided death. Had Mr Watt raised the vehicle up on the blocks but not entered under it there would not have been an accident that resulted in Mr Watt's death.

[59] While there were, on the evidence, several other ways in which the vehicle could have been secured, and secured more safely than supporting it on blocks, the central precaution that might have avoided the death was the precaution of not entering under the vehicle while it was insecurely supported. Had the vehicle been insecurely supported but Mr Watt stayed outside it then even if it had come off the supports there would not have been an accident resulting in death. The risk of death was not from its inadequate support per se but from the fact that he went underneath a vehicle so supported.

[60] In the circumstances I am not satisfied that it is necessary for me to go beyond that determination in terms of section 6 (1) (c).

[61] In terms of section 6 (1) (d) the issue is focused on defects in systems of working, rather than on precautions, and the extent to which, if any, such defects contributed to the death or the accident resulting in death. It was a matter of agreement that the test is one of the balance of probabilities and that a causal link would require to be established before such a determination could be made.

[62] On the evidence I was satisfied on the balance of probabilities that working under an inadequately secured vehicle was a system of working that was defective and that that defect contributed to Mr Watt's death or the accident resulting in his death.

[63] As above the difficulties arose from the fact that Mr Watt was working under the inadequately secured vehicle rather than the insecurity per se. Had he not been underneath any accident would not have been fatal. Accordingly it follows that in the context of

subsection (1) (d) the defect in the system of working arose from working underneath that vehicle.

[64] While it is not the function of the Inquiry to apportion blame I pause to reflect on the finding in fact that Mr Young knew Mr Watt had been under the vehicle on the morning of his death.

[65] Turning then to section 6 (1) (e) I was asked by the Crown to make a determination in the public interest of any facts relevant to the circumstances of Mr Watt's death. The significant fact, in my view, is the risk that arises from persons taking on the legal responsibilities of employers without an adequate understanding of the duties and obligations that that entails.

[66] Here it is clear from the evidence that there was no recognition by Mrs Young of what it was that she was required to do vis a vis Mr Watt now that she was his employer and not just a colleague. The organic way in which that relationship grew up gives some explanation for that but it is not sufficient to excuse what came over as her rather ambivalent attitude towards her responsibilities as an employer.

[67] Equally difficulties arose given that Mr Young had had a very active and hands on involvement in Mr Watt's predecessor employer but did not, on the evidence at least, try to make a clear delineation between that relationship and the one existing at the time of his death. That would not have assisted Mrs Young in recognising her responsibilities towards Mr Watt nor would it highlight for Mr Watt who was responsible to him in any concerns he had about his employment. I accepted the evidence of Mr Watt's children that he had expressed to them reservations about aspects of his employment relationship with Landtrac and, in particular, that he voiced concerns about what equipment was available for his use.

[68] Connected with this was the total lack of clarity about who owned what at Mr Watt's place of work, some of which was caused by the fact that it was also Mr and Mrs Young's home and some because by the rather opaque arrangements there were in relation to the assets of RHY. Given that that company was in liquidation it did seem unlikely that Mr Young would himself be permitted to store its assets at his home address but that was his position in evidence.

[69] It was difficult to avoid an impression that Mr Young had a role to play in Landtrac, even if that was just in the background, and that Mrs Young was simply continuing to operate as the administrator. However as that is not directly relevant to the issues in the Inquiry I do not propose to make any formal determinations to that effect.

[70] However I am satisfied on the evidence that Mrs Young's failure to recognise her responsibilities as employer encompassed a failure on her part to have regard to Mr Watt's

health and safety and that that is a circumstance that is relevant to the death. I make a determination to that effect.

[71] Finally I would like to extend my condolences to Mr Watt's family and friends. It is tragic that he should have died in such circumstances and I am sure they feel his loss each day.

Susan Craig

Sheriff

27 January 2014