

SHERIFFDOM OF TAYSIDE, CENTRAL AND FIFE AT FALKIRK

[2017] FAI 5

B380/16

DETERMINATION

BY

SHERIFF CHRISTOPHER M SHEAD, ADVOCATE

**UNDER THE FATAL ACCIDENTS AND SUDDEN DEATHS INQUIRIES (SCOTLAND)
ACT 1976**

into the death of

JAMES McLEAN

The sheriff, having considered the evidence adduced, Determines in terms of section 6(1) of the Fatal Accident and Sudden Deaths (Scotland) Act 1976:

- a) That the late James McLean died at Forth Valley Royal Hospital, Larbert on 13 January 2016 at 14:05 having been fatally injured in an accident which occurred in the course of his employment.
- b) That the cause of death was compression of the chest.
- c) That had the deceased applied the parking brake on the fork lift truck which he was repairing the accident would not have occurred.
- d) That there was no defect in any system of working which contributed to his death.
- e) That other facts relevant to the circumstances of the death are set out in the findings which follow.

Findings in Fact

1. On 13 January 2016 the deceased sustained fatal injuries having been crushed between a fork lift truck which he was repairing and a transit van which he used in the course of his employment.
2. At the time of his death the deceased was employed by Valmar Handling Services Limited as a fork lift engineer. He had been working for the company on the day of the accident. The accident occurred at the premises occupied by James Callander & Son Ltd in Abbots Road in Falkirk. His employers had sent him there to service nine fork lift trucks. He was scheduled to work on the vehicles between 11 and 13 January.
3. On 12 January he had serviced a "Terra" fork lift truck serial number JU3478. Subsequently the driver of the truck noticed that the fuel gauge was faulty which was reported to the deceased. On 13 January the deceased examined the truck again with a view to repairing the fault. He parked the transit van close to the truck he was intending to repair.
4. At approximately 13:20 Mr Gordon Beattie, an employee of James Callander & Son Ltd, saw the deceased trapped between the side of the fork lift truck and the transit van. The deceased was turning purple. Mr Beattie summoned help and Mr Alan Paterson turned off the engine of the fork lift truck. He then got into the transit van but there were no keys in the ignition. As a result he used another fork lift truck to lift the van away from the deceased who was, by then, unconscious. An ambulance was called at 13:28 and the deceased was taken to Forth Valley Royal Hospital in

Larbert for treatment. He was pronounced dead there by Dr. Richard Maccallum at 14:05 on 13 January 2016.

5. On the instructions of the Procurator Fiscal at Falkirk a post-mortem examination was carried out on 22 January 2016. That examination established that the cause of death was compression of the chest which occurred while the deceased was trapped between the two vehicles.
6. After the accident the fork lift truck which was being repaired by the deceased was examined by Mr Peter Dodd a specialist engineer employed by the health and safety executive. The fork lift truck is only capable of forward motion when the parking brake is disengaged, the forward drive is engaged and the accelerator depressed. Having regard to the training he had received the deceased ought to have known to apply the parking brake. Mr Dodd identified no fault with the truck which would have allowed it to move forward unless the three steps described had been taken. The vehicle had been regularly maintained and serviced.
7. The investigations conducted by the health and safety executive suggested that the deceased had been trying to fix a leak in the engine. He was pressing the accelerator manually from outside the cab of the truck to help him identify the fault.
8. While doing so the truck moved forward and crushed the deceased between it and the transit van.

A summary of the main points of the evidence

[1] The Crown led evidence from two witnesses and lodged a joint minute which the parties had helpfully agreed.

Michelle Gillies

[2] Ms Gillies is an inspector with the Health and Safety Executive. She had attended the premises where the accident occurred on 13 January 2016.

[3] Her inquiries suggested that the accident had happened about 13:20. The deceased was last seen eating his lunch about 10 minutes before he was discovered by Mr Beattie crushed between the two vehicles. It seems that earlier the deceased had moved his van close to the fork lift truck. His tools were in the van. He was trying to repair a fault which had been reported to him.

[4] She confirmed her understanding that the fork lift truck had not been moved between the time of the accident and her examination of the scene. Photographs had been taken which showed, in her opinion, that the truck had moved forward because it had displaced a pile of timber.

[5] Her conclusion was that the deceased appeared to have been operating the accelerator and the tilt function in an effort to identify the source of the problem. Since the parking brake was not engaged the vehicle moved forward. In her opinion the deceased had been standing outside the truck operating the controls manually. In operating the controls it is possible that the deceased might have knocked the vehicle into forward drive.

[6] She confirmed that the truck could not have moved if the parking brake had been on.

[7] She had checked that the deceased had been properly trained in the operation of the truck. According to the training he had received the parking brake should have been applied.

[8] There was no gradient in the yard which might have caused the truck to roll without the engine running.

[9] In cross-examination she confirmed that she had no criticism of the training which his employers had given to the deceased and that he ought to have known to apply the parking brake in the circumstances.

Peter Dodd

[10] Mr Dodd is a specialist inspector employed by the health and safety executive. He has expertise in mechanical engineering. He had attended the scene of the accident and produced a report.

[11] His understanding was the fork lift truck had a leaking valve which the deceased was trying to fix. It appears that the deceased was testing the hydraulic circuit associated with the platform tilt function of the sideloader in an effort to try to find the source of the leak. He may have been trying to increase the hydraulic pressure in the circuit. This is a technique sometimes used by service engineers to diagnose the source of a leak. If so it is likely that the deceased would have been pressing both the accelerator pedal and moving the joystick in the cab of the truck at the same time.

[12] In his opinion the deceased was outside the cab leaning in and using both his hands to operate both the joystick and the accelerator pedal.

[13] When he examined the truck the parking brake was off. Had it been engaged then, in his opinion, the accident would not have occurred.

[14] He could find no fault with the truck itself. In more modern versions of similar vehicles there is a safety device fitted which means that the vehicle will not move forward unless someone is sitting in the seat in the cab but he had no particular criticism to offer of the safety features on the truck being worked on by the deceased.

[15] He confirmed that there was no gradient in the yard which might have explained the occurrence of the accident.

[16] He was asked about the alignment of the wheels. He said that the deceased might have moved the wheels using the steering wheel after the vehicle was in motion.

[17] He concluded that there was no evidence of a systematic failing in the working practices of the deceased's employers.

The submissions

[18] The Procurator Fiscal asked me to make findings as required by section 6(1) (a) and (b) of the 1976 Act.

[19] Ms Bonomy for Valmar Handling Services Limited began by expressing the company's deep regret at the death of the deceased. He had been a valued employee. She then invited the court to find under (1) (c) that had the deceased applied the parking brake the accident would not have happened. She also invited me to consider that the

same conclusion might be reached in relation to the alignment of the wheels. In other words had the wheels not been in the position depicted in the photographs then the truck would not have moved in the direction it did and would not have trapped the deceased between the vehicles. She had no submission to make in respect of (d) and (e)

[20] Having considered her submission and in light of the evidence I reached the view that I should make a finding in respect of the failure to apply the parking brake but not in respect of the alignment of the wheels. However the evidence on the latter point did not appear to me to be sufficiently clear to warrant such a finding.

Conclusion

[21] I should like to express my condolences to the family and friends of the late Mr McLean.

Sheriff of Tayside, Central and Fife

At Falkirk 1 February 2017