SHERIFFDOM OF OF GRAMPIAN HIGHLAND AND ISLANDS AT TAIN

[2026] FAI 9

TAI-B78-23

DETERMINATION

BY

SHERIFF NEIL WILSON

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

into the death of

KENNETH BEGG

Tain 25 February 2026

Determination

The Sheriff having considered the information presented at the inquiry, determines in terms of section 26 of the Act that:

1. In terms of section 26(2)(a) - Kenneth Begg, date of birth 9 August 1970, of 3 Invergordon Mains, Invergordon, died at 1150 hours on 15 April 2021, at Aberdeen Royal Infirmary.

2. In terms of section 26(2)(b) - The accident resulting in the death occurred at about 0706 hours on 15 April 2021 at Auchintoul Farm, Rosskeen, Invergordon.

3. In terms of section 26(2)(c) - The cause or causes of the death were:

- 1a: Multiple Injuries due to

- 1b: Incident at work
- 2: Cardiac Enlargement.

4. In terms of section 26(2)(d) - The immediate cause of the accident resulting in the death of Kenneth Begg was his failure to have the wand switch positioned between himself and the boring machine, this being the device designed to stop the machine if the operator approaches too close to the rotating boring bar. Had the wand switch been correctly positioned, such that it would have been activated by his approaching the boring bar, it would have stopped the machine and thus prevented him becoming entangled in the boring bar.

5. In terms of section 26(2)(e) -It would have been a reasonable precaution for Mr Begg to have correctly positioned the wand switch. Had he done so, this would realistically have prevented his death.

6. In terms of section 26(2)(f) – It was a defect in the safe system of working that the safety measures in place, and specifically the associated inspection regime, did not include:

a) a requirement to increase the frequency of safety checks if breaches of Rosskeen's safe systems of working were noted

b) a requirement that any and all breaches of the safe system of working noted by the external health and safety consultant be reported to Rosskeen's management.

7. In terms of section 26(2)(g) - There are no other factors which are relevant to the circumstances of the death.

Recommendations

8. There are no recommendations arising.

NOTE

Introduction

[1] This is a mandatory inquiry in terms of section 2(3) of the Inquiries into Fatal Accidents and Sudden Deaths etc (Scotland) Act 2016 because Mr Begg died as a result of an accident in the course of his employment.

[2] The Procurator Fiscal, who represents the public interest, issued notice of the inquiry on 19 October 2023.

[3] All Preliminary Hearings were held online.

[4] The matter first called by way of Preliminary Hearing on 8 December 2023, on which occasion Ms Eadie appeared for the Crown, Ms Mitchell for the First Participant (Rosskeen Engineering Limited) and Mr Cowie for the Second Participant (Emma Begg, daughter of the deceased). The matter was continued to an in person evidential hearing at Tain Sheriff Court on 27 and 28 February 2024.

[5] By Interlocutor of 22 February 2024, a further Preliminary Hearing was assigned for 23 February 2024. At that Hearing, on the unopposed motion of the Crown, the inquiry dates were discharged and a further Preliminary Hearing assigned to 12 April 2024 to allow investigation regarding the scope and potential for criminal proceedings

against the First Participant arising from the same circumstances as gave rise to this inquiry.

[6] The matter thereafter called by way of Preliminary Hearings on 12 April 2024, 12 July 2024 and 8 November 2024, and on each occasion, on the unopposed motion of the Crown, was continued to await the outcome of criminal proceedings against the First Participant.

[7] Further Preliminary Hearings on 31 January, 15 April, 5 June, 10 July and 4 November 2025 were all discharged administratively, without the necessity of the matter calling in court, again to await the outcome of criminal proceedings against the First Participant.

[8] On 19 November 2025, at Tain Sheriff Court, the criminal matter was brought to an end by way of the Rosskeen Engineering Limited pleading guilty, on summary complaint, to a contravention of section 2(1) and section 33(1) of the Health and Safety at Work etc Act 1974. The disposal was a fine of £12,000. Full details of the criminal case are contained in the resultant Sentencing Statement and are attached hereto in Appendix B.

[9] Thereafter, at a Preliminary Hearing on 4 December 2025, on the joint motion of Ms Adair for the Crown, Ms Mitchell for the First Participant and Mr Cowie for the Second Participant, the Fatal Accident Inquiry was allowed to be dealt with by way of Joint Minute, this Minute and any written submissions to be lodged by 19 January 2026 and a Hearing on Submissions was assigned to 26 January 2026.

[10] The Fatal Accident Inquiry was held, online, on 26 January 2026. All the evidence to be presented to the court was agreed by way of Joint Minute. In addition, the Court had the benefit of detailed written submissions from the Crown and Ms Mitchell for the First Participant. Mr Cowie for the Second Participant adopted the submissions by the Crown and the First Participant.

The legal framework

[11] The inquiry is held under section 1 of the Fatal Accidents and Sudden Deaths etc (Scotland) Act 2016 (the 2016 Act) and is governed by the Act of Sederunt (Fatal Accident Inquiry Rules) 2017 (the 2017 rules). The purpose of such an inquiry is set out in section 1(3) of the 2016 Act and is to; (a) establish the circumstances of the death, and; (b) consider what steps (if any) might be taken to prevent other deaths in similar circumstances.

[12] The Procurator Fiscal represents the public interest in a Fatal Accident Inquiry. An inquiry is an inquisitorial process, and it is not the purpose of an inquiry to establish either criminal or civil liability.

Summary

[13] The entirety of the evidence before the inquiry was agreed by way of Joint Minute. Rather than summarise this evidence, it is narrated in full below (paragraphs 1-36).

Background

1. Kenneth Begg, born 9 August 1970 of 3 Invergordon Mains, Invergordon was at the time of his death employed by Rosskeen Engineering as an engineering technician and was a trained turner mechanical fitter. He had been employed there since 20 July 2001. He was a widower with two adult daughters. One of Mr Begg's daughters saw Mr Begg a few weekends prior to 15 April 2021 and noted he was upset that his other daughter had cancer which was not able to be treated.

2. The accident leading to the death of Mr Begg involved the use of a horizontal boring machine.

3. A horizontal boring machine is a metal cutting machine used primarily for boring holes in or through varying dimensions and types of metal, referred to as the workpiece. While its exact age is unknown, it is suspected to pre-date the commencement of the Health and Safety at Work etc Act 1974. It is electrically powered.

4. The workpiece is clamped securely to the worktable while the cutting tool, referred to as a boring bar with a drill or cutting piece at its tip, rotates to undertake the cutting. The term "horizontal" refers to the plane in which the boring bar was mounted.

5. The use of the horizontal borer involves several hazards, including entanglement in its rotating parts.

6. Mr Begg, who had used the machine under its previous ownership, joined the company in 2005 at the same time that the previous company, including the borer, was purchased by Rosskeen Engineering Limited.

7. Within the company, Mr Begg was regarded as having the greatest expertise in its operation and was by far its most frequent user over the next two decades. He was regarded by his colleagues as an experienced, knowledgeable and conscientious worker, and very good at his job.

8. Mr Begg was significantly involved in the drafting of the risk assessment for the use of the machine and its subsequent revisions. Mr Begg provided all of the technical input. The risk assessment, together with a number of other safety measures, was revised in 2015 following an inspection by HSE.

9. One of the safety measures implemented after the HSE inspection in 2015 was a "wand-switch". This is an electronic trip probe which is to be positioned between the operator and the rotating stock bar of the borer when the machine is in use, mitigating against the risk of entanglement when close observation of a work piece is required.

10. The wand switch mitigates the extent of injury by quickly stopping the machine.

11. The wand switch must be correctly positioned to be effective; the risk assessment states that the wand switch should be positioned where the operator is working or standing. Consequently, if the operator approaches too close to the machine, the wand switch will be tripped and the machine brought to a stop within a small number of revolutions.

12. In addition to the wand switch, a moveable perimeter fence had been procured after the HSE inspection in 2015. This was portable and capable of being erected around the machine when it was in use. Its purpose was not to afford the operator any protection, but to keep other employees at a safe distance when the machine was in use.

It was also suggested to the company that they procure some external health and safety advice which they duly did. Weekly visits from an external health and safety consultant, Rosalind Jardine, started. Rosskeen Engineering Limited were very co-operative and keen to get things right in the future.

Events on 15 April 2021

13. Just after 0700 hours on 15 April 2021, Mr Begg started the horizontal boring machine to bore a hole through a metal workpiece known as a pad eye arrangement which was already in position on the worktable. This does not require close observation. His use of the machine was recorded by an internal CCTV camera covering the interior of the company's premises.

14. The following can be seen on CCTV:

- 07:03:00 Mr Begg enters camera view.
- 07:03:20 Mr Begg starts up the borer.
- 07:04:54 Mr Begg starts the cutting tool.
- 07:06:15 Mr Begg leans close to the rotating tool. He is not holding the control pendant.
- 07:06:16 Mr Begg's upper body starts to become entangled in the rotating tool.

15. Mr Begg had been noted by a colleague to be distracted during the week prior to the accident.

16. Mr Begg had not placed and extended the wand switch between himself and the rotating spindle before commencing work. At the time of the incident the wand switch was retracted.

17. Shortly after 0706 hours, Mr Begg leaned into the rotating spindle, causing his boiler suit to catch on the spindle. He was spun around the rotating spindle a number of times before the machine slowed and came to a stop.

18. Several members of staff immediately entered the area, where they attempted to isolate the machine, assist Mr Begg and contact emergency services.

19. Scottish Ambulance Service personnel attended and Mr Begg was noted to have sustained very severe injuries. He was transported by air ambulance to Aberdeen Royal Infirmary but shortly after arrival there, he suffered a cardiac arrest. He could not be revived and was pronounced dead at 1150 hours.

20. A post mortem examination was conducted by Drs Leighanne Deboys and Tamara McNamee on 19 April 2021 at the Aberdeen Mortuary.

21. Post mortem examination determined that Mr Begg died from multiple injuries including fractures to most of his ribs, both legs and left arm, together with a laceration and soft tissue damage to his left arm. The examination also identified that he had an enlarged heart, which would have contributed to his death.

22. Following post mortem examination, the cause of death was given as

- 1a: Multiple Injuries
- 1b: Incident at work
- 2: Cardiac Enlargement.

- Post-Accident Investigation

23. The HSE commenced an investigation following the accident.

24. It was found that in order for the wand switch to operate as an effective safeguard, a system of management ought to have been in place to ensure that the operator consistently and correctly used the wand switch when operating the machine.

25. Said system ought to include frequent checks by a supervisor when the machine is first used by an operator, to ensure the trip probe is correctly and consistently placed prior to using the machine. The frequency of said checks may be reduced once it is established that the operator is correctly using the trip probe, but should be increased if it becomes known that the operator has on any occasion not used the probe or has used it incorrectly.

26. Prior to the COVID pandemic, senior managers in the company undertook periodic safety checks and walkarounds. Monthly checks would look at whether the wand switch was working and positioned correctly.

27. Said checks were supplemented by the company's external health and safety consultant who visited on a weekly basis and carried out checks to ensure employees' compliance with the company's safe systems of work.

28. The weekly visits from the company's health and safety consultant ceased from the start of the said COVID pandemic until April 2021. During this time, senior managers continued with their periodic safety checks at the company's premises.

29. During the first visit by the health and safety consultant after work recommenced, she observed that the safety fence around the machine was not in situ. She discussed this with Mr Begg.

30. The same issue arose a week later on 14 April 2021 and at that time the health and safety consultant again raised the issue with a Director and Senior Foreman of the company as well as Mr Begg.

31. On one occasion after the resumption of visits, the health and safety consultant noted that the wand switch was not positioned correctly when Mr Begg was setting up with the machine in the off position. She reminded him about it, causing him to move it into the correct position.

32. None of Mr Begg's co-workers reported having seen him working without the wand switch in situ.

33. Following notification of the Directors about the issues with the fence, dialogue took place between the Directors and the health and safety consultant regarding the acquisition of alternate fencing such as extendable guards.

34. No further action was taken in relation to Mr Begg's positioning of the wand switch while setting up the machine.

Criminal proceedings

35. Rosskeen Engineering Limited pled guilty, on 19 November 2025 at Tain Sheriff Court, on summary complaint to a contravention of section 2(1) and section 33(1) of the Health and Safety at Work etc Act 1974.

Post-incident actions

36. Following the death of Kenneth Begg, Rosskeen Engineering Limited participated in extensive engagement with HSE inspectors from the local Inverness office as well as specialist inspectors from further afield, to arrive at a solution for the safe use of the machine in all situations.

[14] Subsequent to the Joint Minute of Agreement being lodged with the court, by email of 11 February 2025, parties were asked to clarify one issue, namely –

> "Paragraphs 29-34 of the Joint Minute of Agreement, state that on the resumption of external inspections post-pandemic in April 2021, issues with the safety fence were noted on two visits, the matter was raised with Rosskeen management on both occasions, and discussions thereafter took place with a view to addressing the problem. There is also reference to the consultant noting the wand switch not being correctly positioned (paragraph 31), but no further action being taken on this issue (paragraph 34). Was the issue of the wand switch not being properly positioned reported to Rosskeen management, and if so, when?"

[15] This query gave rise to a brief additional submission from those representing Rosskeen Engineering, namely –

> "The observation in relation to the wandswitch not being correctly positioned was made by Miss Jardine when Mr Begg was engaged in the set-up of the machine. It had not yet been turned on. Mr Begg then moved the wandswitch into position ready for when he started the machine. This interaction between Miss Jardine and Mr Begg was not reported to management as it was simply a reminder to position it before starting work. No-one, including Miss Jardine, reported ever seeing the machine being operated by Mr Begg without the wandswitch being in position. The fencing was raised with Mr Begg by Miss Jardine on 6 April 2021, and then again on 14 April when Miss Jardine also raised it with management. The accident occurred first thing in the morning of 15 April before management had the opportunity to speak with Mr Begg."

[16] Paragraph 35 of the Joint Minute refers to the criminal case in which the First Participant pled guilty. The complaint libelled that:

> "Between 23 March 2020 and 15 April 2021, both dates inclusive, at the premises occupied by you at Auchintoul Farm, Rosskeen, Invergordon, Ross-shire IV18 0PL you ROSSKEEN ENGINEERING LIMITED, a company incorporated under the Companies Act with registration number SCS281406 and whose registered office is at said Auchintoul Farm, being an employer within the meaning of aforementioned Act did fail to ensure the health, safety and welfare at work of your employees, in so far as was reasonable practicable, in that you did fail to implement and maintain a safe system of work for the use of a Horizontal Boring Machine, that was, so far as reasonably practicable, safe and without risks to health and safety in that you did fail to ensure that a trip probe intended to minimize the risk of injury through entanglement in the moving parts of said machine was properly positioned by the operator and in consequence thereof on 15 April 2021, your employee Kenneth Begg, care of Health and Safety Executive, Inverness, whilst using said Horizontal Boring Machine, came into contact with the rotating stock bar of said machine and his clothing became entangled in the moving parts of said machine whereby he was so severely injured that on 15 April 2021 he died at Aberdeen Royal Infirmary, Aberdeen;
>
> CONTRARY to Section 2(1) and Section 33(1)(a) of the Health and Safety at Work etc Act 1974"

[17] The Crown Narrative and plea in mitigation arising from the criminal prosecution are attached hereto as Appendix 1 and can be referred to for their terms.

[18] The Sentencing Statement arising from the criminal prosecution is attached hereto as Appendix 2 and can also be referred to for its terms.

Discussion and conclusions

[19] That the entirety of the evidence was agreed by Joint Minute was extremely helpful. Thereafter the Court had the benefit of written submissions from the Crown

and Rosskeen Engineering's legal representatives. Unsurprisingly, given the agreement of all factual matters, there was little dispute as to appropriate findings.

[20] Other than adopting these written submissions, Emma Begg's legal representative thanked the Crown for raising criminal proceedings against Rosskeen Engineering, indicating this had provided some measure of comfort to Mr Begg's family. He also acknowledged the traumatic effect Mr Begg's death would have had on his work colleagues, both those who witnessed the accident and its aftermath, and others who had known and worked alongside him for many years.

[21] Given the contents of the Joint Minute, the inevitable, and only possible, finding, in terms of section 26(2)(d), was that the immediate cause of the accident resulting in the death of Mr Begg was the failure, on his part, to place the wand switch between him and the machine.

[22] Therafter, as regards possible section 26(2)(e) findings, the court was invited by the Crown to conclude that it would have been reasonable to increase the frequency of safety checks following the instances of Mr Begg failing to erect safety fencing and correctly position the wand switch, and had this been done, his death may have been realistically avoided.

[23] For Rosskeen Engineering it was submitted that, Mr Begg being an extremely experienced operator of the boring machine who had been involved, in 2015, in devising the risk assessment and safe system of working for the borer, it would have been a reasonable precaution for Mr Begg to have correctly positioned the wand switch. Had he done so his death might have been realistically avoided.

[24] Of these two submissions, the latter was preferred as a section 26(2)(e) Finding. The issue raised by the Crown, namely failings in the system of safety regime checks, will be addressed in considering possible section 26(2)(f) Findings.

[25] The Crown and those representing Rosskeen Engineering were in agreement on the safety measures in place for the use of the boring machine, namely -

a) That a risk assessment carried out in 2015 resulted in a safe system of working for the boring machine which included a requirement that the wand switch be placed between the rotating stock bar and the operator when the machine was running.

b) That the risk assessment and system of working was regularly reviewed and updated.

c) That Mr Begg, being a very experienced operator of the boring machine, was actively involved in these assesssments and reviews.

d) That, prior to the COVID pandemic, senior managers undertook periodic safety checks, which would include monthly checks to ensure the wand switch was correctly positioned and working.

e) That these inhouse checks were augmented by a weekly check by an external health and safety consultant whose inspections included confirming that employees were complying with the company's safe systems of work. Whilst it is not explicitly agreed in the Joint Minute, it can be fairly assumed that these inspections included checking the positioning of the wand switch.

f) That the external checks stopped at the start of the COVID pandemic, and resumed in early April 2021.

[26] Representatives for Rosskeen made the point that the level of external inspection was unusual for a relatively small company, and was indicative of taking health and safety seriously.

[27] The external inspection regime was introduced in 2015, following an inspection by the Health and Safety Executive. This inspection also led to the introduction of the use the wand switch and a perimeter fence. The latter feature was designed not protect the operator of the machine, but to keep other employees at a safe distance when the machine was in use. (Joint Minute, paragraph 12)

[28] As narrated in paragraphs 29 -34 of the Joint Minute, the external consultant noted, in the course of two visits approximately a week apart in early April 2021, that the safety fence was not in place around the boring machine. On the first of these visits, the consultant discussed this with Mr Begg, and the issue was raised with a Director of Rosskeen Engineering and the senior foreman.

[29] The same issue having been noted on the second visit, the consultant again raised it with senior figures at Rosskeen Engineering, as well as again discussing it with Mr Begg. This gave rise to discussions between the Directors and the consultant regarding alternative fencing.

[30] However, this issue having been raised with Rosskeen management by the external consultant, no enhanced safety inspection regime was introduced in the form of more frequent safety checks, and there was no evidence of senior management

discussing the issue of the safety fence with Mr Begg. This observation comes with the caveat that the issues with the safety fence arose only a few days before the fatal accident, and accordingly there was little time for Rosskeen management to react.

[31] As already narrated, the safety fence was not designed to protect the operator of the boring machine. There is no evidence as to whether or not it was correctly positioned at the time of the accident. It is not disputed that, if it was correctly positioned, it would not have prevented the accident. However, the issue of the safety fence having been raised with Rosskeen management it is of significance that there is no evidence of either an enhanced inspection regime being introduced immediately or of the matter being discussed with Mr Begg.

[32] Of more significance is that Mr Begg had previously been observed, by the external health and safety consultant, to have failed to correctly position the wand switch. This was not whilst the machine was running, but during the stage of setting it up. This was brought to the attention of Mr Begg by the consultant, and he rectified his error. Whilst it is not clear when this occurred, given that the external consultant had only resumed her post-pandemic visits to Rosskeen Engineering in the two weeks leading up to the accident resulting in Mr Begg's death, it can be safely assumed it was shortly before the accident.

[33] To summarize, it was a matter of agreement that the appropriate risk assessment and resultant safe systems of work were in place for the use of the boring machine, and were regularly revised and updated.

[34] It was also a matter of agreement that Rosskeen Engineering had in place a system of regular safety inspections, comprising regular checks carried out by Rosskeen management, and augmented by weekly inspections by an external consultant.

[35] However, what was not present in the safe system of working were requirements that any breaches would give rise to more frequent safety checks. This is illustrated by Rosskeen management's reaction to the issue with the safety fence, namely that discussions took place regarding alternate fencing, but the safety breach did not give rise to any increase in the frequency of safety inspections. Whilst, as already narrated, it is accepted that the safety fence was not designed to protect the operator of the borer, an immediate reaction in the form of an enhanced inspection regime would have served to remind Mr Begg of the general importance of complying with safety measures.

[36] Also absent was evidence of a clear requirement that any safety issues noted by the external consultant, in addition to being pointed out to the person responsible for immediate resolution, should be reported to Rosskeen management. The observed failure by Mr Begg to properly position the switch wand was not reported to the management of Rosskeen Engineering. Had it been, and had it thereafter triggered a system of more frequent supervisory checks, this may have emphasized to Mr Begg the importance of correctly positioning the wand switch. This in turn may have prevented his death.

[37] This gives rise to the section 26(2)(f) finding narrated above, in essence that the system of working was insufficiently rigorous in reporting breaches of compliance, and insufficiently flexible in reacting to any reported breaches.

[38] Given the terms of the section 26(2)(f) findings, there are no other factors which are relevant to the circumstances of the death, and accordingly there are no Section 26(2)(g) findings.

[39] The recommendations arising from the Health and Safety Executive investigation, as narrated in paragraphs 24 & 25 of the Joint Minute, essentially mirror the section 26(2)(f) findings narrated above.

[40] The reassurances offered to the Court that, subsequent to the accident giving rise to this inquiry, appropriate steps were taken by Rosskeen Engineering Limited, in consultation with the Health and Safety Executive, to address the failings present in the system of working which contributed to the death of Kenneth Begg, (Joint Minute paragraph 36) are found to be sufficient that it is not necessary to make any recommendations.

Observations

[41] A few weeks before the accident, Mr Begg had been noted to be upset due to a close family member's health difficulties, and further in the week leading up to the accident he was noted by a colleague to be distracted. (Joint Minute, paragraphs 1 & 15 respectively)

[42] These matters are referred to, in passing, by the Crown in submissions regarding possible section 26(2)(e) precautions.

[43] Submissions for Rosskeen Engineering, regarding possible section 26(2)(f) factors, also referenced Mr Begg's apparent mental state at the time of the accident, but

go on to state that speculation as to whether this contributed to the accident would be inappropriate.

[44] I am firmly of the view that any speculation Mr Begg's apparent mental state at the time of the accident would be entirely inappropriate, and accordingly will not form part of any finding.

[45] Whilst the notice of the inquiry was issued on 19 October 2023, the accident giving rise to this inquiry happened in April 2021, and it is only now, almost 5 years later, that this matter has come to a conclusion. Given this apparent delay, I should make it plain that I attach no blame to any party for the passage of time from the issuing of the notice in October 2023 to the inquiry being held in January 2026.

[46] The related criminal case required to be resolved prior to the inquiry, and it is of note that, once the criminal case was brought to court, Rosskeen Engineering pled guilty immediately.

[47] Thereafter the subsequent inquiry was dealt with expeditiously by way of Joint Minute. I would wish to thank the legal representative of the various participants for doing so. This avoided the necessity of leading evidence in court, a process which may well have caused further unnecessary trauma to Mr Begg's family.

[48] I would wish to conjoin in the sentiments expressed by the representative of Mr Begg's daughter (paragraph 20) and acknowledge the traumatic effect Mr Begg's death would have had on his work colleagues, both those who witnessed the accident and its aftermath, and others who had known and worked alongside him for many years.

[49] Finally, and most importantly, I would wish to express my condolences to Kenneth Begg's family and friends, in particular his two adult daughters. I would hope that both the criminal case and this inquiry now being concluded provides some measure of solace and closure.

Appendices

- Appendix 1 (Crown narrative and plea in mitigation from the Joint Minute); and
- Appendix 2 (Sentencing Statement)

Rosskeen Engineering Ltd HS22000008

Crown Narrative

Overview

This case relates to an incident that occurred on 15 April 2021, in which Kenneth Begg died as a result of becoming entangled in a horizontal boring machine that he was operating at the time.

The incident took place at Mr Begg's place of employment, Rosskeen Engineering Limited, Auchintoul Farm, Rosskeen, Invergordon, Ross-Shire.

History of the Accused

Rosskeen Engineering Ltd (the company) is a general engineering company undertaking machining and fabrication. The company has 26 employees. Its premises, and the registered office of the company are as set out on the instance of the complaint.

The last three years' accounts have been provided to the Court by the defence.

At the time of the incident there were two directors, namely David Wood and Anne Wood.

The company has no previous convictions.

The Deceased

Kenneth Begg was 50 years old when he died. He was a widower and was survived by his adult daughters, aged 23 and 26 when he died.

He was employed as an Engineering Technician with the company, having commenced employment there in 2001. He was a time-served turner and mechanical fitter.

The Horizontal Boring Machine

A horizontal boring machine is a metal cutting machine used primarily for boring holes in or through varying dimensions and types of metal, referred to as the workpiece. While its exact age is unknown, it is suspected to pre-date the commencement of the 1974 Act. It is electrically powered.

The workpiece is clamped securely to the worktable while the cutting tool, referred to as a boring bar with a drill or cutting piece at its tip, rotates to undertake the cutting. The term 'horizontal' refers to the plane in which the boring bar was mounted. The image below shows the incident machine in operation on a horizontal plane.

The use of the horizontal borer involves several hazards, including entanglement in its rotating parts.

When the company purchased the machine from its previous owner, Mr Begg, who had used it under its previous ownership, effectively accompanied the machine and joined the company at the same time it was purchased.

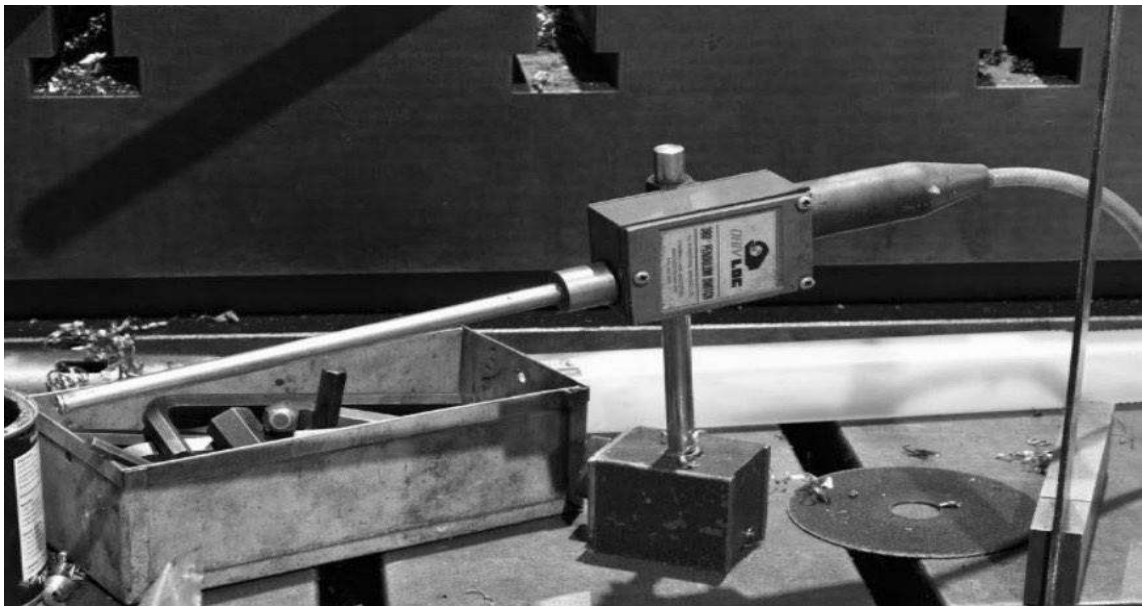
Within the company, Mr Begg was regarded as having the greatest expertise in its operation, and was one its most frequent, if not indeed the most frequent user of it over the next two decades.

He had had a significant involvement in the drafting of both the risk assessment and method statement for its use. These, together with a number of other safety measures were revised in 2015 following an inspection by HSE.

One of these safety measures was a "wand-switch", a simple electronic trip probe which is positioned between the operator and the rotating stock bar of the borer when the machine is in use and which mitigates against the risk of entanglement when close observation of a work piece is required.

The wand switch is not intended to prevent the operator coming into contact with the dangerous rotating parts, but it mitigates the extent of injury by quickly stopping the machine. The wand switch must be correctly positioned to be effective; the risk assessment states that wand switch should be positioned between the operator and the rotating spindle. This is so that if the operator approaches too close to the machine, the wand switch will be tripped and the machine brought to a stop within a very few revolutions.

The image below shows the wand switch that was employed in relation to the horizontal boring machine, albeit the image does not show the wand switch in situ.



In addition to the wand switch, a moveable perimeter fence had also been procured after the HSE inspection in 2015. This was portable and able to be erected around the machine when it was in use. Its purpose was not to afford the operator any protection but keep other employees at a safe distance when it was in use.

Narrative of Events

Just after 07:00 hours on n 15 April 2021, Mr Begg was using the horizontal boring machine to bore a hole through a metal workpiece known as a pad eye arrangement. His use of the machine was recorded by an internal CCTV camera covering the interior of the company's premises.

For unknown reasons, Mr Begg did not place the wand switch between himself and the rotating spindle before commencing work. He leaned into the rotating spindle, causing his boiler suit to catch on the spindle. He was spun around the rotating spindle a number of times before the machine slowed and came to a stop.

Several members of staff immediately entered the area, where they attempted to isolate the machine, assist Mr Begg and contact emergency services.

Scottish Ambulance Service personnel attended and Mr Begg was noted to have sustained very severe injuries. He was transported by air ambulance to Aberdeen Royal Infirmary but shortly after arrival there, he suffered a cardiac arrest. He could not be revived and was pronounced dead at 1150 hours.

Pathology

A post-mortem examination was carried out on 19 April 2021 at Aberdeen.

It determined that Mr Begg died from multiple injuries including fractures to most of his ribs, both legs and left arm, together with a laceration and soft tissue damage to his left arm. The examination also identified that he had an enlarged heart, which would have contributed to his death.

Cause of Death

Following post mortem examination, the cause of death was given as

1a. Multiple injuries

1b. Due to an incident at work

2. Cardiac Enlargement

Failings by the Accused

For the wand switch to be considered an effective safeguard, HSE concluded that a system of management ought to have been in place to ensure that the operator consistently and correctly used the wand switch when operating the machine. According to such a system, when the machine was first used by an operator, frequent checks would be carried out by a supervisor to ensure the trip probe was correctly placed prior to using the machine. Once it was established that the operator was consistently using the trip probe, the frequency of the checks could reduce. By the same token, if it was known that the operator had on occasion not used the probe, the frequency of checks would then require to increase for a period.

Prior to the COVID pandemic, senior managers in the company undertook periodic safety checks and walkarounds which were supplemented by the company's external health and safety consultant who visited on a weekly basis and carried out checks to ensure employees' compliance with the company's safe systems of work.

The weekly visits from the company's health and safety consultant ceased from the start of the pandemic until April 2021. During this time, senior managers continued with their periodic safety checks at the company's premises.

During the health and safety consultant's first visit after work had resumed, the health and safety consultant observed that the safety fence around the machine was not in situ and this was raised with the Directors of the company. She also had occasion to speak to Mr Begg about the same issue a week later and again raised the issue with the Directors of the company. On one occasion, she noted that the wand switch was not positioned correctly when Mr Begg was setting up

with the machine in the off position. At that time she reminded him about it, causing him to move it into the correct position. None of Mr Begg's co-workers reported having seen him working without the wand switch in situ.

Following the notification of the Directors about the issues with the fence, there followed a discussion about procuring alternate fencing such as extendable guards.

When it was observed at this time that Mr Begg was not always complying with the erection of the fencing and positioning of the wand switch, more frequent checks should have been instigated to ensure his compliance with safety regimes, but this did not occur.

Mitigating and Aggravating Factors

In the aftermath of this tragic incident, the company has had lengthy engagement with HSE inspectors from the local Inverness office as well as specialist inspectors from further afield, to arrive at a solution for the safe use of the machine in all situations.

It is acknowledged by the Crown that a considerable sum of money has been spent by the company in doing so.

The company has fully co-operated with HSE throughout the investigation and as stated, continue to do so in its endeavours to arrive at the most effective system of work for the machine's continuing safe use.

No aggravating factors have been identified.

Resolution

This case has a long and complex procedural history. In summary, the company was formally placed on notice of criminal proceedings in late 2024, at which time discussions between the company and HSE regarding the safe use of the machine were ongoing. Following extensive and co-operative discussions between the Crown, the defence and HSE, agreement was reached on the complaint that is before the Court in September 2025. Whilst this may appear to the Court to be a

lengthy period, the Crown would respectfully advise the Court that this was principally due to the complex nature of the case, and the requirement to engage in tripartite discussions to address several matters and arrive at a mutually acceptable resolution. In particular, no delay was occasioned by any actions of the company.

IN THE SHERIFFDOM OF GRAMPIAN, HIGHLAND & ISLANDS
AT TAIN

SUBMISSIONS BY COUNSEL

for

ROSSKEEN ENGINEERING LIMITED

in causa

PROCURATOR FISCAL v ROSSKEEN ENGINEERING LIMITED

PLEA IN MITIGATION

1. Company Information
2. Circumstances of the Offence
3. Sentence

1. COMPANY INFORMATION

1.1 ROSSKEEN ENGINEERING Limited (hereinafter "Rosskeen" or "the company"), is a small engineering firm providing precision machining, fabrication and welding services to a range of clients, notably in the offshore and energy sector. The company was incorporated following following a management buyout by the present Director in 2005 but the business was established over 40 years ago. The company has a wide range of specialist plant and machinery from the very traditional to state of the art CNC machines.

1.2 Presently the company has 20 employees, of whom a number are long-standing and highly experienced engineers, of whom Mr Begg was one. One employee has 44 years' unbroken service with the business. Rosskeen provides valuable, skilled, well-paid employment and two apprentices completed their training with the company in 2024. Working to high standards of precision and quality, Rosskeen is accredited to the internationally recognised and independently audited ISO9001 standard for quality management systems.

1.3 The company has no previous convictions and more generally, and importantly, the court is invited to accept that the company has a responsible attitude to health and safety; and a good safety record. Details of the financial position of the company are dealt with below, under reference to the accounts.

2. CIRCUMSTANCES OF THE OFFENCE

2.1 Reference is made to the agreed Crown Narrative, which clearly and fairly sets out the relevant facts and circumstances. By its guilty plea, the company accepts that it breached its non-delegable duties owed under section 2 of the Health and Safety at Work Act 1974 and nothing said in mitigation is intended to detract from that.

2.2 It is important to acknowledge at the outset that the accident and Mr Begg's loss has had, and will continue to have, a profound impact on those involved. The Court will understand that the employees at Rosskeen – including the Director who works daily, on the premises, in very much a "hands on" role – are a small and close-knit team who have been badly affected by this tragedy, compounded by the inexplicable nature of the accident for an operator as experienced as Mr Begg.

2.3 Turing to the court's consideration of the breach here, firstly, the court will note that a number of safety measures were in place for use of the horizontal borer,

including the perimeter fencing and the trip probe or "wand switch," developed for use by the company. This bespoke measure was devised and implemented by Rosskeen, in consultation with Mr Begg as the most experienced operator of the borer. It effectively operated as a moveable guard, capable of being extended and positioned on its magnetic base in the correct position given highly variable nature of the work being undertaken using the borer. At the time of the machine's manufacture such safety features were unthought of and Rosskeen have been proactive and innovative in their approach to applying modern safety standards to the machine. Consultation with the independent industry body suggests Rosskeen are leaders in their approach to safe operation of the machine.

2.4 Secondly, whilst it is regrettable that there was a lapse in checking of placement of the trip probe, there can be no doubt that Mr Begg knew that it ought to have been positioned, having been involved in its development and the risk assessment and safe system of work devised in 2015; and operated safely and successfully since that time.

2.5 Lastly, and consistent with all that has been said already, the court is invited to accept that the company responded appropriately and responsibly to this accident. Rosskeen cooperated fully in the investigation by the authorities. In addition, the company carried out a thorough internal investigation. Lessons have been learned, and further – and continuing – improvements in safety made, consistent with the company's pro-active approach to safety. The total cost of work done in response to this accident and investigation is signficant. The court is invited to accept that the company takes the health and safety of its employees very seriously and sincerely regrets this breach.

3. SENTENCE

3.1 Reference is made to the line of authority on sentencing in such cases in Scotland. The court's attention has been drawn to the Definitive Guideline produced by the Sentencing Council (*Health and Safety Offences, Corporate Manslaughter & Food Safety & Hygiene Offences*) in 2016, which were the subject of consideration in the case of *Scottish Power Generation Ltd v HM Advocate*, 2017 JC 85. In *Scottish Power*, the court first set out the general approach to the application of English Guidelines in Scotland, under particular reference to the case of *Geddes v HM Advocate* (2015 SLT 415 at para. [18]):

> "It is important to observe that, while the court has encouraged judges to "have regard" to the English guideline in death by dangerous driving cases, it has not been said that it should be interpreted and applied in a mechanistic way" […] In order to achieve a degree of consistency in this jurisdiction, albeit paying due regard to local circumstances, it may be equally important to have regard to existing precedent […]
>
> There is no reason to depart from that approach in this case. However, although with many types of offence, sentencing decisions will be "instantaneous, if not quite instinctive… once the material is ingathered and understood (*Ferguson v HM Advocate*, 2014 SCCR 244, *per* LJC (Carloway) at para. [103] citing *Gemmell v HM Advocate*, 2012 JC 223, *per* LJC (Gill) at para. [59], guidelines from the Sentencing Council will often provide a useful cross check, especially where the offences are regulated by a UK statute (*Sutherland v HM Advocate*, 2016 SLT 93 *per* LJC (Carloway) at para. [20])"
>
> (*Scottish Power, ibid., per* Lord Justice General (Carloway) at para. [35]) (emphasis added).

3.2 Further, it is important to bear in mind that the Court has repeated and consistently warned against the dangers of applying English guidelines too rigidly, particularly having regard to the "different sentencing regime" in Scotland (*Milligan v HM Advocate*, 2015 SCL 984; [2015] HCJAC 84 at para. [5]) (emphasis added). Whilst *Scottish Power* is authority for the proposition that English Guidelines may provide a useful cross-check where offences are regulated by a UK statute, equally, the court has made plain that they should not be applied "in a rigid or mechanistic fashion, given the differences in sentencing purposes, practices and regimes between the two jurisdictions" (*Sutherland v HM Advocate*, 2016 SLT 93 at para. [20]) (emphasis added).

3.3 It is submitted, therefore, that the relevant starting point is the line of domestic authority considered by the court in *Scottish Power*, and that thereafter regard should be had to the Guideline as a cross check. The relevant factors to be taken into account are, it is submitted, are most clearly set out in *Scottish Sea Farms*, in which case the court sought to summarise the authoritative guidance, expressing the relevant principles in the following list (*Scottish Seafarms Ltd & Logan Inglis Ltd v HM Advocate*, 2012 SLT 299, *per* Lady Dorrian at paragraphs [18] and [19], under reference to which the following submissions are made:

(a) where death occurs as a consequence of the breach, that is an aggravating feature, multiple deaths being viewed even more seriously than single deaths.

This aggravation applies and no attempt is made to minimise the tragic consequences of this accident.

(b) a breach with a view to profit is a serious aggravation.

The court is invited to accept that this aggravation does not apply. No financial gain was made, nor intended to be made. The breach was not deliberate or calculated, but rather occurred by omission.

(c) the degree of risk and extent of the danger and in particular whether this was an isolated incident or one continued over a period.

In this case it is accepted that the company fell short of the required standard. However, the risk was restricted to a very small number of trained and highly skilled operators (chiefly Mr Begg), who well understood the nature of the danger; and falls to be considered in the context of the safety measures put in place by the Company.

(d) Mitigation will include (1) a prompt admission of responsibility; (2) steps taken to remedy deficiencies; and (3) a good safety record

It is submitted: (1) that the plea has been tendered by agreement at the earliest *practicable* opportunity to do so. The investigation of this accident took some time – complicated by co-existent Fatal Accident Inquiry proceedings – and there has been further delay in bringing this case to court, none of which is attributable to the company. Under reference to section 196, and to the cases, *inter alia*, of *Du Plooy*, *Spence* and *Gemmell*, the court is invited to regard the plea as one carrying considerable utilitarian value; (2) the company has taken effective steps to remedy the deficiency here; and (3) the court is invited to accept that the company has a responsible attitude to health and safety and no previous convictions.

(e) […]

In relation to the company's means and the effect of a fine on the company, reference is made to the accounts and to the submissions made below.

3.4 Insofar as the court may wish to have regard to the Sentencing Guideline as a cross check on the sentence arrived at, it is submitted that the court might reasonably consider culpability to be "medium" (Guideline at page 4), having regard to the definitions in the Guideline. Such "categorisation," however, requires to be treated by the sentencing court with care and discretion having regard to the requirement not to apply such guidelines mechanistically. Bearing in mind the same consideration, it is submitted that the harm category ought to be assessed as being at "category 3," having regard to a proper assessment of the low likelihood of it arising. Such an assessment produces a suggested starting point of **£14,000**, for a "micro organisation," that figure to be further adjusted in accordance with other relevant factors.

Financial information

3.5 The court in *Munro* echoes what is said in *Howe* and makes clear that the accused company (or other business entity) must "place before the court sufficiently detailed information about its financial position to enable the court to see the complete picture without having to resort to speculation" (*Munro*, *ibid. per* Lord Nimmo Smith at 275 F [para 30]).

3.6 Accounts for Rosskeen for the year ended 2024 are produced. The court's attention is drawn to page 3 of the Accounts, where the turnover figure is shown, together with profit and loss figures. In all the circumstances of this particular case, the court is invited to impose a relatively modest penalty, which is no greater than the interests of justice demand.

SUBMISSIONS BY COUNSEL

for

ROSSKEEN ENGINEERING LIMITED

in causa

PROCURATOR FISCAL v
ROSSKEEN ENGINEERING LIMITED

12 November 2025

CLYDE & CO. LLP
Aberdeen
Ref. Q0001.00611

Procurator Fiscal Tain v Rosskeen Engineering Ltd

Sentencing Statement

It is appropriate to start by extending the court's deepest sympathies to the deceased Kenneth Begg's family, in particular his two daughters. I can only hope that the conclusion of this court case may provide them with some small measure of solace and closure.

It is also appropriate to acknowledge the profound and ongoing effect Mr Begg's death has undoubtedly had on his colleagues, particularly those who were present at the time of the accident.

Rosskeen Engineering Ltd, a company, has pled guilty, on summary complaint, to a single charge libelling that –

(1) Between 23 March 2020 and 15 April 2021, both dates inclusive, at the premises occupied by you at Auchintoul Farm, Rosskeen, Invergordon, Ross-shire, IV18 0PL, you ROSSKEEN ENGINEERING LIMITED, a company incorporated under the Companies Act with registration number SCSC281406 and whose registered office is at said Auchintoul Farm, being an employer within the meaning of the aforementioned Act did fail to ensure the health, safety and welfare at work of your employees, so far as was reasonably practicable, in that you did fail to implement and maintain a safe system of work for the use of a Horizontal Boring Machine, that was, so far as was reasonably practicable, safe and without risks to health and safety in that you did fail to ensure that a trip probe intended to minimise the risk of injury through entanglement in the moving parts of said machine was properly positioned by the operator and in consequence thereof on 15 April 2021, your employee Kenneth Begg, care of the Health and Safety Executive, Inverness, while using said Horizontal Boring Machine, came into contact with the rotating stock bar of said machine and his clothing and body became entangled in the moving parts of said machine whereby he was so severely injured that on 15 April 2021 he died at Aberdeen Royal Infirmary, Aberdeen,:
CONTRARY to Section 2(1) and Section 33(1)(a) of the Health and Safety at Work etc. Act 1974.

In deciding on the appropriate disposal, I had the benefit of helpful written and oral submissions from both the Crown and defence. I also referred myself to both the Scottish

Sentencing Council's general framework regarding the sentencing process, and the more detailed advice contained within the (England and Wales) Sentencing Council's Definitive Guideline for Health and Safety offences. With regard to the latter source, I have been urged by Senior Counsel for Rosskeen not to apply these guidelines in an overly mechanistic fashion. This is the accepted approach in Scottish Courts, and indeed Counsel have referred me to case law in support of this submission. Nonetheless I found the Sentencing Council's approach in considering Health and Safety offences helpful.

Kenneth Begg was, at the time of his death, 50 years old, and a widower with two adult daughters. He was a time-served turner and mechanical fitter and had been employed by Rosskeen Engineering as an Engineering Technician since 2001. He was regarded as being very experienced in the use of the Horizontal Boring Machine with which this case is concerned, and indeed had a significant role in drafting the risk assessment and method statement for its use.

Amongst the safety features introduced to mitigate the risks of operating the machine was what was described as a "wand switch", essentially an electronic trip probe which, when placed between the operator and the borer, would stop the machine if the operator came too close to the dangerous rotating parts. Crucially, this wand switch was not fixed in situ; it could be actively moved in and out of position by the machine operator.

A further safety feature was the installation of a moveable perimeter fence around the machine. On the basis of the facts as narrated by the Crown, I regarded this element as less important, as this feature appeared to be designed not to protect the operator of the machine, but to prevent others present from straying too close.

Just after 7am on 15th April 2021, Mr Begg was using the Horizontal Boring Machine. He had not placed the wand switch between himself and the rotating part of the machine, and in leaning into the rotating spindle his boiler suit became entangled in the machine and he was spun around several times. I do not think it appropriate to narrate the details of the multiple, very severe injuries Mr Begg sustained; suffice to say that following his being transferred by air ambulance to Aberdeen Royal Infirmary he was pronounced dead at 1150am on the same day.

The Crown's position, as agreed by the defence, was that Rosskeen Engineering's failings lay in not having in place an adequate system of supervision to ensure that, at all times when the Horizontal Boring Machine was being operated, the wand switch was properly positioned between operator and machine. More specifically, such a system would involve frequent checks by a supervisor, the frequency of these checks to be increased if non-compliance was noted, and decreased if consistent compliance was observed.

Prior to the COVID pandemic, the supervision regime consisted of periodic checks by the company's senior managers, supplemented by weekly checks by an external health and safety consultant.

The latter element of the supervision regime was suspended at the start of the pandemic, and upon its resumption in April 2021, some compliance concerns were raised. The external consultant noted the safety fence around the machine to be absent, and this was raised with the Directors. This same issue was again noted a week later, pointed out to Mr Begg, and once again raised with the Directors.

More pertinently, the external consultant observed Mr Begg setting up the boring machine without the wand switch positioned correctly; this only being rectified when she pointed this out to him.

In essence, it was the Crown's position, as laid out in the narrative agreed with the defence, that when Rosskeen Engineering became aware of Mr Begg not always complying with the safety regime, more frequent checks should have been introduced to monitor his use of the Horizontal Boring Machine, but this was not done.

Senior Counsel for Rosskeen Engineering, in addressing the court in mitigation, described the company as a small engineering firm, established more than 40 years ago, providing precision machining, fabrication and welding services to clients, mostly in the offshore and energy sectors. The court was also told that the company had a reputation for working to high standards and quality, and provided well-paid employment to 20 employees, some of whom are highly experienced engineers.

More particularly, it was stressed that the company had no previous convictions, and has a responsible attitude to safety in the workplace. I had no reason to doubt these submissions.

Notwithstanding the above submissions, Senior Counsel for Rosskeen Engineering accepted that the company was in breach of the duties owed under Section 2 of the Health and Safety at Work Act 1974. However, it was pointed out that safety measures were in place, and indeed that the wand switch which formed an integral part of these measures was developed by the company, with input from Mr Begg. It was further submitted that Rosskeen are leaders in the safe operation of the Horizontal Boring Machine.

However, it was plain from the Crown Narrative that the safety regime was not properly adhered to or monitored. Senior Counsel for the company has pointed out that Mr Begg knew where the wand switch should properly have been placed. That is undoubtedly true, but does not relieve Rosskeen of their duty to ensure that their safety regime is properly implemented.

It was also submitted by Senior Counsel for Rosskeen Engineering that the company had responded appropriately and responsibly to the accident. Given that the Crown Narrative made reference to the company co-operating fully with the Health and Safety Executive in the resultant investigation, and devoting considerable time and money to developing improved safety measures for the use of the Horizontal Boring Machine, I had no difficulty accepting this submission.

In deciding on the final disposal, I settled upon an approach of using the first four steps of the Sentencing Council guidelines as a framework, and thereafter applied the appropriate reduction to the resultant figure in light of the timing of the plea.

I started by determining the offence category as being Medium, in that Rosskeen Engineering had systems in place but these were not sufficiently adhered to or implemented.

As regards the seriousness of harm, given that the offence involved the death of an employee, Level A can be the only appropriate category.

I was not persuaded by Senior Counsel for the defence's submission that there was a low likelihood of harm. Given the terms of the Crown Narrative, in particular the obvious apparent dangers of working in close proximity to moving machinery in the absence of an appropriate safety measure, i.e. the wand switch, I concluded that there was a medium likelihood of harm.

Applying the seriousness and likelihood of harm factors, as detailed above, gave a provisional Harm Category of 2.

Thereafter, in assessing the final harm category, I did not find the offence aggravated by a number of workers or members of the public exposed to risk of harm. Whilst I did find that the offence was a significant cause of the actual harm, I did not regard this as sufficient to change the harm category. Therefore I found the final Harm Category to be 2.

Rosskeen Engineering is plainly, in terms of the guidelines, a micro organisation. Given that I settled upon a harm category of 2, this gave a starting point of £30,000, within a range of £14,000- £70,000. Given the particular circumstances of the accident as outlined in the Crown Narrative, I saw no reason to adjust this figure of £30,000 either upwards or downwards.

However, given that this matter is being prosecuted at summary level, I am constrained to start the sentencing process with a figure of £20,000, and accordingly will do so.

Thereafter, given the company's lack of previous convictions, the evidence of steps taken to voluntarily remedy the problem and the level of co-operation with the Health and Safety Executive investigation I felt able to adjust the figure to one of £18,000. At this stage I did not taken into account the company's acceptance of responsibility by way of a guilty plea.

In assessing whether the fine was proportionate to the overall means of the company, notwithstanding the low level of profit in recent years, I noted the consistent figure for turnover to be in the region of £1.5 million. Accordingly no adjustment fell to be made to take into the company's financial situation.

In addition, I found that this level of fine should not adversely affect the company in making restitution to the family of Mr Begg or improving conditions to comply with the law, and there will be no significant impact on staff, customers or other third parties.

I noted from the Crown Narrative that it is a matter of agreement that Rosskeen Engineering has invested a considerable sum of money addressing the failings revealed by this accident. However, this factor has already been taken into account in adjusting the starting figure, and accordingly no further adjustment was necessary or appropriate at this stage.

Finally, it is a matter of concession by the Crown that, notwithstanding the considerable passage of time between the accident and this matter being brought to court, none of this delay was caused by the actions of Rosskeen Engineering. Therefore I will treat the plea as being tendered at the earliest possible opportunity, and accordingly the fine will be reduced by one third, giving a final figure of £12,000.