

SHERIFFDOM OF TAYSIDE, CENTRAL AND FIFE AT STIRLING

2012 FAI 40

DETERMINATION

of

SHERIFF FIONA TAIT

**Under the Fatal Accidents and Sudden Deaths
Inquiry (Scotland) Act 1976**

in respect of

the Fatal Accident Inquiry into the death of

**RUSSELL NORMAN WILSON
(born 9 September 1983)**

Stirling, 18 December 2012

The Sheriff, having considered the cause, determines:

1. In terms of section 6(1)(a), Fatal Accidents and Sudden Deaths Inquiry (Scotland) Act 1976 that Russell Norman Wilson, born 9 September 1983, latterly residing at Milton of Castleton, Huntly, died at Harpers Transport Site, Norbord, Station Road, Cowie, and was pronounced dead at 0800 hours on 23 April 2008, although there is evidence that points to his death having taken place some time after 1930 hours on 22 April 2008 when he was last seen alive.
2. In terms of section 6(1)(b) of the said 1976 Act that the causes of death were (a) head, neck and chest injuries and (b) entrapment under wooden boards (lorry trailer load) at work.

3. In terms of section 6(1)(c) of the said 1976 Act that a reasonable precaution whereby Mr. Wilson's death and the accident resulting in his death might have been avoided would have been for the chipboard which collapsed onto Mr. Wilson to have been loaded in such a manner that it did not collapse.

4. In terms of section 6(1)(d) of the said 1976 Act that defects in the system of work which contributed to the accident resulting in Mr. Wilson's death were as follows:

(1) a lack of a suitable and sufficient risk assessment of the health and safety of Harpers Transport employees engaged in the tasks of loading, transporting and unloading chipboard;

(2) a failure to maintain plant, namely the trailer onto which the chipboard was loaded, in a condition that was safe;

(3) a failure to provide a safe system of work for the loading, transporting, storage and unloading of chipboard and

(4) a failure to provide suitable information, instruction, training and supervision to employees engaged in loading, transporting and unloading of chipboard.

Note

The Evidence

Evidence in the inquiry was led on 29 and 30 August 2012. Miss Carrie Macfarlane, Senior Procurator Fiscal Depute, Glasgow represented the Crown. Mr Edward, Solicitor Advocate, Aberdeen represented Harpers Transport, also known as Harpers, the employers of Mr. Wilson.

The Crown led evidence from Keith McIntyre, Kenneth McLeod, Raymond Stevenson, Paul Ridley -all employees of Harpers Transport at the date of the accident- and from

Karen Moran and Dr W. Stewart Arnold, respectively HM Inspector and HM Specialist Inspector with the Health and Safety Executive.

By the date of the Inquiry, Mr. McIntyre and Mr. Ridley had left the employment of Harpers Transport. Mr. McIntyre was employed as Recycling Manager with Harpers Transport at the date of the accident and Mr. Ridley as an HGV driver.

Mr. McLeod was both at the date of the accident and of the Inquiry employed as Plant and Transport Manager with Harpers Transport. Mr. Stevenson was employed at both dates as a plant operator.

The evidence of a number of other witnesses was agreed in an extensive Joint Minute of Agreement.

No evidence was led on behalf of Harpers Transport.

The Submissions

In submissions, both parties were agreed on the findings in terms of section 6(1)(a), (b), (c) and (d) of the 1976 Act. Neither proposed that there were any other facts relevant to the circumstances of Mr. Wilson's death and I am content that there should be no finding in terms of section 6(1)(e) of the 1976 Act.

The Crown's submission in respect of section 6(1)(b) of the 1976 Act was based on the findings in the Post Mortem Examination Report, Crown Production number 3, the details of which are agreed in the Joint Minute at paragraph 8.

In respect of section 6(1)(c) of the 1976 Act, the Crown submitted that it was clear on the evidence that Mr. Wilson's death was attributable solely to the collapse of the stack of chipboard, which would have been avoided had it been loaded in a safe manner. Although Mr. Wilson need not have removed the strap securing the stack as part of his employment, he should have been able to remove the strap without the stack of chipboard collapsing.

Mr. Edward on behalf of Harper Transport adopted the Crown's submissions in respect of section 6(1)(a) and (b).

In respect of section 6(1)(c) of the 1976 Act, Mr. Edward submitted that there was no eyewitness to speak to what Mr. Wilson was doing at the trailer. However, Kenneth McLeod's evidence was to the effect that he believed that Mr. Wilson had removed the strap securing the stack of chipboard for his own purposes. Dr. Arnold's evidence was to the same effect that Mr. Wilson was attempting to remove the strap. Mr. Edward accepted that the evidence was clear that Mr. Wilson's death was solely attributable to the collapse of the stack of chipboard. Even although Mr. Wilson ought not to have removed the strap, it was accepted that the strap should have been capable of being removed without the stack collapsing. Accordingly he accepted that there was a real possibility that Mr. Wilson's death might have been avoided if the chipboard had been loaded differently. He adopted the Crown's submissions in respect of section 6(1)(c).

In respect of section 6(1)(d) of the 1976 Act, Mr. Edward observed that the defects in the system of working mirrored the failures which formed part of the charge by summary complaint under the Health and Safety at Work etc Act 1974 against Harpers Transport, Crown Production number 17 and referred to in the Joint Minute at paragraph 13. Harpers Transport had pled guilty to the charge at Stirling Sheriff Court. Mr. Edward accepted that the evidence was sufficient on a balance of probabilities to justify the finding proposed by the Crown, to the effect that the four failures labelled contributed to the accident resulting in Mr. Wilson's death. Accordingly, he adopted the Crown's proposed findings.

Determination

The evidence in the present inquiry gave rise to no dispute. Witnesses were subject to very limited or no cross-examination. I found all of the witnesses to be credible and reliable.

Keith McIntyre, Recycling Manager at Harpers Transport at the time of the accident, spoke to the division of management roles at the Cowie site between himself and Kenneth McLeod: his role was office based and involved the 'paperwork' in connection with health and safety issues whereas Mr. McLeod was an operational manager with greater responsibility for implementation in respect of health and safety, on-job training and assessment.

Mr. McIntyre spoke to Crown Production number 11, the induction pack for new employees in use at the date of the accident. He also spoke to Crown Production number 4, the risk assessment which covered loading and unloading of vehicles, again being the assessment in use at the date of the accident. Mr. McIntyre's evidence was that the various risk assessments were held in his office which had an open door policy.

With respect to training and assessment of employees, Mr. McIntyre spoke to the operation of a buddy system and to practical, on-job training with Kenneth McLeod carrying out initial capability assessments and subsequent supervision. It was clear from the evidence of Mr. McLeod himself and of Raymond Stevenson that Mr. McLeod was a constant presence in the yard and that he would intervene if he considered that any task was not being performed properly.

Further, the standards employed by Harpers Transport in respect of risk assessments, training and employee assessments were consistent with those employed and required by Norbord. The impression which I gained from each of witnesses McIntyre, McLeod and Stevenson was that prior to the accident, they considered that proper systems of work were in place. Mr. McLeod expressly stated that he had no concerns about loading and unloading operations as nothing had fallen off. He had no concern about the loaded trailer on the date of the accident although did state that he had not studied it.

However, all three witnesses contrasted the pre-accident position with what happened after the accident. Mr. McLeod was clear that chipboard would simply not be moved again in the way which it was prior to the accident. Mr. McIntyre and Mr. Stevenson spoke to the high standard of training which took place after the accident and acknowledged the improvements in the changed working practices.

I heard evidence from Dr. W. Stewart Arnold, HM Specialist Inspector in Mechanical Engineering with the Health & Safety Executive (Field Operations Directorate Specialist Group- Mechanical). Dr. Arnold spoke to his Accident Investigation Report dated 16 August 2008, Crown Production number 10. I found Dr. Arnold to be an impressive witness and accept his conclusions which were unchallenged. Dr. Arnold's conclusions were:

1. The fatal injury to Mr. Wilson occurred when he was struck by a toppling load of chipboard as he removed a lashing strap from a parked trailer.
2. The load comprised of four stacks of chipboard of various dimensions. The rear most stack, which fell onto Mr. Wilson, had been poorly constructed. The stack was narrow at the top of the first layer with larger boards on top, thereby reducing stack stability. The employee who constructed the stacks had no formal training on the use of a telehandler.
3. The condition of the trailer was very poor and unsuitable for transporting chipboard. In particular, the trailer had no brakes, many of the decking boards were missing, the remaining deck was uneven and covered in chipboard debris. These factors increased the potential and likelihood for the load to move in transit.
4. It is probable that the stack was intrinsically unstable when Mr. Wilson removed the lashing due to a combination of contributory factors, namely:
 - (i) the trailer deck was uneven
 - (ii) the stack was poorly constructed
 - (iii) there were no trailer brakes
 - (iv) only one lashing was used
 - (v) the load could have 'sprung' as tension was released on the strap.
5. It is probable that Mr. Wilson may have pulled on the lashing strap to release it when
the unstable load toppled.

Further, Dr. Arnold observed that Mr. Wilson, when removing the lashing strap, may not have noticed any instability issues with the stack and that the stability could have been reduced if the load had 'sprung back' as Mr. Wilson released the tension in the strap. As the physical indicators were that the stack did not immediately topple, Dr. Arnold posited that the initiating event to cause the topple may have been the pulling on the strap.

From the evidence of these witnesses, I conclude that Mr. Wilson was fatally injured when struck by a toppling load of chipboard as he removed a lashing strap from a trailer load of stacked chipboard. The stacks were intrinsically unstable. I accept Mr. McLeod's evidence that Mr. Wilson as a lorry driver had no authorised purpose in attending at the trailer and every indication is that Mr. Wilson was present in an attempt to remove the lashing strap

for his own use. Nonetheless, and as reflected in the submissions of both the Crown and on behalf of Harpers Transport, the strap should have been capable of being removed without the stack collapsing.

I have no hesitation in finding that a reasonable precaution whereby Mr. Wilson's death and the accident resulting in his death might have been avoided would have been for the chipboard which collapsed onto Mr. Wilson to have been loaded in such a manner that it was stable and so would not collapse.

Similarly, I find that the defects in the system of work which contributed to the accident resulting in Mr. Wilson's death were as follows:

- (1) a lack of a suitable and sufficient risk assessment of the health and safety of Harpers Transport employees engaged in the tasks of loading, transporting and unloading chipboard;
- (2) a failure to maintain plant, namely the trailer onto which the chipboard was loaded, in a condition that was safe;
- (3) a failure to provide a safe system of work for the loading, transporting, storage and unloading of chipboard and
- (4) a failure to provide suitable information, instruction, training and supervision to employees engaged in loading, transporting and unloading of chipboard.

Clearly some considerable time has elapsed between the date of the Inquiry and the accident. I note that immediate steps were taken by Harpers Transport and Norbord to address these failures and defects in the system of work.

I have noted that there was considerable agreement between the Crown and on behalf of Harpers Transport. I was particularly impressed by the careful preparation and presentation on behalf of the Crown and Harpers Transport by Miss Macfarlane and Mr. Edward respectively.

Finally, I should like to extend my sympathy to Mr. Wilson's family. Although not present at the Inquiry, Miss Macfarlane was careful to advise me of the keen interest which they had taken in its progress. She also asked that I note that Mr. Wilson remains a much loved and much missed son and brother, described by his family as "a big man with a big heart". It was apparent to me that Mr. Wilson was also a valued employee who is missed by his former colleagues. That was echoed by Mr. Edward on behalf of Harpers Transport who described Mr. Wilson as a popular employee, whose death had had a significant impact. Condolences were extended to Mr. Wilson's family by both the Crown and on behalf of Harpers Transport.