

SHERIFFDOM OF GRAMPIAN, HIGHLAND AND ISLANDS AT DINGWALL

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

DETERMINATION

By

SHERIFF ALASDAIR LORNE

MACFADYEN

IN

FATAL ACCIDENT INQUIRY

INTO THE DEATH OF

GORDON STEWART LENNON

DINGWALL, 20th February

2012

The sheriff, having resumed consideration of the Fatal Accident Inquiry into the death of Gordon Stewart Lennon, born 15 February 1983, Determines in terms of the Fatal Accidents and Sudden Deaths Inquiry (Scotland) Act 1976 as follows:-

In terms of section 6 (1) (a)

Gordon Stewart Lennon, born 15 February 1983, of 15 Linside Avenue, Paisley, Renfrewshire, died at about 1630 hours on 7 June 2009 at Brahan Estate, Maryburgh, Ross-shire.

In terms of section 6(1) (b)

The cause of death was electrocution. The cause of the accident was that the vehicle, a Mercedes-Benz G-Wagon 230 GE 4 wheel drive motor vehicle, driven by Fraser Hughes, in which the deceased was a passenger, was travelling too fast for the conditions on a track within a wood in Brahan Estate aforesaid in the vicinity of an obvious electricity pole, left on its nearside the track along which it had been travelling and the front

nearside wheel and wing struck a wooden electricity pole. The pole was broken by the impact of the collision with the vehicle. That caused the conductors, that is the power lines, to drop. One of the conductors became caught under the front bumper of the vehicle and shortly thereafter electricity passed through Mr. Lennon's body.

In terms of section 6(1) (c)

The accident would have been avoided if Fraser Hughes, the driver of the G-Wagon, had firstly driven with sufficient care and attention and maintained proper control of his vehicle and secondly driven at a lower speed appropriate to the conditions as he approached the electricity pole.

In terms of section 6(1) (d)

No finding is made.

In terms of section 6(1) (e)

1. The electricity pole which was struck and the local electricity grid and supply it supported was operated by Scottish Hydro Electric Power Distribution Limited ('Scottish Hydro Electric'). There were no defects either in the equipment or in the system operated which had a material impact on the accident. There can be no criticism of the delayed auto reclose relay feature set up to restore power after the system had automatically tripped off the live supply when it detected a sudden disruption or surge in the current. The circumstances of the accident involved several such episodes of tripping off and reclosing of the supply before the supply at the locus was finally switched off. The statutory and other responsibilities and duties owed by Scottish Hydro Electric to their customers including customers who may have been harmed or prejudiced by sudden withdrawal of electrical power required such a system to be in place so that a transitory event, such as tree branches touching a line in high winds, did not result in the entire area, which in this case covered several thousand businesses and homes, being cut off.
2. Because the off-roading activity fell outwith the scope of the Health & Safety at Work etc Act 1974 because of the way it was organised and the status of the

parties involved and could not therefore be regulated by the Health & Safety Executive, the sheriff Recommends that the Highland Council consider whether off-road events which are open to the public and involve some form of commercial payment should be included in the list requiring a public entertainment licence in terms of section 41 of the Civic Government (Scotland) Act 1982 .

3. The sheriff Recommends that Northern Constabulary review its policy on the investigation of vehicle collisions which do not occur on the public highway to ensure, so far as practicable, that evidence is appropriately and timeously gathered and preserved.

NOTE

Introduction

[1] This inquiry was held in terms of section 1 of the Fatal Accidents and Sudden Deaths Inquiry (Scotland) Act 1976 in respect that the Lord Advocate considered it in the public interest that an inquiry be held into the death of Gordon Lennon on 7 June 2009 at Brahan Estate, Ross-shire.

[2] Section 6(1) of the Act requires the sheriff to make a determination setting out the following circumstances of the death so far as they have been established to his satisfaction:

- a) where and when the death and any accident causing the death took place;
- b) the cause or causes of death and any accident resulting in the death;

- c) the reasonable precautions, if any, whereby the death and any accident resulting in the death might have been avoided;
- d) the defect, if any, in any system of working which contributed to the death or any accident resulting in the death; and
- e) any other facts which are relevant to the circumstances of the death.

[3] The only method of establishing those circumstances is by the assessment of the evidence led by the Procurator Fiscal and any other interested party represented at and participating in the inquiry. In addition, it has often been said, correctly, that a fatal accident inquiry is concerned with fact-finding, not fault-finding. That is a statement which should be borne in mind at all times. The purpose of the inquiry is not to attach fault, far less criminal responsibility, to any person. Rather it is to inquire into all the circumstances of the accident and the death in order to discover the truth, identify any reasonable precautions which might have been taken and ascertain if any lessons can be learnt which might serve to prevent the re-occurrence of any similar accident.

[4] Finally, in describing the purpose of an inquiry such as this, I can do no better than to quote from Sheriff Kearney in his determinations in relation to the deaths of Mildred Allan and James McAlpine, issued on 14th November 1985 and 17th January 1986 respectively, when he said:

‘Fatal accident inquiries may be regarded as having two essential purposes and one important corollary. The essential purposes are the enlightenment of those legitimately interested in the death, i.e. the relatives and dependants of the deceased, as to the cause of death (and of any accident resulting in the death) and the enlightenment of the public at large, including the relatives, as to whether any reasonable steps could or should have been taken whereby the death might have been avoided so that lessons may be learned or, at least, the attention of further inquiries directed into ways whereby practices which may have contributed to the death can be improved.’

[5] At this inquiry parties were ably represented as follows:

- the Crown: Mr. Ian Smith, Procurator Fiscal Depute;
- Alexander and Silvana Lennon, the parents of the deceased, Scott, Buchan and Heather Lennon, his brothers and sister and Kelly Dempsey, his fiancée: Mrs. Katherine Brydon, solicitor, Messrs. McGrigors, Glasgow;
- Braham Estates, referred to in this note as ‘the Estate’: Miss Diane Turner, solicitor, Messrs. Burness, Glasgow;
- Scottish Hydro Electric Power Distribution plc: Mr. Gregor Rolfe, solicitor, Messrs. Dundas and Wilson CS, Edinburgh;
- The Health and Safety Executive: Mr. James Herd, solicitor, Messrs. Morton Fraser, Glasgow.
- Fraser Hughes, driver of the vehicle in which the deceased had been a passenger: Mr. Martin Smith, solicitor, Messrs. South Forrest, Inverness.

[6] I am particularly grateful to all of them for their sensitive conduct of the inquiry and for their carefully prepared written submissions.

[7] The following persons gave evidence to the Inquiry:

1. Dr Shanthi Ravichandran, emergency practitioner at Raigmore Hospital, Inverness (affidavit);
2. Dr Roslyn Rankin, consultant pathologist (affidavit);
3. Detective Constable Christopher Fisher, a police officer who took photographs of the scene of the accident;
4. James Hampton, the brother-in-law of Mr Lennon's fiancée;
5. Fraser Hughes, the driver of the vehicle in which Mr Lennon was travelling immediately before the accident;
6. Steven Murty, legal and technical director of the International Organisation of Professional Drivers;

7. William Hogg, who was at the Brahan Estate at the time of the accident;
8. Andrew Matheson, a trustee of Captain A.F. Matheson's Grandchildren's Trust, the proprietor of that part of Brahan Estate where the accident occurred, i.e. a representative of the owners of the Estate;
9. Robin Fraser, Environmental Health Officer with the Highland Council;
10. Innes MacLeod, team manager of Scottish Hydro Electric who attended the scene following the accident to make the electricity conductors safe;
11. Constable George MacAskill, of the Northern Constabulary Roads Policing Unit;
12. John Madden, Her Majesty's Principal Specialist Inspector of Electrical Engineering;
13. Edward Marshall, Her Majesty's Inspector of Health and Safety;
14. Sergeant James Mackay, who was the first police officer to arrive at the scene of the accident.
15. Neil Campbell, who was at the Brahan Estate on the day of the accident;
16. John Martin, Fraser's Hughes' brother who was at the Brahan Estate at the time of the accident; and
17. Alasdair MacKenzie, joint acting head of legal services at the Highland Council (affidavit).

[8] There were documentary productions lodged by the Crown, the family of the deceased and Fraser Hughes. In the course of the inquiry I had the benefit of a view of the location of the accident and also saw the electricity pole at the premises of Scottish Hydro Electric in Dingwall.

Findings in fact

[9] It will be helpful to set out the facts which I found proved as follows:

1. Gordon Lennon was 26 years old at the date of his death. Mr Lennon was a part-time professional footballer with Dumbarton Football Club. He had no significant

medical history. Samples of Mr Lennon's blood and urine were collected and tested for alcohol following the accident, which proved to be negative.

2. On Friday 5 June 2009, Mr Lennon arrived in Inverness with his family. They were visiting his fiancée Kelly Dempsey's sister Sarah Hampton and her husband James Hampton for the weekend. They were due to stay in Inverness until Monday 8 June 2009
3. During the course of the weekend, Mr Hampton received a call from his friend Fraser Hughes inviting him to go off-road driving at the Brahan Estate on Sunday 7 June 2009. He initially declined due to Mr Lennon's visit. However, having discussed the matter with Mr Lennon, Mr Hampton telephoned Mr Hughes and asked if both Mr Hampton and Mr Lennon could come along to the Brahan Estate on the Sunday. Arrangements were made for Mr Hampton and Mr Lennon to attend. Mr Hampton was to be a passenger in the vehicle of John Martin, Mr Hughes' brother. Mr Lennon was to be a passenger in Mr Hughes' vehicle. The deceased had no experience in off-road driving.
4. The Brahan Estate, by Maryburgh, Ross-shire comprises approximately 3,500 acres of land split into arable farming land and forestry. The name 'Brahan Estate' is a collective term for a number of trusts and businesses which own parts of, and operate from, the Estate. The relevant organisations for the Inquiry's purposes included:
 - Brahan Farms Limited, which produces cereal and seed potatoes and rents out fields for grass; and
 - Captain AF Matheson Grandchildren's Trust ('the Trust'), which owns approximately 1,500 acres of woodland, including the area where the accident occurred.

5. The Trust does not have any employees. Mr. Andrew Matheson and his wife, Judith, are the Trustees of the Trust.
6. The Estate Manager was James Gilzean. He was self-employed and worked under a contract with Brahan Farms Limited. He was the health and safety officer within Brahan Farms Limited. Brahan Farms Limited also employs a gamekeeper called Roderick Rolfe, who looks after any game in the woodland, and a forester called Ian Nisbet, who carries out any necessary maintenance work in the woodland owned by the Trust. Messrs Gilzean, Rolfe and Nisbet had 4x4 vehicles which they used should they require access to the woodland.
7. The Estate offered and continues to offer 4x4 off road driving elsewhere on the Estate. This activity is run by Mr Rolfe. The service is advertised on the Estate's website. This off roading takes place primarily in one of the fields on the Estate. It does not take place in the woodland. The Estate supplies the vehicles for this activity. The participants are accompanied by Mr Rolfe. The Estate has a risk assessment for this activity. A fee is also charged for this service. Insurance is in place. Mr Matheson regarded this as a totally different activity to the off-roading on the first Sunday of every month, which Mr Lennon attended on 7 June 2009.
8. The area where the accident took place is used predominantly for forestry. The trees were last felled and replanted in 1937. Younger trees were under planted around 10-15 years ago.
9. The location of the collision ('the locus') was an unclassified track within the Brahan Estate, which runs close to the A835 Tore/Ledmore public road in a general east to west direction.
10. The track was first created more than 200 years ago when the Estate used water from Loch Ussie to power a mill at the end of the track.

11. The track was about 2.25 metres wide and had a centre section of grass about 1.4 metres wide. The centre section and the verges on both sides were higher than the track itself. In a westerly direction the locus is approach by a straight section of track about 85 metres long which is preceded by two right hand bends. The decline from the first bend to the second bend was about 3.8 degrees and from the second bend to the locus about 2 degrees.

12. The tracks or "ruts" varied in depth between 0 and 10 inches but were roughly 4 inches deep. The part of the track immediately prior to the locus was of quite good quality.
13. The track is bordered on the south side by a grass verge about 2 metres wide which thereafter slopes down steeply. On this verge, at a distance of about 0.68 metres from the edge of the track (measured from the edge of the track to the mid-point of the pole) there was a large electricity pole, the property of Scottish Hydro Electric Power Distribution plc.
14. The track was bordered on the north side by a grass verge about 2 metres wide which thereafter inclines upward steeply and was tree covered.
15. Access to the Estate was taken by turning off the A835 at Tallysow onto an unclassified road to Ussie. To the west of that road there was a field next to the former Tollie Scout Camp where the drivers would meet. In the corner of the field, there was a gate leading into the Estate and on to the track where the accident took place. The gate was not locked and would usually be opened by Mr Hogg so that the drivers could access the Estate.
16. Access to the track could also be taken from a gate, some distance west of the scene of the accident, directly onto the A835. That gate was secured with a chain and padlock. It could however be lifted on its hinges and moved to the side.
17. Few members of the public made use of that part of Brahan Estate where the track was situated, other than the drivers who met there monthly for off-road-driving.
18. The Estate was first approached regarding the provision of off road driving approximately 6 years before the accident. Mr Matheson's recollection was that he was approached by an individual named Ian McFadyen.

19. It was agreed that Mr McFadyen could come with his friends and their four wheel drive vehicles to drive in the woodland on a Sunday once per month. There was to be a charge of £10 per vehicle to use the woodland, which later increased to £15. Mr McFadyen was initially responsible for collecting the money. This responsibility passed to Mr. William Hogg when Mr McFadyen stopped participating.
20. Passengers did not pay any additional charge.
21. There had never been a conversation between the Estate and the off road drivers to point out the dangers associated with the activity. Mr Matheson did not consider it his place to do so since he did not feel he was in a position to judge what the risks might be. No risk assessment was prepared by the Estate.
22. The Estate did not discuss the group's credentials before allowing them on to the Estate. The Estate knew that the individuals involved were not part of an organised club. The Estate did not ask whether the group had any safety procedures or insurance. The Estate did not ask who would be coming on to the Estate, how many vehicles would attend or the experience or competence of the drivers. Nevertheless, the Estate was content to allow them to use the woodland. Mr Matheson said that he was 'not concerned'. However the Estate did ask the participants to sign a disclaimer, which sought to exclude liability from the Estate for accidents or injuries suffered during the off road driving.
23. Mr Hughes had been attending this event regularly for between 1.5 and 2 years prior to the accident. William Hogg had originally approached Mr Hughes to ask if he wanted to come driving at the Brahan Estate. Other drivers, including Mr Hogg had been meeting at the Estate for a number of years.

24. Some of the drivers attending at the Estate drove their road-going vehicles off-road. Others had specialist vehicles which were only used for off-roading.
25. The drivers were not organised as a formal club, although some of the drivers were also member of the Highland Four Wheel Drive Club. Not all of the drivers and passengers knew each other.
26. The 'event' at the Estate was not organised.
27. The drivers would generally arrive at around 10 am and stay until late afternoon, depending on the hours of daylight.
28. Mr Hogg usually collected the money and disclaimers and give these to Roderick Rolfe at the Estate office on the Monday after the meeting. This money was paid to the Trust. It was regarded as a business venture by the Trust. They were offering the land for use and receiving payment in return.
29. However, Mr. Hogg did not attend every event. If he was absent, somebody else collected the money and disclaimers. There was no formal system in place to ensure who carried out those functions if Mr. Hogg were absent for any reason.
30. Mr. Hogg was keen to give up the responsibility of collection of the money and disclaimers.
31. On the day of the accident, Mr Hogg knew that he was going to arrive late and he asked Mr Hughes to collect the money.
32. The Estate had no system to verify the number of vehicles, drivers or passengers participating on any particular day. They relied on the honesty of the drivers.

33. Neither Mr Lennon nor Mr Hampton paid a fee on Sunday 7 June 2009.
34. At some point following the commencement of off-roading at the Brahan Estate, the Estate prepared a disclaimer form. Mr Matheson could not recall the provenance of this document, although he speculated that his insurer might have provided it.
35. The form stated that it was to be signed by all drivers and passengers. This was Mr Matheson's expectation. The intention was that it was to be signed by the participants on each occasion. It appears that the practice was that only drivers signed the disclaimer form. The forms were only occasionally signed and were not checked on behalf of the Trust.
36. Mr Hughes, who drove regularly at the Estate, had never signed a disclaimer form for his G-Wagon, although he had signed a disclaimer form in relation to his previous vehicle.
37. Mr Lennon did not sign a disclaimer form. There was no evidence that he was shown a disclaimer form, or warned of the risks outlined in the disclaimer form.
38. In general, there was a casual approach to the signature of disclaimer forms amongst the group.
39. The disclaimer form makes reference to an attached plan. None of those who drove regularly at the Estate could recall having seen a plan.
40. The disclaimer form stated that 'This route follows a rough track, which contains many hazards. It is not designed for speed and so vehicles should be driven slowly at all times.' The hazards are not specified in further detail. Mr Matheson

gave evidence that the Estate had been concerned about the deep ruts in the track and the possibility that drivers might lose control.

41. The Estate did not carry out any checks to ensure that vehicles were being driven slowly at all times. They did not consider it their responsibility to do so.
42. The form also required the participant to certify that 'the vehicle I will be using to participate in this event has a current road fund licence, valid MOT certificate (where applicable) and a valid certificate of insurance.'
43. The Estate did not carry out any checks on the vehicles being used on the Estate to ensure that the Estate's requirements were being complied with.
44. Mr Hughes' G-Wagon was not taxed, had no MOT certificate and was not insured. There was no requirement in law for it to be taxed, inspected for an MOT certificate or insured if it were only to be driven off road.
45. The purpose of the disclaimer was to make the people participating aware that they were responsible for their own safety. However, no system was in place which allowed the Estate to ensure that the disclaimer was being signed and therefore that participants understood the risks associated with off road driving at the Estate.
46. The Estate did not regard the activity as being under their control. The Estate were the 'gatekeepers' who allowed 4x4 off road driving to take place on the Estate's land. Without the Estate's permission, the group would not be in a position to drive off-road in the Brahan Wood.

47. Mr Matheson accepted that aside from preparing the disclaimer to try to limit the Estate's liability, the Estate took no further steps regarding the matters mentioned in the disclaimer.
48. The tracks were not maintained or inspected.
49. Spot checks on the drivers were never carried out.
50. No speed limits were imposed.
51. At an earlier point in time, a convoy system had operated whereby Mr Hogg used to drive at the front of the convoy and the other vehicles would follow. As the number of vehicles and drivers taking part increased, this system ceased to be used.
52. Mr Hogg estimated that in the six months prior to the accident the numbers attending had risen from around a dozen to nearer thirty. They would all be driving in different parts of the woodland. Mr Hogg felt that some of these individuals were doing what he described as 'crazy daft' off-roading. He did not consider their driving always to be safe. Mr Hogg felt that the meeting had grown out of control. He said that he felt there was an accident waiting to happen.
53. Mr Hogg had seen people driving too fast on the Estate prior to the accident.
54. Neither Mr. Hogg nor any other person had any control over who attended the meetings at the Estate. He could not stop people coming in. He had no power of discipline over any driver.

55. The Estate occasionally raised concerns about damage being caused to tracks by the off-road driving. Mr Rolfe would discuss such matters with Mr Hogg, who would relay any message to the rest of the group.
56. There was a strong social element to the day at Brahan Estate.
57. The Estate did not inform Scottish Hydro Electric about the off-road driving activity on the Estate.
58. Where Scottish Hydro Electric were aware of dangerous activities in the vicinity of the electricity lines elsewhere on the Estate, for instance fly fishing, extra signage was put in place as a precautionary measure.
59. Mr Hughes owned a white Mercedes-Benz G-Wagon 230G (the 'G-Wagon'). It was a four wheel drive vehicle, suitable for driving off-road.
60. Mr Hughes bought the G-Wagon from another driver at the Brahan Estate around six months before the accident.
61. The G-Wagon did not come with a registration document. However, Mr Hughes had seen an old road tax disc in the G-Wagon which had a registration number with an 'x' suffix. As a result, it is likely that it dated from the early 1980s.
62. The G-Wagon had been 'bobtailed', or shortened, for the purposes of off-road driving. That was achieved in the following way. Mr Hughes had removed the overhang from the rear of his G-wagon by shortening it by around one foot. The back seats, rear windows, and body work had been removed and the roof bent over to create the back of the cab behind the front seats. Visually, the modified G-Wagon looked similar to a pick up truck.

63. Mr Hughes was not a qualified mechanic and had no previous experience of carrying out such extensive modifications.
64. The 'bob-tailing' modification of the G-Wagon made no significant difference to its driving or surface- handling characteristics.
65. Mr Hughes had also fitted off-road tyres to his G-wagon, known as Insa Turbo Special Tracks. The tread pattern was designed to assist with boggy and muddy conditions. They had improved grip in comparison with a road tyre.
66. The front bumper had been shortened so that there was no bumper in front of the front wheels.
67. The G-wagon was not taxed or insured for use on the public road. Mr Hughes made arrangements to have the G-Wagon taken to the Brahan Estate by trailer for the purposes of driving it off-road.
68. The G-wagon was not fitted with anti-lock brakes.
69. In addition to the gear lever, the G-Wagon was fitted with a gear ratio lever.
70. The G-Wagon could be driven either in 2 wheel drive, 4 wheel drive high ratio, or 4 wheel drive low ratio. The appropriate setting for off-road driving is 4 wheel drive low ratio.
71. Mr Hampton and Mr Lennon arrived at the field next to the Tollie Scout Camp at around 10am on Sunday 7 June 2009. They met Mr Hughes and Mr Martin there.
72. The weather was fair.

73. No one provided Mr Lennon with any safety information about the day.
74. There were between twenty five and thirty drivers and passengers in attendance at the Brahan Estate on 7 June 2009.
75. During the course of the day, the drivers drove along various tracks on the Estate and took part in a number of 'challenging' activities, such as driving in and out of boggy holes, tackling steep inclines and declines and driving over rocky terrain.
76. Later in the day, Mr Hughes, Mr Lennon, Mr Martin and Mr Hampton were 'playing at a muddy hole towards to the top, or eastern end, of the track leading to the scene of the accident. Mr Lennon drove Mr Hughes' G-wagon at this muddy hole.
77. By approximately 4 pm, some of the drivers had already gone home for the day. Messrs Hughes, Lennon, Martin and Hampton and others decided to undertake one final challenge at a muddy hole known as the 'bomb hole' located on the North side of the unclassified track, to the West of the locus.
78. The drivers had already visited the bomb hole earlier in the day.
79. Mr Hughes and Mr Lennon set off first. Mr Martin followed with Mr Hampton in his vehicle. However, they were delayed in leaving the muddy hole at the top of the track because another vehicle was obstructing Mr Martin's vehicle and he had to shunt around it to get back onto the track.
80. Behind Mr Martin's vehicle, Alan Beaton followed with passengers in his Land Rover Series, followed by Alastair Locke in his Land Rover Discovery.

81. Access from the muddy hole back onto the track was gained by vehicles passing to the south of a post and then turning left onto the track.
82. The locus is not visible at certain points further up the track. There was a bend in the track approximately 85 metres from the accident site. It was not possible to see the scene of the accident until leaving this bend.
83. Mr Hughes was driving his G-Wagon in a westerly direction towards the locus of the accident. Mr Lennon was in the passenger seat.
84. The G-Wagon left the track on the nearside and the front nearside wing and the wheel of the G-Wagon struck electricity pole number 124 situated on the south verge of the track. The G-Wagon then rotated more than 90 degrees anticlockwise and came to rest across the track. This is confirmed by damage to the G-Wagon and pole and by the resultant position of the vehicle.
85. According to the instrumentation on Scottish Hydro Electric's equipment, the collision occurred at 16.29. At this time, circuit breakers at Conon Bridge, Dingwall and Beaully tripped, disconnecting power from the Inchroary overhead line. This also caused the generators at the hydro-electric generating plants to become disconnected from the system. At this point, the overhead line conductors at the scene of the accident became dead.
86. As a result of the collision, the electricity pole broke approximately 1.5 metres above ground level, which resulted in the electricity conductors (i.e. the electricity cables designed to carry or conduct the current) dropping.
87. It is likely that the tripping operation was caused by the three conductors clashing as the wood pole (pole 124) broke after being struck by the G-wagon and as the top section fell to the ground. This would have caused very large currents

- momentarily to flow in the circuit and those would have been detected by the protection relays in the substations, which caused the circuit breakers to trip – this type of operation can occur in less than a second (depending upon the magnitude of the current and the way in which the relays are set up).
88. As the cross-arm fell to the ground each of the three conductors disengaged from its porcelain insulator. Two of the conductors became suspended in free air, supported by the two poles adjacent to the affected pole, and the third conductor became lodged underneath the G-Wagon's bumper. This whole sequence probably occurred within a few seconds of the pole being struck.
89. The pole broke into two sections. The upper section was approximately 5.8 metres long and the lower section was 3.7 metres long (approximately 1.5 metres of this length would have been buried underground prior to the accident). The broken ends of each section were splintered.
90. Neither Mr Lennon nor Mr Hughes was wearing a seatbelt. Mr Hughes gave evidence that he did not suffer any injuries as a result of the collision. It is unclear whether Mr Lennon suffered any injuries as a result of the collision.
91. There were no independent witnesses to the collision.
92. After the circuit breakers had tripped, the conductors remained dead for a period of 14 seconds. After 14 seconds had elapsed circuit breaker 3L5 in Beaulieu substation was automatically reclosed by a relay called a delayed auto reclose relay. This relay is set up to allow one attempt to reclose the circuit breaker a defined period of time after the circuit breaker has tripped. When the circuit breaker is closed, electricity flows through the circuit. When it is open, the supply is interrupted and electricity does not flow. The rationale for the autoreclosure, namely reclosure of the circuit breaker without any human

intervention, is that in the large majority of cases circuit breakers trip due to transient events on the circuits that they feed, examples being lightning strikes, or large birds straddling the conductors, or wires clashing in very high winds. In order to reduce the period of time that customers are off-supply, some circuit breakers are automatically reclosed to try to restore supplies as quickly as possible. In most cases the circuit breakers then stay in, because the cause of the trip was a transient momentary event, but in some cases the cause still exists, in which case the circuit breaker will trip again. On some circuits there will be up to three attempts automatically to reclose the circuit breaker but on this circuit the auto reclose relay was set up for one attempt.

93. By the time the circuit breaker 3L5 reclosed the nature of the fault on the circuit had changed. Rather than the conductors clashing, the situation now was that one of the conductors was trapped underneath the G-wagon's bumper. This meant that when the circuit was reenergised there was a voltage of 19,052 volts applied between the bumper and the ground where the tyres were touching it. Current flowed from the conductor through the structure of the G-wagon and its tyres into the earth and then back to the point of supply at Beaulieu; this is known as an earth fault. The magnitude of the current flowing through the tyres would have been restricted by the electrical resistance in the tyres, the consequence of this being that the protection relays operating the circuit breakers would have taken longer to trip than if the current had been much higher in value.

94. When the G-wagon had come to a stop, Mr Hughes heard crackling noises and a noise which sounded like surging electricity. He saw flames in front of the G-wagon, although he could not say whether it was the G-wagon or the ground which was on fire.

95. The current flowing through the G-wagon and its tyres would have caused localised heating, with very high temperatures being reached. This may have led

- to ignition of the combustible materials and the fire damage seen. Alternatively, the fire might have been caused by the collision itself.
96. Mr Hughes shouted to Mr Lennon to get out of the G-wagon. He saw Mr Lennon reach for the handle of the passenger door. Mr Hughes then exited the G-wagon through the driver door.
97. Mr Hughes then ran down the track, away from the G-wagon in a westerly direction.
98. As Mr Martin's vehicle turned the corner at the eastern end of the straight stretch of track leading to the accident scene, Mr Martin and Mr Hampton saw the scene of the collision. Mr Hampton saw intense flashes of light and heard what he described as "weird electrical noises". The G-wagon was on fire.
99. Five seconds after the 3L5 circuit breaker closed, the transformer (TR2) circuit breaker at Canon Bridge also closed automatically under the control of its autoreclosing relay. Five seconds after that, circuit breaker 3L5's autoreclosing relay reset, allowing it automatically to reclose again should the circuit breaker trip again. The circuit breaker did trip again at 16:30:53 because of the earth fault conditions on the circuit, resulting in the wire snagged under the G-wagon becoming dead. However, some three seconds later circuit breaker 3L5 automatically reclosed again before tripping off some seven seconds later.
100. The overall result of this was that, after the initial trip and the fourteen second dead time, the conductor attached to the G-wagon became live for forty one seconds before tripping off for three seconds and then being reenergised for seven seconds.

101. It is likely that Mr Lennon was electrocuted during either the 41 second period or the 7 second period when the conductor was energised. He died as a result of the electrical current from the trapped conductor passing through his body, either through the vehicle when he was in contact with the vehicle. It is also possible that the electrical current passed through the ground into his feet and then through his body even after he was clear of the vehicle.
102. It is possible that Mr. Hughes' exit from the vehicle occurred during the 14 second dead time.
103. Mr. Innes Macleod of Scottish Hydro Electric received a call at approximately 16.30 regarding the feeder trip on the Beaulay to Dingwall 33Kv line. He was instructed by the Control Room in Perth to proceed to the nearest switching point at Marybank.
104. Mr Martin thought he approached the scene of the accident in second or third gear travelling at around 15-20 mph.
105. Mr Martin stopped his vehicle and exited it, as did Mr Hampton. Mr. Hampton ran towards the scene of the accident, followed by Mr Martin. Mr Martin gave evidence that there was a lot of smoke as a result of the fire in the G-wagon. However, he recalled the passenger door being open. Mr Martin and Mr Hampton did not see Mr Lennon at this point.
106. The G-wagon was blocking the track. Mr Martin and Mr Hampton ducked underneath the electricity cable and ran around Mr Hughes' G-wagon on the south verge of the track. Mr Martin heard a scream.

107. As he was running away from the G-wagon, Mr Hughes also heard a scream. He turned back towards the G-wagon, ducked under the wires and onto the south verge and along the bottom of the embankment.
108. As he travelled back towards the G-wagon, he met Mr Martin and Mr Hampton. They asked him where Mr Lennon was. Mr Hughes did not know. All three witnesses began to shout for Mr Lennon and ran back towards the G-wagon. They passed back under the electricity wire on the South verge and returned to the East of the G-wagon.
109. At that point, the three witnesses saw Mr Lennon lying on his back parallel to the G-wagon with his head in the bushes on the North verge of the track and his legs next to the passenger side rear wheel. The leg of Mr Lennon's trousers was on fire.
110. Mr Hampton grabbed Mr Lennon by the jacket and pulled him away from the G-wagon, approximately 15 feet. Mr Hampton extinguished the fire on Mr Lennon's leg and began to administer first aid. Mr Hampton tried to "bring Mr Lennon round".
111. Mr Martin telephoned the emergency services. He passed the telephone to Mr Hughes to describe the location of the accident.
112. Mr Locke and Mr Beaton arrived at around this point.
113. The G-wagon was on fire and the witnesses Hampton, Martin and Hughes were worried about the possibility of an explosion from the fuel tank. As a result, they decided to move Mr Lennon further up the track. Whilst doing so, Mr Lennon's jacket came off. Mr Hampton resumed first aid and began to administer CPR in the form of chest compression and mouth to mouth resuscitation.

114. Due to concern that the track was not suitable for an ambulance, a decision was made to move Mr Lennon back up the track to the former Tollie Scout Camp field. Mr Lennon was placed into the back of Mr Beaton's Land Rover Series 3 and was driven back along the track in an easterly direction. On they way back along the track, the paramedics arrived in Mr Locke's Land Rover Discovery.
115. The paramedics took over from Mr Hampton at that point. The paramedics took Mr Lennon by ambulance to Raigmore Hospital in Inverness.
116. While the aforementioned electrical sequence was occurring, the control engineer in Scottish Hydro Electric's control room in the company's headquarters in Perth would have been monitoring the event via his instrumentation and control system displays. He had the facility to remotely operate the 3L5 circuit breaker in Beaully and at 16:42:02 he used this to close the circuit breaker. This was in accordance with the company's procedures. The circuit breaker stayed on for 5 seconds, during which time the three wires at the scene of the incidence would have been live, before tripping again.
117. At 16:56 the control room received an emergency call from the fire brigade warning about the circumstances of the accident. After that, no automated or remote attempts were made to restore supplies.
118. Mr. Innes Macleod, a team manager employed by Scottish Hydroelectric received a call from the control room whilst on his way to Marybank to advise that there had been an accident at the Brahan Estate. He was instructed to go there instead to investigate what had happened. He arrived at the Brahan Estate shortly afterwards.
119. Having identified the cause of the trip and following discussion with the control room in Perth, Mr Macleod proceeded to Brahan Lodge West to open a

switch there to isolate the line at the scene of the accident. One of Mr Macleod's colleagues proceeded to an isolate point at Bakerhill, on the other side of the scene of the accident.

120. Mr Lennon was pronounced dead at 1752 hours on 7 June 2009.
121. Mr Macleod returned to the Brahan Estate and applied Circuit Mains Earths (CMEs) at poles 123 and 125 to earth the conductors at 18:15 and 18:26 respectively. This prevented the conductors in the vicinity of pole 124 re-energising.
122. Once the conductors had been made safe, the Fire Brigade were able to approach the scene. The fire had more or less burned out by then.
123. At approximately 18.15, Detective Constable Fisher, Northern Constabulary, arrived at the scene of the accident. He waited for around twenty minutes while the electricity was made safe before taking the photographs of the scene of the accident.
124. The Fire Brigade were then able to release the conductor from underneath the G-wagon. No further works were undertaken that night.
125. The following day, with the permission of the police, Mr Macleod returned to site with some colleagues to remove the broken pole, install a new pole and reattach the cross-arm and conductors. The broken pieces of pole were taken to Scottish Hydro Electric's Dingwall Depot for storage. Chisholms, a firm in Inverness which provides vehicle recovery services to Northern Constabulary, also removed the G-wagon from the locus.

126. Mr Hughes accepted that if he was travelling at 15-20 mph in low gear ratio, he would have been at the top of the gear. In other words, he would have been travelling at or near the maximum speed for that gear. The accelerator pedal would have been pushed all the way to the floor and the engine noise would have been audible. In that scenario, Mr Hughes was not able to provide an explanation as to how he was able to "apply power" when the rut pulled him to the side.
127. An increase in speed would increase the chances of losing control.
128. It cannot be said with certainty whether the G Wagon was in high or low gear ratio at the time of the accident.
129. The fact that Mr Hughes was not able to correct his steering prior to hitting the pole suggests that Mr. Hughes was driving too fast for the conditions.
130. It is likely that Mr Hughes was travelling at between 30 and 40 mph immediately prior to the collision. That conclusion is based on the amount of rotation of the G-wagon after hitting the pole, the damage to the G-wagon itself and the fact that the pole broke.
131. Mr Hughes lost control of his G-wagon.
132. The track immediately before the scene of the accident was relatively straight and was not particularly challenging.
133. Mr Hughes had driven at the Brahan Estate between 18 and 24 times before the accident and had regularly driven down the track where the accident took place.

134. He was familiar with the locus and considered the electricity pole to be an obvious hazard.
135. His G-Wagon had never been pulled off the track in the vicinity of the electricity pole prior to the accident.
136. There had been not previous accidents on this stretch of track, nor reports of other vehicles leaving the track.
137. PC MacAskill did not consider the depth of the tracks leading up to the point of collision to be particularly deep. He thought they were less than 4 inches. He would not expect such ruts to pose a problem to an experienced off-road driver. He would not expect such ruts to pull a vehicle to the side and off the track. There was no obvious evidence that the ground to the left hand side of the track was disturbed or broken up, as he would have expected if the tyre had caught the side of the track.
138. The stones on the track would not pose a problem for competent driver travelling at a safe speed.
139. The tyre patterns on the electricity pole suggested that the G-Wagon did not turn sharply towards the pole as it approached. It is likely that it had come along the verge from some distance back.
140. The G-wagon was almost completely destroyed by fire. The only remaining combustible materials were the two front tyres.
141. The G-wagon had sustained damage to the front nearside wheel, wing and headlamp unit. This damage has resulted in the front axle being forced backwards

on the nearside, forcing the nearside radius arm rear mount off the longitudinal chassis member.

142. A mechanical examination was carried out by Constable MacAskill and no pre-collision defects were found which could have contributed to the collision. The chassis was found to be sound.

143. The damage was indicative of a heavy impact on the nearside of the G-wagon because the mount itself is very strong. A heavy impact would be required to push the radius arm through the back of the mount. The whole purpose of the mount is to prevent the axle moving backwards during breaking. The mount is around 5 mm thick.

144. Constable MacAskill examined the G-wagon approximately one week after the accident at Chisholm's yard in Inverness. At that point, the gear lever was lying flat on the floor of the car. As a result, it was not possible to tell which gear the G-wagon was in at the point of collision.

145. In his report, Constable MacAskill expressed the opinion that the gear ratio lever was in the high position. This was based on discussions with Mercedes, during which Constable MacAskill was informed that if the lever was pointed towards the rear of the G-wagon, this was indicative that the G-wagon was in the high gear ratio. PC MacAskill was not aware that there were left and right positions. PC MacAskill found the lever pointing towards the rear. The information put to him during his evidence left him unable to say whether the car was in high or low gear ratio at the time of the collision. Accordingly it cannot be said which gear ratio the vehicle was in at the time of the accident.

146. It was not possible to calculate the speed immediately before the collision of the Mercedes G-Wagon.

147. The cause of the accident, that is the collision between the vehicle and the pole, rests entirely with the driver, Mr. Hughes. He drove along the track at the locus, failed to maintain a straight course and struck the electricity pole on the south verge. It is highly unlikely that control of the G-wagon would be lost by a competent driver at low speed. The damage to the pole, G-wagon and the rotation of the G-wagon all point towards a relatively high speed for these off road conditions.

148. An electricity line runs through the forest, creating a sterile area to either side of the line where the Trust cannot plant trees. The electricity line was first installed in the 1950s, which pre-dated Mr. Andrew Matheson's direct involvement with the Estate.

149. The line was rebuilt in 1997. New poles were installed at this point.

Pole 124 was made of Scots Pine sourced from Finland, was 9.5 metres long, was of 'stout' construction and had been supplied in 1997 by James Jones Ltd of Larbert. This information was stamped into the surface of the pole. Poles typically last for around 30 years before they require to be replaced.

150. Hundreds of thousands of these poles are in use throughout the UK.
151. Electricity poles are not designed to withstand collision. The British Standard (BS1990 of 1984) regarding the specification of poles does not contain any specification regarding side impulse shocks.
152. The overhead line had last been inspected in March 2008. Such an inspection would usually include a visual inspection of the line and poles, including pole number 124. It would usually also include a tap test with a hammer to check the condition of the pole.
153. The inspection included an assessment of risk, based in part on the use of the surrounding land. The assessment would only take account of uses which were apparent on the date of the inspection. Scottish Hydro Electric would not necessarily be aware of occasional activities, such as 4x4 off road driving once per month, unless they were informed about them by the Estate.
154. Inspection of the pole following the accident led to the conclusion that it appeared to be in good condition with no evidence of rot or other degradation or damage that may have contributed to its collapse.
155. There is no minimum distance governing how far a pole should be from a road or track. There would be little, if any, need for barriers around the pole to protect against collision into it by a slow moving vehicles. There was space for a barrier next to pole 124.

156. The overhead power line involved in this accident was part of Scottish Hydro Electric's 33,000 volt power distribution network and was known as the Inchrory circuit. The circuit distributed power to primary substations at Conon Bridge, Dingwall, Marybank, Comrie and Conon Falls where the voltage was stepped down to 11,000 volts to allow power to be distributed to consumers in the areas local to those substations. The main power in-feed to the circuit was at Beaully Grid substation through a circuit breaker identified as '3L5' although there were some small hydro-electric generating stations connected to the network.
157. The overhead line at the site of the accident was of typical construction and configuration. It comprised three conductors with a voltage of 33,000 volts between any two of the three conductors and a voltage of 19,052 volts between each of the conductors and earth. Each conductor was supported on porcelain insulators attached to steel cross-arms on the top of wooden poles. These poles are numbered in sequence and the pole involved in the accident was number 124.
158. The legal requirements relating to the safety of overhead lines are set out in the Electricity Safety Quality and Continuity Regulations 2002. The line at the scene of the accident was above the statutory minimum height of 5.8 metres. The span height was 7.2 metres high measured from the ground.
159. The line satisfied the statutory requirements relation to the provision of warning notices. Following the accident, there was found a yellow and black 'danger of death' notice amongst the pole parts recovered by Scottish Hydro Electric. This sign had become detached from the pole as a result of the collision.
160. The line between Beaully and Dingwall substations was last inspected on 11 March 2008. No record of the inspection was found on pole 124 itself during examination by Mr Madden, HM Health and Safety Inspector. He made inquiries about this matter with the Procurator Fiscal but heard nothing back. He would

have expected such evidence to have been secured by the police at the scene of the accident.

161. Nevertheless, records were found on poles 123 and 125. Scottish Hydro Electric also produced a spreadsheet showing the risk assessment following the 11 March 2008 inspection. Pole 124 was noted to have been manufactured in 1997, to be 9.5 metres high and to be an intermediate pole. The span height was 7.2 metres high measured from the ground, which was higher than the statutory minimum clearance.

162. The pole was classified as being adjacent to a road or footpath, with bare conductors. There was no evidence of vandalism, dumping or congregation. Mr Madden gave evidence that this was an appropriate classification assuming Scottish Hydro Electric were unaware of the off-road activities taking place in the woodland.

163. Scottish Hydro Electric relied upon information from the landowner in relation to any activity taking place which would not be obvious from a visual inspection of the line.

164. Mr. Innes Macleod, team manager of Scottish Hydro Electric, considered that quite a lot of force would be required to break a pole. He would consider 15 mph to be an appropriate speed at which to pass the pole. He did not consider 4x4 off-roading at speeds faster than 20 mph to be an unsuitable activity so close to the pole.

165. Mr Macleod was nevertheless surprised that the collision had caused the pole to snap. He had not seen any similar instances of poles snapping as a result of impact with the pole, even though he had been working with them for years.

He had witnessed pole snapping under severe ice loading on the conductors, or if trees fell onto the conductors, adding to their weight.

166. All electrical distribution circuits must have a means of protecting the circuit against damage caused by excess of current arising from faults and overloads. In the case of the Inchrory circuit this was done using circuit breakers and associated protection relations in the primary substations at Dingwall, Conon Bridge, and Beaully.
167. The control equipment for the circuit comprised protection equipment for:
- detecting phase to phase faults (configured as distance protection);
 - detecting overcurrent and earth faults (inverse definite minimum time overcurrent and earth fault protection);
 - detecting low magnitude earth faults (sensitive earth fault protection); and
 - providing delayed automatic reclosure of the circuit breaker after it had tripped due to operation of the distance protection or the overcurrent/earth fault relays – this was backed up by other devices for checking that the system parameters (voltage and phase synchronisation) were in order before allowing the automatic reclosing to proceed.
168. The circuit breakers protecting the circuit in the event of faults operated correctly and appropriately and there was nothing untoward in the way that they were set up or operated. The arrangement for automatic re-energisation of the circuit after a fault may appear at first sight to be hazardous since it is most likely that this contributed to Mr Lennon's death. However, in designing electrical

power distribution networks there needs to be a balance between, on the one hand, controlling the risks that may arise from such automatic reclosing and, on the other hand, the public interest in minimising the frequency and duration of interruptions to supplied. The design of the Inchrory circuit reflected that balance.

169. There was an issue with the sensitive earth fault (SEF) relay on the 3L5 circuit breaker. This relay operated after the pole had collapsed and should have transmitted an alarm back to the control engineer in Perth; however, the relay had been disconnected from the communication system during previous maintenance works and, in error, had not been reconnected. The control engineer did not know, therefore, that the SEF relay has operated. Mr Madden gave evidence that he could not be precise about when the SEF relay operated, but it was likely to be after a delay of between 5 and 10 seconds.

170. The disconnection of the SEF relay played no material part on the sequence of events: it would not have prevented circuit breaker 3L5 autoreclosing. However, had the control engineer known about the operation of the SEF relay, he might have taken a more cautionary approach to autoreclosing the circuit. His decision to do so had the potential to endanger those who were first on the scene to assist Mr Lennon. Fortunately however no further injury was caused to any other person.

Cause of the accident

[9] In every inquiry under the 1976 Act, the court has to identify what was ‘the accident’ which caused the death. In my view the accident in this case was Mr. Hughes’ vehicle leaving the track and colliding with the electricity pole. I found the evidence of Police Constable George MacAskill both in the witness box and in the collision investigation report, of which he was the author, to be impressive. It enabled me to find that the primary cause for the accident was that Mr. Hughes was driving his vehicle too fast for the terrain on which he was driving to the extent that he lost control

of his vehicle. He was unable to maintain its position on the road, leading to its moving to its left and colliding with the pole with all the ensuing consequences.

[10] In reaching that conclusion, I preferred the evidence of Constable MacAskill to that of Mr. Hughes. I formed the impression that Mr. Hughes was trying to downplay the speed which he had been driving his vehicle at along the stretch of track leading to the location of the accident. Although, it in fact could not be said which gear ratio the gearbox had been in at the relevant time, it seemed that on any view Mr. Hughes was driving at such a speed that he lost control of his vehicle. It is significant that neither he nor any of the other experienced drivers had ever lost control of their four wheel drive vehicles on that stretch of track at any time either previously or on that day.

[11] I also rejected Mr. Hughes' evidence that the lugs on his tyres played any part in pulling his vehicle over to the left. That was a phenomenon unknown, in particular, to Constable MacAskill. The simple truth was that he could have driven the vehicle at a speed where he would be able to react appropriately to hitting stones or ruts in the track and it seemed to me to be inescapable that he lost control of his vehicle only because he was driving too fast for the location and all the surrounding conditions.

[12] There was some evidence of the G Wagon, immediately before the collision with the pole, 'fish-tailing', i.e. the rear of the vehicle being beyond the control of the driver and swinging from side to side. That was said to have been a possible consequence of the vehicle becoming inherently unstable as a result of its adaptation by Mr. Hughes. Mr. Murty thought that it was possible that this had happened. However, there was no basis in the known facts to support any finding that this had occurred. Mr. Murty referred to some flattened grass in the photographs to support his view on that. However, there could have been any number of explanations for the flattening of the grass other than the G Wagon fish-tailing. Constable MacAskill did not consider that there was any evidence of the vehicle having behaved in this way. I was not satisfied that there was any evidence led which would have entitled me to make a finding of the vehicle having behaved in this way immediately prior to the impact with the pole.

Reasonable precautions whereby the accident or the death might have been avoided

[13] Risk is attached to all activity. It is self-evident that driving off-road must attract risk flowing from uneven, untrained terrain combined with the presence of hazards, such as rocks, cliff faces, slopes, water, trees and, as in this case, electricity poles situated in the area being driven through. Even driving a motor vehicle on the public road involves risks: street furniture such as street lighting poles are frequently positioned no further away from the carriageway than the electricity pole involved in this case was from the track. There is no doubt that the closeness of the electricity pole to the track did present a hazard to drivers and occupants of vehicles being driven along the track, but only, in my view, to vehicles being driven at excessive speed. Accordingly, the primary finding under section 6(1)(c), namely a reasonable precaution whereby the accident or the death might have been avoided can only be that Mr. Hughes was driving his vehicle too fast along that stretch of the track.

[14] The activity on 7 June 2009 took place on private land. Accordingly the terms of the Road Traffic Act 1988 did not apply to it. In the particular circumstances, the activity was not subject to any control measures under the Health and Safety at Work etc. Act 1974.

[15] The context in which the accident occurred therefore was as follows: a group of like-minded enthusiasts for off-road driving met once a month to pursue their hobby at a location which belonged to none of them for which they paid £15 per vehicle to the landowner, who also expected them to sign a disclaimer absolving the landowner of liability for any accident which might occur. The money was collected by one of their number. The landowner specified certain areas which the vehicles should not enter, to prevent damage to trees or erosion and the like. Otherwise the drivers drove around the land going from site to site, at which sites they would be faced with challenges to their driving skills, such as water, mud, rocks and steep inclines.

[16] The accident however happened on a track leading from one of those challenging sites to another. It was a track used frequently by all of those present, including Mr. Hughes. Mr. Hughes, and others, had used it on many previous occasions.

[17] The solicitor for the family and the solicitor for the Health and Safety Executive both submitted that reasonable precautions whereby the accident might have been avoided went beyond self-control by the driver. It was suggested that reasonable precautions might also consist of:

- Some form of protection around the pole, such as bales of hay; and
- A warning to those present by way of a simple but clear hazard sign advising against driving at excessive speed along that stretch of track.

[18] It was recognised that such measures could only be identified as suitable and appropriate after the carrying out of a risk assessment of those parts of Brahan wood in which driving was going to take place. I am quite satisfied that those measures, the placing of hay bales around the pole and a warning signs were precautions which might have served to persuade Mr. Hughes to drive at a slower speed and, if he did not, to minimise the consequence of collision after the vehicle left the track. The question is whether, with the benefit of hindsight and in light of all the circumstances, those precautions could be truly characterised as reasonable.

[19] In order to answer that question, it is necessary to decide upon whose shoulders would fall the responsibility to carry out that risk assessment and then to put in place those protective measures. Should that have been the landowner, the estate? The solicitor for Mr. Lennon's family suggested that it was incumbent on the estate to carry out a risk assessment, failing which to take steps to ensure that the drivers had carried out, and implemented the measures identified in the risk assessment. In my view, that placed too high a responsibility on the landowner. Since about the 1960s this estate had evolved a policy of allowing and positively encouraging public access to the estate land. Such a policy is now no more than what the law allows by virtue of the Land Reform

(Scotland) Act 2003, although of course there is no right of access for motor vehicles without the agreement of the landowner. However, in my view the Estate's involvement in this activity was minimal and simply an extension of that policy operated by it for four decades or more. As might very well be expected, the Estate's land had a line of electricity poles running through it, delivering electricity supply to various communities. That line of poles was obvious to anybody entering the estate. The estate management was not aware of which route any particular driver would take on any particular day. For environmental reasons they forbade entry into certain areas in the wood. However, they did not even on a day to day basis have in place any system of enforcement of that requirement. The event on 7 June 2009 was organised only to the extent of the individual drivers knowing to turn up at Brahan wood on that particular date and an employee of the estate knowing to attend to unlock the gate. Otherwise, once the drivers and their vehicles were beyond the gate, where they went within the wood was entirely a matter for each individual driver. Given that that was the nature of the event, I do not see how the estate could be expected to have had in place a system of risk assessment and warnings that could cover every possible eventuality. In my view, to expect the estate to have such a system in place would not have been a reasonable precaution.

[20] The question then arises as to whether anyone else might be expected to have carried out a risk assessment and, if so, who? That is a difficult question, given the nature of the event. Other than having one person present to collect the money from each driver, there was nothing which could be characterised as organised about these events. Neither was there any person who could be described as an event organiser, far less a marshal. The money collector latterly was Mr. William Hogg. In evidence he said that at one time he had thought of developing safety measures for the Sunday morning event at Brahan. He had asked the drivers to think about safety, but felt that he could go no further than to simply ask them. In his own words, 'You can only ask.' His position was based on the fact that the Sunday event at Brahan was simply a number of people paying the money and enjoying themselves. He stressed that it was not a club event. Had it been so, then matters would have been completely different.

[21] The problem is highlighted by the fact that Mr. Hogg did not in fact manage to attend all of the events. Had this been a club event and had he been a course director or marshal, then the effect of his absence would most likely be the cancellation of the event. However, it seemed that the event at Brahan simply proceeded whether he was there or not. In that situation, even if there had been a risk assessment carried out, who would ensure that hay bales were placed at the base of the pole and a speed restriction sign erected by the side of the track on days when he was absent.

[22] Accordingly, on the basis that this was simply a group of like-minded enthusiasts meeting to pursue their hobby at the same time in the same general location, I cannot identify any person, of their number, on whose shoulders should have rested the responsibility to identify and set in place protective measures. I express my view in that way because the accident occurred in the context of such an event. It may be that such events, on other people's property, ought not to take place in an unregulated way: I shall discuss that aspect of the inquiry later.

[23] Another difficulty which arises is actually whether any form of protection, such as hay bales, around the pole was actually necessary. Steven Murty, who I took to be a skilled witness, was the technical and legal director and, he thought, the sole director of the International Organisation of Professional Drivers. That organisation was accredited by the Department of Transport to regulate the conduct of off-road events involving motor vehicles, in terms of Statutory Instrument 1370 of 1992.. Mr. Murty, who was very experienced in the organisation of motor sport, said that he did not think that the pole would have needed protection by straw bales if it were positioned, as was the case here, near to a route between sites of interest to the drivers. He did qualify that statement by saying that that opinion was predicated on the drivers of vehicles going along the track driving 'slowly, sensibly and in a roadmanlike manner'. Interestingly, although he had not visited the scene of the accident, Mr. Murty ventured 20 miles per hour as the maximum safe speed in such circumstances.

[24] As already noticed, off-road driving, by its very nature, is a hazardous pastime. That may form part of its attraction to those who enjoy it. It is self-evident that to drive at excessive speed, whatever that may be according to the conditions present at the time

and place, in the near vicinity of an electricity pole is foolhardy. However, no witness said that fast driving between the different locations of interest formed any part of the hobby. Mr. Hogg mentioned that some fast driving did take place from time to time. It was clear that he disapproved of that but given the nature of the event felt powerless to do anything to prevent it.

[25] I certainly accept that the placing of a speed restriction sign at the eastern end of the stretch of track leading to the scene of the accident and the placing of bales around the base of the pole might have prevented the accident from occurring. However, in all the circumstances of this activity I cannot identify any person who might reasonably have been expected to both devise such measures and then on a regular basis take steps to ensure that they were enforced every month. For that reason, I decline to include those steps as reasonable precautions in terms of section 6(1) (c).

The electricity supply network

[26] There was a great deal of evidence regarding the part played by the electricity supply in the accident, given that the cause of Mr. Lennon's death was electrocution. I am indebted to the witness John Madden a specialist electrical engineering inspector of the Health and Safety Executive, for his report, lodged as a production, and his clear explanation of the operation of the public electrical supply and what happened to it on 7 June 2009. That evidence forms the basis for the findings in fact on the electricity aspect of the inquiry.

[27] Little needs to be added to those findings. A conclusion from Mr. Madden's evidence was that there nothing untoward in how the circuit was set up and the relay system of autoreclosure at Inchrory was in accordance with acceptable practice within the electricity supply industry, striking a reasonable balance between risks from autoreclosing on the one hand and the maintenance of public supply on the other.

[28] Mr. Madden explained that Mr. Lennon appeared to have the classic signs of having been electrocuted and that this appeared to have happened by him in some way making contact with the vehicle and thereby providing a path for the electrical current to pass from the 'live' vehicle through his body to earth on one of the occasions when

the vehicle was energised, by reason of the conductor being caught under the bumper of the vehicle.

Regulation of off-road driving

[29] Evidence was also led at the inquiry on the issue of the regulation of off-road driving.

[30] Firstly it was common ground at the inquiry that the provisions of the Health and Safety at Work etc Act 1974 did not apply to the off-roading activity at Brahan on 7 June 2009. The reasoning for that conclusion, which I accept is as follows:

[31] Section 2 of the 1974 Act imposes duties on employers in relation to their employees and Section 3 of the 1974 Act imposes duties on employers in relation to persons other than employees (such as members of the public).

[32] Section 4 of the 1974 Act imposes duties on person who make available non-domestic premises as a place of work.

[33] None of these sections applied because:

- (a) Neither Mr Lennon nor Mr Hughes was at work at the time of the accident;
- (b) The Trust had no employees, and therefore no duties under the Act;
- (c) The employees of Brahan Farms Limited took no role in organising the off-road driving, other than collecting the money on behalf of the Trust; and

- (d) Neither Mr Lennon nor Mr Hughes were using work equipment supplied by the Trust or Brahan Farms Limited.

Public Entertainment Licensing

[34] Another question which arose was that of whether the activity undertaken by the drivers at Brahan Estate on 7 June 2009 might have been subject to any form of licensing by the local authority. The Highland Council is the local authority responsible for the issuing of public entertainment licences in terms of section 41 of the Civic Government (Scotland) Act 1982 (the "1982 Act").

[35] Section 41(1) of the 1982 Act provides that a public entertainment licence shall be required for the use of premises including land as a place of public entertainment. This section provides for an optional scheme of licensing of public entertainments which are not defined other than by a list of activities which are specifically excluded therefrom in terms of subsection (2).

[36] Section 41(2) of the 1982 Act defines "place of public entertainment" as any place where, on payment of money or money's worth, members of the public are admitted or may use any facilities for the purposes of entertainment or recreation but does not include-

- (e) an athletic or sports ground while being used as such;
 - (f) premises which have an indoor sports entertainment licence issued under section 41A of the 1982 Act;
 - (g) an educational establishment while being used as such;
 - (h) theatres, cinemas and premises licensed under the Gambling Act 2005;
 - (i) premises with a liquor licence during permitted hours;
- premises in which machines for entertainment or amusement are provided incidentally to the main purpose or use of the premises.

[37] In terms of section 9(2) of the 1982 Act: “ A Licensing Authority may, in accordance with this section, resolve that, as from a day specified in the resolution (which must not be before the expiration of the period of nine months beginning with the day on which the resolution was made) any activity provision for the licensing and regulation of which is made by the optional provisions shall require to be licensed in accordance with the provisions of this Act relating to that activity and shall be regulated by those provisions.”

[38] On 26 February 1998 the Highland Council published its intention to licence a number of public entertainment activities and to extend the definition of public entertainment licensing to all classes of premises (including land) where the defined activities are proposed to be carried out for money or money’s worth.

[39] The introduction of these activities came into effect on 1 December 1998 following the statutory nine month period and from this date a licence was required for any persons undertaking the activities detailed in the resolution.

[40] The resolution included, *inter alia*, premises used for go-karting, but did not include 4x4 off-road driving.

[41] The statutory definition appears wide and any activity which falls within it could be licensed if the Council resolved to include it on the list of defined activities.

[42] In my view, 4x4 off-road driving was easily capable of falling within the statutory definition of activities which the local authority could include in a resolution made under section 9(2).

[43] Any proposal to amend, add or remove categories from the list would initially be investigated by officials (employees of the Council) from the Licensing section of the Chief Executive’s Service and the Environmental Health section of Transport,

Environmental and Community Services (TECS). Consultation would be undertaken with outside bodies such as Northern Constabulary and the Highland and Islands Fire and Rescue Service. Officials would prepare a Report to the Council's Civic Government Working Group of elected councillors which is a working group set up by the Council's TECS Committee. The Working Group would in turn make a recommendation to the TECS Committee which is the Committee of elected councillors that has delegated powers from the Highland Council to make resolutions in terms of the Act. If the TECS Committee agreed that it wished to make a resolution to include a new category of licensable activity then in terms of section 9(6) of the Act the Council would require to publish in a newspaper or newspapers circulating in its area a notice stating: the terms of the proposed resolution, that the Council intended to make the resolution and inviting written representations within 28 days of the first publication of the notice.

[44] In terms of section 9(7) of the Act before the TECS Committee proceeded to make the resolution it could make such modifications to the proposed resolution as it thought fit in the light of representations made to them about it provided such modifications do not extend its scope.

[45] In terms of section 9(8) of the Act, as soon as the resolution has been made a further notice requires to be published stating: the terms of the resolution, that with effect from the date on which the resolution comes into effect it will be an offence to do without a licence whatever the resolution specifies as being an activity requiring to be licensed and that applications for licences will be considered after one month of the date of making the resolution.

[46] Section 9(2) of the Act provides for a minimum period of nine months' grace from the passing of the resolution before a licence will be required.

[47] In order to obtain a public entertainment licence, the organiser would require to apply to Highland Council. For a new licence, this would involve an inspection of the premises by an Environmental Health Officer responsible for matters including health

and safety. Mr. Robin Fraser, of the Highland Council, who gave evidence at the inquiry is responsible for carrying out such inspections. He gave evidence that a risk assessment for the activity would be required outlining control measures which would be put in place to minimise the risks posed. Mr Fraser might well take advice from his colleagues within the HSE with electrical expertise on the proximity of the electricity pole to the track. Mr Fraser also gave evidence that he would be looking for safety policies and procedures. Information would be required on the experience of the company or individual organising the activity, where the activity was to take place, the number of persons involved and what insurance was in place. A list of other statutory consulters, including the fire authority and the police would also be given the opportunity to comment on the application.

[48] It cannot be said with certainty that if the driving on 9 June 2009 at Brahan Estate had been subject to the licensing regime under section 9 of the Civic Government (Scotland) Act 1982, the accident might not have happened. The evidence pointed to the cause of the accident being the quality of Mr. Hughes' driving and it was not certain that a risk assessment would have identified the pole as presenting a significant risk that required any protective measures around it.

[49] On the other hand, it has to be recognised that this accident occurred in an entirely unregulated context in which no individual present could be described as an organiser. The question arises as to whether that is a satisfactory situation when the activity involves mechanised transport and, as Mr. Hogg said in evidence, there was no control over the number of drivers and vehicles who attended on any given day. In my view, it is legitimate for the local authority to at least consider whether such an activity might be amenable to being licensed under section 9 and I have so recommended.

The police investigation of the accident

[50] There was a difference of opinion between Sergeant Mackay and the officers in attendance from Northern Constabulary's Road Policing Unit immediately following the accident as to the appropriate approach to the police investigation. The officers from

the Road Policing Unit, Sergeant Murray and Constable Forsyth, in attendance determined that the accident was not a matter for the Road Policing Unit to deal with. It was suggested to Sergeant MacAskill However, PS MacAskill was not aware of any policy that Northern Constabulary or the Procurator Fiscal might have on the investigation of road accidents which did not occur on the public highway.

[51] Sergeant Mackay gave evidence that Sergeant Murray and Constable Forsyth conducted a ' cursory examination ' of the locus and determined that it did not fulfil the criteria of a road traffic accident due to the location, which they did not consider to be a public road. As a result, no collision investigation took place at that point. However, PS Mackay nevertheless proceeded as if the accident did happen on the public road in terms of his interview with Fraser Hughes. It may have been helpful for the officers from the Roads Policing Unit to do the same to ensure that evidence relevant to this Inquiry was collected and preserved at the earliest opportunity. That would have been in line with investigation of the causes of any accident that had occurred on the public highway.

[52] The police officers who attended the scene of the accident on Sunday 7 June did not take steps to preserve evidence at the scene of the accident. PS Mackay did not feel that it was necessary to protect the locus so the broken pole and G-wagon were left *in situ* overnight.

[53] Constable MacAskill did not receive instructions to prepare a collision investigation report until Tuesday 9 June. He was instructed to carry out an investigation by himself. The investigation was not carried out to the standard expected for a collision on the public road.

[54] A road traffic accident would usually be investigated by two collision investigators. The investigation would be conducted as quickly as possibly following the accident, and the road would remain closed until the investigation was completed. The vehicle would be in its accident resultant position and any tyre marks would be left undisturbed.

[55] Constable MacAskill did not attend the locus until 1800 hours on Tuesday 9 June 2009, to carry out an initial inspection. By then, the weather conditions had changed (it was raining heavily), the electricity pole had been removed to Scottish Hydro Electric's depot in Dingwall and had been replaced with a new pole. The G-Wagon had been removed to Chisholm's yard in Inverness. An unknown number of vehicles had driven on the track.

[56] Constable MacAskill did not consider these to be ideal circumstances in which to conduct his investigation. He knew that evidence would have been lost because the scene of the accident was not as it was when the accident happened. He considered himself at a disadvantage from the start. PC MacAskill was not able to undertake a detailed investigation.

[57] All of these factors might well have had a material impact on the ability of PC MacAskill to reach conclusions as to the cause of this accident. Clearly it would have been better if the inquiry had heard evidence of a thorough examination of the scene of the accident, the pole and the vehicle itself. An example of the disadvantage suffered by the inquiry is the uncertainty as to which position the gear ratio lever was in immediately after the accident. Had the vehicle been inspected and photographed in detail *in situ*, that uncertainty might have been removed.

[58] Because of that, I agree with the submission on behalf of the family that a recommendation be made that the police and Procurator Fiscal should review their policy on the investigation of vehicle collisions which do not occur on the public highway.

Concluding remarks

[59] The evidence described a terrifying sequence of events. In my view, all of those present immediately after the accident did what they could to assist Mr. Lennon. However I would single out for particular praise the conduct of Mr. James Hampton who

it seems had no regard for his own safety and jumped over what may have been a live electricity conductor in order to try to rescue Mr. Lennon and to carry out CPR on him until the arrival of the ambulance personnel.

[60] Mr. Lennon's family attended throughout the inquiry and added a dignity to the proceedings. Mr. and Mrs. Lennon senior were assisted in following the evidence by two British sign language interpreters and the court expresses its thanks to them for their efficient services.

[61] Mr. Lennon's death can only be described as tragic and untimely. I offer my personal condolences to all of his family.