SHERIFFDOM OF GRAMPIAN, HIGHLAND AND ISLANDS AT INVERNESS

[2025] FAI 45

INV-B204-25

DETERMINATION

BY

SHERIFF GARY AITKEN

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

into the death of

ALISTAIR IAIN CAMPBELL

Inverness 28 November 2025

Determination

The sheriff, having considered the information presented at the inquiry, determines in terms of the Inquiries into Fatal Accidents and Sudden Deaths etc. (Scotland) Act 2016, (hereinafter referred to as "the 2016 Act"):

In terms of section 26(2)(a) of the 2016 Act (when and where the death occurred)

The late Alistair Iain Campbell died at 2113 hours on 15 July 2024 at the haulage yard operated by Alistair Campbell Haulage at Glen Mor, near Invergarry.

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

The accident resulting in death took place at approximately 2000 hours on 15 July 2024 at the haulage yard operated by Alistair Campbell Haulage at Glen Mor, near Invergarry.

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

The cause of the death of said Alistair Iain Campbell was chest and pelvic injuries as a consequence of being crushed beneath a lorry chassis.

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

The cause of the accident resulting in the death of said Alistair Iain Campbell was a strop holding up a lorry chassis, under which he was working, shearing through. The strop had been secured to a log grab which had become sharpened through use over time. The sharpened log grab cut through the strop resulting in the chassis falling and crushing said Alistair Iain Campbell.

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)

Firstly, it was reasonable for packing material to have been placed between the log grab and the strop which might realistically have prevented the strop from being sheared through by the sharpened log grab, preventing the chassis from falling and thereby avoiding the accident and the death of said Alistair Iain Campbell.

Secondly, it was reasonable to use of axle stands, tyres or some other item placed beneath the chassis to cushion against any fall and this might realistically have prevented the chassis from crushing Mr Campbell when the strop that was holding it sheared through causing the chassis to fall, thereby avoiding the accident and the death of said Alistair Iain Campbell.

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 are no defects in any system of working which contributed to the death or the accident which resulted in the death of said Alistair Iain Campbell.

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

There are no other facts relevant to the circumstances of the death of said Alistair Iain Campbell.

Recommendations

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)

There are no recommendations made.

NOTE

Legal Framework

[1] This inquiry was held in terms of section 1 of the 2016 Act and was governed by the Act of Sederunt (Fatal Accident Inquiry Rules) 2017 (hereinafter referred to as "the 2017 Rules"). This fatal accident inquiry was presented by the Crown as a mandatory inquiry in terms of section 2 of the 2016 Act as Mr Campbell died as a result of an accident in the course of his employment or occupation.

[2] The purpose of this inquiry is set out in section 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. It 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 Crown, in the form of the Procurator Fiscal, represents the public interest.

[3] In terms of section 26 of the 2016 Act the inquiry must determine certain matters, namely where and when the death occurred, when 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 avoided the death or any accident resulting in the death, 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 subsection 4 of section 1 of the 2016 Act.

Introduction

[4] This inquiry was held into the death of Alistair Iain Campbell. He was a 63 year old man who was self-employed as a heavy goods vehicle operator. He died on 15 July 2024 when a lorry chassis which he was working on and which was suspended from a log grab fell and crushed him. He was carrying out maintenance on the lorry chassis in the course of his business at his business premises in Glen Mor, Invergarry.

[5] A preliminary hearing was held by Webex at Inverness Sheriff Court on 8 October 2025. It was clear that the evidence was not likely to be disputed and the Crown undertook to prepare a notice to admit evidence.

[6] The inquiry proceeded by Webex at Inverness Sheriff Court on 10 November 2025. Ms Stewart, Procurator Fiscal Depute, represented the Crown. No other parties were represented. Ms Stewart lodged a substantial notice to admit evidence. I accepted the facts set out in the notice to admit evidence. The findings in fact listed at paras [9] to [23] below are derived from the notice to admit evidence.

[7] The Crown also lodged an inventory of documentary productions as follows:

1. Intimation of Death
2. Post Mortem Report
3. Toxicology Report
4. Health and Safety Executive Report
5. Goods Vehicle Operating License details
6. Photographs
7. Witness statements

[8] There being no other parties to the inquiry, the inquiry proceeded on the basis of the notice to admit evidence, which was read by Ms Stewart.

The facts

[9] Alistair Iain Campbell (hereinafter referred to as "Mr Campbell") was 63 years old having born on 19 June 1961 and formerly resided in Glen Mor, Invergarry. He is survived by three daughters.

[10] Mr Campbell had no significant past medical history of note.

[11] Mr Campbell was a professional heavy goods vehicle driver and operator. At the time of his death he was a sole trader, trading as Alistair Campbell Haulage. He held a Standard National Goods Vehicle Operator's Licence with authorisation for five vehicles and six trailers. The operating centre was specified as Glen Mor, Invergarry PH35 4HN, where Mr Campbell also resided.

[12] At approximately 1830 hours on 15 July 2024 AB, a work acquaintance of Mr Campbell's, attended at the operating centre at Glen Mor, Invergarry, in order to assist Mr Campbell by fitting a seal on the axle of a motor lorry. Mr Campbell arrived at the yard about 10 minutes after AB. AB commenced work on the lorry which was half in a shed to the west side of the operating centre and he went underneath said lorry in order to complete the work.

[13] Mr Campbell commenced work on a bare lorry chassis, removing the wheels in order to remove the brake callipers. Mr Campbell was working about fifty metres away from the shed where AB was working and out of his line of sight.

[14] Just after 2000 hours AB heard a loud bang which sounded like metal hitting the ground and thereafter heard the sound of moaning. He shouted "Are you okay?" as he tried to remove himself from under the lorry he was repairing in order to attend to Mr Campbell. He heard a further moan in response. He went to the bare chassis that Mr Campbell had been working on and found Mr Campbell with the lower half of his body under the back nearside of the chassis. Mr Campbell was sitting up but twisted to the right with his right arm trapped. Mr Campbell was conscious but clearly struggling.

[15] AB observed that a green lifting strop and a blue ratchet strap had been attached to the log grab of another vehicle and to the back of the chassis Mr Campbel was working on. The log grab had then been used to raise the chassis Mr Campbell was working on. The green lifting strop had snapped causing the chassis to fall. AB therefore grabbed a nearby yellow strop. He noted it was frayed but there was nothing else to hand. He attached the yellow strop between the chassis and the grab crane,

lifting the chassis off Mr Campbell and moving it to the side. He simultaneously called the emergency services. The call to emergency services is recorded as being at approximately 2016 hours. Mr Campbell was reportedly trapped under the chassis for a couple of minutes.

[16] AB supported Mr Campbell's head. Mr Campbell was trying to move but going in and out of consciousness at this time.

[17] Scottish Ambulance Service personnel arrived at the operating centre at 2025 hours and found Mr Campbell being supported by his acquaintance. Mr Campbell was observed to look grey in colour, was conscious and breathing but unresponsive to verbal commands. He was clearly very badly injured and went into cardiac arrest shortly after the arrival of the ambulance personnel.

[18] Scottish Fire and Rescue Service personnel attended and assisted the ambulance personnel with Mr Campbell's medical care. The entrance to the site was secured for the arrival of the Critical Care team and the Air Ambulance.

[19] The Critical Care team arrived at 2059 hours. Throughout their journey to the operating centre, they received regular updates on Mr Campbell's condition. On their arrival, medical interventions continued but to no avail. At 2113 hours Mr Campbell's life was pronounced extinct.

[20] Following an autopsy examination on 19 July 2024 a pathologist certified that Mr Campbell had died as a result of chest and pelvic injuries sustained when he was crushed beneath a lorry chassis.

[21] An investigation carried out by the Health and Safety Executive established that Mr Campbell had used a green two tonne strop and ratchet strap to lift the rear part of the chassis he was working on. The strop and ratchet strap were attached to the log grab of another vehicle and to the chassis and the log grab had been used to lift the chassis. The weight of the chassis was within the lifting capacity of the strop and of the log grab.

[22] The green strop was in less than perfect condition, however it was not possible to ascertain what damage occurred during the incident. The green strop had sheared through its full width. It was noted that the log grab being used to carry out the lift had a sharp edge due to wear caused by logs and this cut through the green strop, causing the chassis to fall. No axle stands or other means of supporting the chassis had been placed under it while it was raised.

[23] The Health and Safety Executive Inspectors confirm that good practice would be to place a stand below the axles of the chassis, or a tyre or wheel to cushion any fall. Use of a packing piece between the strop and the log grab would have reduced the likelihood of the strop being cut by the sharp edge on the log gab.

The evidence

[24] Ms Stewart intimated that all the evidence to be presented at the inquiry was contained within the notice to admit evidence, which she read out. The salient facts from the notice to admit evidence are noted above and the principal notice to admit evidence is lodged with the inquiry papers.

Crown submissions

[25] Ms Stewart very helpfully lodged written submissions on behalf of the Crown. She made formal submissions in relation to when and where Mr Campbell's death and the accident resulting in his death occurred, based on the evidence contained in the notice to admit evidence. Likewise, she made formal submissions in relation to the cause of Mr Campbell's death, in accordance with the findings of the pathologist at autopsy.

[26] Ms Stewart submitted that Section 26(2)(e) of the 2016 Act sets out a two-stage test. First, the inquiry requires to be satisfied on the evidence that there was a precaution which could reasonably have been taken. Secondly, the inquiry has to be satisfied, again on the evidence led, that if the precaution in question had been taken, then it might realistically have prevented the death. Unless both criteria are met, no finding should be made in terms of section 26(2)(e).

[27] The use of the word "reasonably" relates to the reasonableness of taking the precautions rather than the foreseeability of the death or accident. A precaution might realistically have prevented a death if there is a real or likely possibility, rather than a remote chance, that it might have done so.

[28] Ms Stewart submitted on behalf of the Crown that the accident which resulted in Mr Campbell's death were entirely unforeseeable. It is only with the benefit of hindsight, that it is possible to identify two precautions which could reasonably have been taken and had they been taken, Mr Campbell's death might realistically have been avoided.

[29] Firstly, the use of packing material placed between the log grab and the strop would have prevented the strop from being sheared through by the sharpened log grab, thereby preventing the chassis from falling and consequently avoiding Mr Campbell's death.

[30] Secondly, the use of an axle stand or tyres placed beneath the chassis to cushion against the fall would have prevented the chassis from crushing Mr Campbell when the strop that was holding it sheared through causing the chassis to fall, thereby avoiding the death of Mr Campbell.

[31] Ms Stewart made no submissions in relation to Sections 26(2)(f) and(g) of the 2016 Act.

[32] Ms Stewart went on to express, on behalf of the Crown, her condolences to Mr Campbell's family and friends.

Discussion and conclusions

[33] It is very clear from the evidence presented to the inquiry what happened which resulted in Mr Campbell's untimely death. All possible steps were taken to assist Mr Campbell after the incident occurred but sadly his injuries were un-survivable.

[34] I concur with the submissions made by Ms Stewart and I largely adopt the Crown submissions in relation to my findings under Section 26(2) of the 2016 Act, as set out above.

[35] In closing this Determination, may I join with Ms Stewart in expressing my condolences to the family and friends of Mr Campbell. His death is a tragedy which is no doubt still very keenly felt.