**SHERIFFDOM OF GRAMPIAN, HIGHLAND AND ISLANDS AT ABERDEEN**

**[2026] FAI 48**

**ABE-B164-26**

DETERMINATION

BY

SHERIFF IAN WALLACE

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

into the death of

**DAVID COUTTS DIXON EWAN**

ABERDEEN, 28 August 2026

**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 that:

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

David Coutts Dixon Ewan ("Mr Ewan"), born 1 May 1938, who resided at Ferniebrae Farm, Barras, Stonehaven, Aberdeenshire, died at 1921 hours on 16 June 2025 at Aberdeen Royal Infirmary.

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

The accident resulting in Mr Ewan's death occurred at approximately 1420 hours on 16 June 2025 at Ferniebrae Farm, Barras, Stonehaven, Aberdeenshire.

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

The cause of Mr Ewan's death was a traumatic brain injury and rib fractures caused by being struck by a cow and knocked to the ground.

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

The accident was caused when Mr Ewan was moving behind cattle in a pass to convey them onto a lorry to be transported for slaughter. One of the cows then turned and ran towards him and struck him.

**In terms of section 26(2)(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):**

Mr Ewan could have waited for assistance to carry out the task of conveying the cattle onto the lorry. His daughter was on her way to the farm to provide assistance and the lorry driver would have helped. They were both younger and more mobile than Mr Ewan and therefore more able to take appropriate action when any cattle became out of control.

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

The pass was too wide, allowing cattle to turn and change direction. The pass did not provide a ready means of escape or refuge for Mr Ewan in the event that cattle did become out of control.

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

Mr Ewan was 87 years old. His health had deteriorated and mobility decreased. He was therefore at greater risk of injury when handling cattle.

**In terms of sections 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):**

Ferniebrae Farm no longer houses any cattle. The family do not intend keeping the farm running, and are planning to sell it. In these circumstances, there are no recommendations to be made.

**NOTE**

**Introduction**

[1] This was a mandatory inquiry held under section 2(3)(b) of the Inquiries into Fatal Accidents and Sudden Deaths etc (Scotland) Act 2016 ("the 2016 Act") as Mr Ewan died as a result of an accident which occurred in the course of his employment.

[2] Mr Ewan's death was reported to the Crown Office and Procurator Fiscal Service on 2 July 2025.

[3] The first notice in relation to this inquiry, in terms of the Act of Sederunt (Fatal Accident Inquiry Rules) 2017 ("the 2017 Rules"), was issued by the procurator fiscal on 9 March 2026.

[4] A preliminary hearing in terms of rule 3.6 of the 2017 Rules was held at Aberdeen Sheriff Court on 29 April 2026. A further preliminary hearing was held on 10 June 2026.

[5] The inquiry proceeded on 18 August 2026 at Aberdeen Sheriff Court. The only participant in the inquiry was the procurator fiscal, represented by Ms Stewart, procurator fiscal depute. The nearest relatives of Mr Ewan and the Health and Safety Executive had received due intimation but declined to take part. Relatives of Mr Ewan, however, attended every hearing. The information they provided to the procurator fiscal was of great assistance to the inquiry.

**Form of evidence**

[6] I allowed evidence to be presented in the form of affidavits, witness statements and productions.

[7] I had regard to statements and affidavits from David G Ewan (son of Mr Ewan); Jacqueline Urquhart (daughter of Mr Ewan); Alistair Brand (lorry driver for Alexander Gauld Limited); June Ewan (daughter-in-law of Mr Ewan); Lynn Smart (employee of Alexander Gauld Limited); Duncan Allan (ambulance technician); Zoe Taylor (forensic scene examiner, Scottish Police Authority); Detective Sergeant Emma Wright; Detective Constable Alfred Stuart; Police Constable Cameron McChesney; and Dr Roland Campbell (consultant, Emergency Department, Aberdeen Royal Infirmary).

[8] I had regard to the following productions:

- The intimation of Mr Ewan's death to the procurator fiscal (production 1);
- Postmortem report (production 2);
- Summary medical records (production 3);
- Abbreviated report from the Health and Safety Executive (HSE) (production 4);
- HSE guidance document entitled *"Housing and Handling Cattle AIS35"* (production 5);
- Photographs of the locus (production 6);
- A sketch by Alistair Brand which showed the location of the lorry when the cattle were being conveyed down the pass (production 9);

- Additional information provided by HSE in relation to work related fatalities, dated 22 May 2026 (production 11);
- Additional information provided by HSE in relation to the construction of the pass and issues relating to Mr Ewan (production 12).

[9] The procurator fiscal further submitted a substantial notice to admit information under rule 4.12 of the 2017 Rules.

**Legal framework**

[10] The purpose of the inquiry is set out in section 1(3) of the 2016 Act as being to establish the circumstances of the death and to consider what steps (if any) might be taken to prevent other deaths in similar circumstances.

[11] In terms of section 26 of the 2016 Act the inquiry must determine certain matters, namely when and where the death occurred; when and where any accident resulting in the death occurred; the cause or causes of the death; the cause or causes of any accident resulting in the death; any precautions which could reasonably have been taken and might realistically have resulted in the death, or any accident resulting in the death, being avoided; any defects in any system of working which contributed to the death; and any other factors relevant to the circumstances of the death. It is open to the sheriff to make recommendations in relation to matters set out in section 1(4) of the Act.

[12] The procurator fiscal represents the public interest. The inquiry is not intended to establish liability, either criminal or civil. The inquiry is an exercise in fact finding,

not fault finding. It is not open to me to engage in speculation. The inquiry is an inquisitorial process.

**The facts**

***Background***

[13] David Coutts Dixon Ewan ("Mr Ewan") was born on 1 May 1938 and died on 16 June 2025. He was 87 years old at the time of his death. He grew up on a farm and had been a farmer all his working life. He married Margaret in 1960 and they had four children. Together Mr and Mrs Ewan owned and ran Ferniebrae Farm, Barras, Stonehaven.

[14] At the time of his death, Mr Ewan was caring for his wife who was suffering ill health. He still worked the farm. He had no employees, but his children would assist him as much as they could. From about 2020, Mr Ewan's health declined. He had poor eyesight and there were concerns that he may be in the early stages of dementia. He had lost a significant amount of weight and was suffering dizzy spells. His mobility was significantly affected. Mr Ewan's family could see that it was becoming increasingly difficult for him to manage the farm. They increasingly stepped in to carry out jobs on the farm and would tell him afterwards what they had done. Mr Ewan was described as not being a man who would ask for help, but he was grateful for all the help that he did receive. For the previous 20 years Mr Ewan had been saying that he would retire the next year, but he never did. The farm was his life and his hobby.

***The events***

[15] At about 1420 hours on 16 June 2025 Alistair Brand, a lorry driver for Alexander Gault Limited, arrived at Ferniebrae Farm to collect three cattle to take them to the slaughterhouse at Portlethen. Mr Ewan's daughter had agreed she would come to the farm to assist in getting the cattle onto the lorry. This followed the usual practice whereby one of Mr Ewan's children would herd the cattle onto the lorry and the driver would shut the door behind the animals. This saved Mr Ewan from being involved in this job. The job of herding the cattle could safely be carried out by one person, however Mr Ewan had not been handling cattle as regularly as he used to.

[16] Mr Brand had arrived slightly earlier than planned. Mr Ewan's daughter was on her way to the farm but had not yet arrived. Mr Ewan told Mr Brand that he would carry out the job of moving the three cattle onto the lorry. Mr Brand had attended Ferniebrae Farm approximately 18 months previously when Mr Ewan had carried out this job. He had no concerns about Mr Ewan doing so again on 16 June 2025.

[17] The cattle were in an enclosed holding area within a shed. A stone wall divided that area from a covered open area of the shed. A sliding door provided access from the holding area to the covered area in which there was a "pass" up which the cattle would walk to the lorry. The pass is also referred to as a "run" or a "race". This pass was formed by the stone wall of the shed on one side and wooden fencing formed by planks attached horizontally to vertical wooden poles. The pass was approximately 30 feet long and between 4 to 5 feet wide.

[18] Mr Brand parked his lorry at the end of the pass with the back door opened to form a ramp into the lorry. He positioned one side of the lorry close to the wall of the shed and attached a gate to the other side to cut off any gap at the end of that side of the pass. This ensured that there was no way out of the pass for the cattle other than up the ramp into the lorry.

[19] As Mr Brand was securing the gate he saw that two cattle were already making their way up the pass toward the lorry. Mr Brand squeezed himself out of the pass between the stone wall and the lorry to get out their way.

[20] The first two cattle went onto the lorry without incident. Mr Brand then saw the third cattle coming toward the lorry at speed. When that cow passed into the light from the shade of the covered area of the shed it spun round and went back down the pass towards Mr Ewan. Mr Brand shouted to Mr Ewan to watch out, but he did not see Mr Ewan and heard no reply.

[21] Mr Brand then squeezed back into the pass from beside the lorry. He immediately saw Mr Ewan lying on the ground, approximately 20 feet from the lorry. Mr Ewan was bleeding from the head. Mr Brand immediately contacted an ambulance. He supported Mr Ewan's head with a boiler suit. Over the next few minutes, a number of family members arrived to provide assistance. Mr Ewan was conscious. He was complaining of having a sore stomach and repeatedly said that he wanted to get up. Appropriate care was provided to Mr Ewan until ambulance staff arrived at approximately 1435 hours. Mr Ewan was initially assessed as being at 14 on the Glasgow Coma Scale (GCS), which would mean that he was a bit dazed and

confused. He then vomited a number of times and deteriorated to 8 GCS, which would indicate a severe brain injury. He was immediately conveyed to Aberdeen Royal Infirmary (ARI).

[22] Mr Ewan was intubated and ventilated at ARI. Scans confirmed that he had suffered significant head injuries, fractured ribs and other injuries. It was assessed by the neurosurgery consultant that Mr Ewan had suffered an unsurvivable traumatic brain injury and that he would not survive any neurological procedure. Sedation and ventilatory support were withdrawn at 1905 hours. Mr Ewan died at 1921 hours that day.

[23] A postmortem examination later confirmed the cause of death as being a traumatic brain injury and rib fractures after having been hit by a cow on a farm.

***Post accident investigations***

*HSE investigation*

[24] The Health and Safety Executive (HSE) declined to conduct an investigation into the circumstances of this incident. The HSE did, however, provide an abbreviated report, general information in relation to the risks associated with handling cattle, and responses to further investigations carried out by the procurator fiscal depute.

[25] The HSE guidance document *"Handling and housing cattle AIS35"* states that "handling cattle always involves the risk of injury from crushing, kicking, butting or goring". When assessing the risk handling cattle, consideration should be given to the person doing the handling, the equipment available, and the cattle being handled.

[26] The risks to those working in agriculture are well documented. Agriculture accounts for 1% of the Great British work force but for approximately 20% of worker fatalities. Where a fatality is caused by an animal, it is almost always cattle. Between 2020/21 and 2024/25 12 members of the public and 14 farm workers were killed by cattle.

[27] The age of the person handling cattle is a significant factor in assessing risk. Between 2020/21 and 2024/25 there were a total of 125 worker fatalities in the agriculture, forestry and fishing sector. Forty-five of these fatalities were of workers aged over 65. There is no recommended upper age limit to handling cattle as individual capabilities vary widely. However, a disproportionate number of accidents involve persons who are beyond normal retirement age. Careful consideration requires to be given to the risks to anyone aged over 65 working with cattle and what they can safely do.

[28] When handling cattle, the arrangement of facilities will be different for each site. But the general principle is to keep people and cattle apart as much as possible. Where this is not possible, other arrangements should be considered such as refuges or escapes so a person can remove themselves from danger when necessary. This is described as a system to allow the cattle handler to go "over, under, behind or through". Going over or under a barrier such as a fence would require a level of physical fitness and agility. For most people it would be easier to go behind a beam or through a purpose designed escape route. Where the handling system does require the handler to be in the same area as the cattle, this should be assessed to take account of the age, fitness and

experience of the hander. The HSE noted that the pass at Ferniebrae Farm was usable but afforded no easy refuge.

*The cattle*

[29] All those ordinarily involved in handling cattle at Ferniebrae were well aware of the unpredictability of cattle and the associated risks. The mother of the cattle being transported for slaughter on 16 June 2025 was known to be particularly "flighty". Mr Ewan had been advised to dispose of her, but he had decided to keep her because she produced good calves. The cattle being transported were usually kept in a field. They were therefore not regularly handled and were wary of people. Mr Ewan had however dealt with the cattle so he knew them and they knew him.

**Submissions for the procurator fiscal**

[30] The submissions for the procurator fiscal depute were consistent with my discussion and conclusions set out below. In making my findings, I have followed the findings recommended by the procurator fiscal depute in her submissions. There is therefore no need to set out the procurator fiscal depute's helpful submissions in detail.

**Discussion**

[31] The injuries Mr Ewan sustained after being struck by the cow were unsurvivable. That was the cause of his death. He received appropriate treatment after he had been

struck, but nothing could have been done to save his life. The focus of this inquiry is therefore what could have been done to prevent him being struck by the cow.

[32] As explained by the HSE, when assessing the risk handling cattle, consideration should be given to the person doing the handling, the equipment available, and the cattle being handled. I will consider these three aspects in turn.

***Mr Ewan's age and physical condition***

[33] Mr Ewan was 87 years old. He was very experienced in dealing with cattle and relatively fit for his age. However, his health had deteriorated in recent years. Significantly, his mobility was very limited. There were therefore obvious risks associated with him handling cattle on his own as he did on 16 June 2025.

[34] It had not been the plan that he would do so. Mr Ewan's daughter had agreed to come to the farm to assist getting the cattle onto the lorry. But when Mr Brand, the lorry driver picking up the cattle, arrived earlier than expected, Mr Ewan did not wait for his daughter. Rather, he immediately got on with the task at hand. Mr Brand would have carried out the task of herding the cattle himself, but Mr Ewan had already sent the cattle down the pass before Mr Brand had finished securing the gate to ensure the cattle were funnelled onto his lorry.

[35] It was Mr Ewan's decision to handle the cattle himself. This would appear to be in keeping with Mr Ewan's character. He had grown up on a farm and worked as a farmer all his working life. He was a man who did the work required, did not complain, and did not ask for help.

***The cattle***

[36] The cow which struck Mr Ewan was described by Mr Brand as approaching the lorry at speed, and so it was already to some extent out of control at that point. It then turned round sharply as it ran from the shade of the shed into direct light. It may have been the light which caused the cow to turn; though it could equally have turned as a result of approaching the lorry at the end of the pass.

[37] As noted above, the mother of the cattle being transported was known as being particularly "flighty". Those cows were not used to being handled, which could make them more wary of people. These are risk factors to take into account. Beyond that, there is no way to conclude that the cattle were more reactive than other cattle or to assess whether this contributed to the incident on 16 June 2025.

[38] In any case, there is a risk associated in handling all cattle. Any cow could potentially react in the same way as the cow which struck Mr Ewan reacted. The same precautions and measures should be taken in relation to all cattle.

[39] It is clear that everyone who had any involvement in handling cattle at Ferniebrae Farm, including Mr Ewan, were aware of the risks. Mr Ewan knew the particular cattle being transported. No witness saw how Mr Ewan was handling the cattle as they were released into the pass. There is no information to support any conclusion that the way the cattle were being handled was a factor in the cow becoming out of control.

***The cattle pass***

[40] When handling cattle, people and cattle should be kept separate whenever possible. However, the realities of a working farm with limited resources are such that this will not always be possible. The set up should nevertheless limit the dangers associated with cattle becoming reactive or uncontrolled. Whenever people are required to be in the same area as cattle they should have a ready means of escape or refuge.

[41] The pass at Ferniebrae Farm was wide enough to allow (at least smaller) cattle to turn. A narrower pass could have prevented the cow which struck Mr Ewan from turning and running back towards him.

[42] The only means of escape from the pass at Ferniebrae Farm was to go over or under the wooden fencing which formed one side of the pass. At the end of the pass closest to the doors to the holding area, there was a gate in the fencing which had been wired shut. However, even if that had been able to be opened it would only afford an escape to a person who was able to get themselves to the gate and open it quickly enough. It would therefore be only a potential and not a reliable means of escape. There was no obvious obstruction behind which a person could take refuge when necessary. Going under the fencing would have been possible for someone with the required agility. But it would be much easier to climb up the horizontal wooden planks of the fencing which ran along the length of the pass. Mr Ewan's son explained that a person who had climbed up to the third plank would be safely out of the way of any cattle. This would be relatively straight forward for a person with reasonable mobility. However, Mr Ewan could not be expected to be able to take advantage of this means of

escape. There was therefore no meaningful way for him to get out pass to avoid cattle when necessary.

**Conclusion**

[43] The job of conveying the cattle from the holding area into the pass and onto to the lorry may have been a one-person job for a fit and healthy person. It was not, however, a job which Mr Ewan could safely carry out on his own. His age and physical condition meant that he would be at increased risk if cattle did become out of control. Help was available. Mr Ewan's daughter was on her way to the farm to provide assistance. Mr Brand would have helped after he had finished securing the gate to his lorry. Wating for assistance is a reasonable precaution which could have been taken and might realistically have resulted in Mr Ewan's death being avoided. I make that finding under section 26(2)(e) of the Act.

[44] The pass was wide enough for the cow which struck Mr Ewan to turn around. A narrower pass could have prevented the cow turning and running towards Mr Ewan. Once the cow had turned, there was no ready means of escape for Mr Ewan. HSE assessed the pass as being usable. This, however, is dependent on the physical capabilities of the person in the pass with the cattle handler. I am satisfied that the width of the pass and the absence of a suitable means of escape or refuge for Mr Ewan constituted defects in the system of working which contributed to his death. I make that finding under section 26(2)(f) of the Act. In making that finding, I acknowledge that

Mr Ewan's capacity to take advantage of any escape gate or refuge to hide behind may have been limited due to his restricted mobility.

[45] I have made a finding under section 26(2)(g) of the Act that a fact relevant to the circumstances of the death was that Mr Ewan was at increased risk due to his age and decreased mobility. Mr Ewan continued to work his farm well beyond retirement age. He did not ask for help and would continue to do whatever work was required despite his declining physical capabilities. He never followed through on his stated plans to retire, no doubt in part because farming was such a big part of his life. It was not just his job but his hobby. These characteristics are not uncommon in Scottish farmers. They are perhaps the very characteristics that can sustain a person through a long life working a farm.

[46] The procurator fiscal depute addressed me in relation to the determination of Sheriff Robert McDonald in the recent Fatal Accident Inquiry into the death of Gordon Addison Chalmers at Banff Sheriff Court ([2026] FAI 23). Ms Stewart, the procurator fiscal depute in this inquiry, had also been the procurator fiscal depute in that inquiry. Some circumstances from that inquiry are worth highlighting again here. Mr Chalmers was aged 78 and was still farming his farm. He died on 18 October 2024 when he was trampled by a cow within his shed. He had been engaged in sorting cattle. Sheriff McDonald found that a reasonable precaution which might have avoided Mr Chalmers' death would have been for him to have been separated from the cattle by a gate. It had been Mr Chalmers' practice to sort cattle himself and he would not allow anyone else to do it for him or change the way he did things. There is no suggestion in

Sheriff McDonald's determination that any lack of mobility contributed to Mr Chalmers' death. However, he had significant health issues and in the aftermath of his accident it became apparent that, given his health issues and frailty, there was no meaningful prospect of recovery from the serious injuries he suffered.

[47] It is well recognised that the risks associated with farming increase with a person's age. The statistics, set out at para [27] above, show the tragic results of these increased risks. These statistics will come as no surprise to anyone working in the farming industry. HSE have set out the wide-ranging programmes of training, guidance and awareness raising they carry out in relation to health and safety in the agricultural industry. These programmes will include reference to the increased risks to those beyond retirement age. I will nevertheless take this opportunity to highlight once again that persons working on farms beyond retirement age are at greater risk and need to take appropriate measures to limit those risks.

[48] It is clear that Mr Ewan, despite his independent nature, received substantial help from his family on the farm. This help he gratefully received. Members of the family have been of great assistance in providing useful information to the inquiry which has informed my findings. Family members attended every hearing. All of this speaks to the love and affection they held, and still hold, for Mr Ewan. I am aware that, since Mr Ewan's death, his wife has also passed away. I would wish to express my condolences to Mr Ewan's family and friends for these losses.