SHERIFFDOM OF GRAMPIAN, HIGHLAND AND ISLANDS AT BANFF

[2026] FAI 23

BAN-B56-25

DETERMINATION

BY

SHERIFF ROBERT MCDONALD

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

into the death of

GORDON ADDISON CHALMERS

BANFF, 12 May 2026

The sheriff having considered the information presented at the inquiry, determines in terms of section 26 of the Act as follows:

1. In terms of section 26(2)(a) that the late Gordon Addison Chalmers, date of birth 10 September 1946, (herein after referred to as "Mr Chalmers") died at Aberdeen Royal Infirmary, Aberdeen where life was formally pronounced extinct at 0635 hours on 20 October 2024.

2. In terms of section 26(2)(b) that the accident resulting in the death of the late Mr Chalmers occurred at approximately 1200 hours on 18 October 2024 at Thriepland Farm, Boyndie, Aberdeenshire.

3. In terms of section 26(2)(c) the cause of the death of the late Mr Chalmers was: 1(a) Multiple Organ Dysfunction Syndrome; 1(b) Polytraumatic injuries; 1(c) being trampled by a cow; and 2 Frailty.

4. In terms of section 26(2)(d) the accident which resulted in Mr Chalmers death was him being trampled by a cow within a cow shed at Thriepland Farm, Boyndie, Aberdeenshire ("the farm"). Mr Chalmers was a partner in the farming partnership, G and M Chalmers along with his wife Margaret Chalmers and his son, Edward James Chalmers. They carried on the business of farming at the farm. On 18 October 2024 Mr Chalmers was working within a cow shed at the farm along with his wife, his son and one of their employees Mr George Smith and they were engaged in sorting cows into groups in preparation for keeping them indoors for the winter. While they were engaged in this operation one of the cows pushed Mr Chalmers onto the ground and against the wall of the cow shed and trampled him.

5. In terms of section 26(2)(e) the following precaution could reasonably have been taken and had it been taken, might realistically have resulted in the death or the accident resulting in the death, being avoided: for Mr Chalmers, while engaged in the task of sorting cattle into groups to have been separated from the cattle by a gate.

6. In terms of section 26(2)(f) there were no defects in a system of working which contributed to the death or the accident resulting in the death.

7. In terms of section 26(2)(g) there are no other facts relevant to the death.

8. I do not consider it appropriate to make any recommendations in terms of section 26(1)(b) as to any of the matters mentioned in section 26(4).

NOTE:

Introduction

[1] This inquiry was held under the Fatal Accidents and Sudden Deaths etc (Scotland) Act 2016 ("the Act") into the death of the late Gordon Addison Chalmers ("Mr Chalmers").

[2] The inquiry was a mandatory inquiry under section 2(3)(a) and (b) of the Act as Mr Chalmers died as a result of an accident which occurred in Scotland in the course of his occupation as a farmer at Thriepland Farm, Boyndie, Aberdeenshire ("the farm").

[3] The Health and Safety Executive (HSE) declined to investigate the circumstances surrounding Mr Chalmers' death. HSE produced an abbreviated report on the circumstances surrounding Mr Chalmers' death from the information reported to them.

[4] The first notice in the inquiry was lodged by the Crown on 8 December 2025.

[5] There was a preliminary hearing on 23 January 2026 which was continued to 6 March 2026 to ascertain from Mr Chalmers' family whether they wished to become participants in the proceedings.

[6] Having heard from the procurator fiscal depute that the family did not wish to participate in the inquiry and that they were content with the Crown's proposal to proceed by way of notice to admit information the continued preliminary hearing was discharged. The procurator fiscal depute confirmed that Mr Chalmers' family had been given sight of the draft notice to admit prepared by the Crown, that they had suggested

certain amendments to the draft and that these amendments had been made to the final version of the notice to admit which was lodged in court on 3 March 2026.

[7] The inquiry took place on 14 April 2026. The only participant in the inquiry was the procurator fiscal who was represented by G Karima Stewart, procurator fiscal depute. I allowed the inquiry to proceed by way of the Crown's notice to admit information without requiring the oral presentation of evidence by witnesses. Ms Stewart on behalf of the Crown read the terms of the notice to admit into the record of proceedings. The notice to admit provided that the documentary evidence contained within the productions lodged by the Crown should be admitted into evidence without the need for that evidence to be spoken to by its author. The Crown productions included an excerpt of Mr Chalmers' general practitioner (GP) medical records, the abbreviated report by HSE, the HSE guidance document Housing and Handling Cattle, photographs of the locus and a number of witness statements. Ms Stewart had lodged written submissions in advance of the inquiry, and these submissions were also read into the record of proceedings. I then made avizandum.

The statutory framework

[8] The inquiry is held under section 1 of the Fatal Accidents and Sudden Deaths etc (Scotland) Act 2016 ("the Act") and is governed by the Act of Sederunt (Fatal Accident

Inquiry Rules) 2017 ("the 2017 rules"). The purpose of such an inquiry is set out in section 1(3) of the 2016 Act and is to:

> "(a) establish the circumstances of the death, and
> (b) consider what steps (if any) might be taken to prevent other deaths in similar circumstances."

[9] Section 26 of the 2016 Act states, among other things, that:

> "(1) As soon as possible after the conclusion of the evidence and submissions in an Inquiry, the sheriff must make a determination setting out –
> (a) in relation to the death to which the Inquiry relates, the sheriff's findings as to the circumstances mentioned in subsection, and
> (b) such recommendations (if any) as to any of the matters mentioned in subsection (4) as the sheriff considers as appropriate.
>
> (2) The circumstances referred to in subsection 1(a) are –
> a) when and where the death occurred,
> b) when and where any accident resulting on the death occurred,
> c) the cause or causes of the death,
> d) the cause or causes of any accident resulting in the death,
> e) any precautions which –
> (i) could reasonably have been taken, and
> (ii) had they been taken might realistically have resulted in the death or any accident resulting in the death, being avoided;
> f) any deficits in any system of working which contributed to the death or any accident resulting in the death,
> g) any other facts, which are relevant to the circumstances of the death.
>
> (3) For the purposes of subsection 2(e) and (f) it does not matter whether it was foreseeable before the death or accident that the death or accident might occur –
> (a) if the precautions were not taken, or
> (b) as the case may be, as a result of the defects.
>
> (4) The matters referred to in subsection 1(b) are –
> (a) the taking of reasonable precautions,
> (b) the making of improvements to any system of working,
> (c) the introduction of a system of working,
> (d) the taking of any other steps,
> which might realistically prevent other deaths in similar circumstances."

[10] The procurator fiscal represents the public interest. An inquiry is an inquisitorial process, and it is not the purpose of an inquiry to establish civil or criminal liability.

Issues for the inquiry

[11] In the notice of inquiry lodged by the procurator fiscal indicated that it was anticipated that the sheriff would be invited to make findings in respect of the death under section 26(1)(a), as to the circumstances mentioned in section 26(2)(a), (b), and (c) of the 2016 Act. The procurator fiscal further indicated that on consideration of the totality of the evidence adduced at the inquiry, the sheriff might also be invited to make findings in respect of the circumstances mentioned in section 26(2)(d), (e) and (f). It was not anticipated by the procurator fiscal that there would be any further substantive issues for the inquiry to address.

Summary of facts

[12] I found the following facts admitted or proved:

1. Gordon Addison Chalmers ("Mr Chalmers") was born on 10 September 1946 and was 78 years of age at the time of his death.

2. At the time of his death Mr Chalmers was married to Margaret Chalmers. They had three children together; Mr Edward Chalmers, Ms Dawn Chalmers and Ms Carol Cook.

3. Mr Chalmers was known to have suffered from a number of medical conditions, mostly cardiac in nature, and had been attending his GP on a regular basis prior to his death.

4. Mr Chalmers grew up on Broomhills Farm and left school as soon as he could to start working on that farm. He and Mrs Chalmers later took over Thriepland Farm, Boyndie as a tenant to the Seafield Estate. Mr and Mrs Chalmers raised their children on the farm which is run as a family business under the name of G and M Chalmers.

5. Thriepland Farm is a sizeable arable and cattle farm with a large number of cattle.

6. During the summer months the cattle are kept in the fields and in late autumn they are brought in from the fields to spend winter in sheds.

7. On 18/10/2024 Mr Chalmers, Mrs Chalmers, Mr Edward Chalmers and employee, Mr George Smith were moving the cattle on the farm to ready them for the winter. Just before approximately 1200 hours they were all working in one of the sheds sorting the cattle, with two animals remaining to be sorted.

8. Mrs Chalmers was at a desk area to the side taking notes on the cattle. Mr Edward Chalmers and Mr Smith were on one side of the shed in the cattle crush area clipping and worming the animals. Mr Chalmers was on the other side of the shed in the collecting area with the cattle, guiding them forward. Due to a wall in the shed Mr Chalmers was out of sight of the others in the shed with him.

9. It was Mr Chalmers' practice to assess the cattle in the collecting area, guide the animal forward through the funnel and shout to Mr Edward Chalmers and Mr Smith how the animal should be sorted. He would shout "barley!" if he wanted the animal fed up on barley or shout if there was an issue with an animal for it to be put elsewhere.

10. Mr Chalmers had sorted the cattle this way for many years and he would not allow anyone else to do it for him or change the way he did things. He was in charge of this sorting process.

11. They were down to the last two cows and while they were all working there was a rumbling or roaring sound from where Mr Chalmers was working. Mr Edward Chalmers and Mr Smith immediately understood that something was wrong and rushed towards where Mr Chalmers was working.

12. Mr Chalmers was on the ground and a cow had its head down "boxing" or "mauling" at him.

13. Mr Edward Chalmers and Mr Smith worked quickly to get the cow away and once it had been removed from the area went to Mr Chalmers aid.

14. Mr Chalmers initially tried to lift his head but was unable to speak. His breathing was shallow and his face was drooping down on one side. Mr Edward Chalmers placed his father in the recovery position, noting his breathing was getting slower, and called emergency services.

15. Emergency services advised Mr Edward Chalmers to begin chest compressions. Mr Chalmers was rolled on to his back and Mr Edward Chalmers began to do chest compressions.

16. Scottish Ambulance Services attended at Thriepland Farm at approximately 1200 hours and found Mr Chalmers unresponsive and receiving CPR from his son. Paramedics removed Mr Chalmers from the shed on the ambulance trolley and continued CPR and administered other lifesaving treatment. They were able to gain a pulse and stabilise Mr Chalmers.

17. Mr Chalmers was conveyed to Aberdeen Royal Infirmary by helicopter where treatment continued and scans noted significant crush injuries. Mr Chalmers was transferred to critical care where he remained for the next 24 hours.

18. It became apparent that given Mr Chalmers comorbidities and frailty there was no meaningful prospect of recovery and he was moved to end of life care. On the morning of 20/10/2024 Mr Chalmers was removed from the ventilator and pronounced life extinct at 0635 hours.

19. Doctors at Aberdeen Royal Infirmary issued a death certificate with Mr Chalmers cause of death recorded as follows: 1(a) Multiple Organ Dysfunction Syndrome; 1(b) Polytraumatic injuries; 1(c) Trampled by cow; and 2 Frailty.

20. The facilities at the place where the accident resulting in Mr Chalmers death took place were appropriate for the task being carried out with an adequate race and crush being available to assist in handling the cattle.

21. Best practice would have been for Mr Chalmers to have been positioned outside the gate of the collecting area to carry out of the majority of his task in sorting cattle.

Discussion

[13] I was able to determine the time and place of death from the notice to admit information which was supported by the form of intimation of death together with the witness statement by Dr David Middleton, critical care consultant at Aberdeen Royal Infirmary both of which were lodged as productions.

[14] I was able to determine the time and location of the accident resulting in Mr Chalmers' death by reference to the witness statements of Mr Edward James Chalmers and Mr George Smith both of which were produced by the procurator fiscal. Although Mr Chalmers was not visible to these witnesses when the accident began, they were working in close proximity to him, and they were alerted to the accident by hearing what they described as a rumbling sound and Mr Chalmers shouting or roaring for help. Immediately they both ran to where Mr Chalmers had been working to find him being attacked by a cow. My determination in this respect is also supported by the witness statements obtained from members of the emergency services.

[15] I was able to determine the cause of death by reference to the intimation of death form together with the witness statement by Dr David Middleton, critical care consultant at Aberdeen Royal Infirmary.

[16] I was able to determine the cause or causes of the accident resulting the death from the witness statements taken from Mr Edward James Chalmers and Mr George Smith.

[17] I was required in terms of section 26(2)(e) to determine whether there were any precautions which could reasonably have been taken and had they been taken, might realistically have resulted in the death or the accident resulting in the death, being avoided. Section 26(2)(e) sets out a two-stage test. First, I require to be satisfied on the evidence that there was a precaution which could reasonably have been taken. Secondly, I have to be satisfied, again on the evidence led, that if the precaution in question had been taken, then it might realistically have prevented the death. Unless both criteria are met, no finding should be made in terms of section 26(2)(e).

[18] The use of the word "reasonably" relates to the reasonableness of taking the precautions rather than the foreseeability of the death or accident. A precaution might realistically have prevented a death if there is a real or likely possibility, rather than a remote chance, that it might have done so. The purpose of a Fatal Accident Inquiry is not to attribute blame, but to examine the facts and circumstances of the death with a view to preventing deaths in similar circumstances in future. It is clear from the witness statements that Mr Chalmers was a gentleman who knew his business and had his own preferred way of doing things, which he would not change.

[19] The Crown produced a copy of the HSE information sheet in relation to the handling and housing of cattle. This information sheet provides general advice for farmers on safe handling of adult cattle. It points out that every year there are deaths and injuries to farmers and other workers while handling cattle and that these are often caused by using poor equipment, ineffective methods of moving cattle and an underestimation of the strength, speed or behaviour of cattle. It notes that handling cattle always involves a risk of injury from crushing, kicking, butting or goring. The information sheet sets out some general principles of cattle handling and advises that consideration requires to be given to the following: the person - including their mental and physical abilities, training and experience; the equipment available - including races, crushes, and loading facilities; and the animal - including its health and familiarity with being handled. It advises that every farm that handles cattle should have proper handling facilities. These should be well-maintained and in good working order. A race and a crush suitable for the animals to be handled are essential and the information sheet gives detailed guidance on the requirements for a race and a crush which does not require to be repeated here.

[20] Although HSE declined to carry out an investigation into this accident they issued an abbreviated report into the circumstances and this report was lodged in process by the Crown. The report comments that from the photographs available to HSE it would appear that there had been an adequate race and crush within the cow shed being used to sort the cattle, albeit the race was fairly short. It was noted that the witnesses indicated that Mr Chalmers was in the area outside the race in the collecting

area, guiding the stock to the race. While there is a gate between the pen and the race he was not separated in any way from the stock.

[21] The report goes on to state that from the description of the practices being used at the time Mr Chalmers was not operating in accordance with best practice. It is realistic to expect that the collecting area be set up in such a way that he could carry out the majority of his task from behind a gate, removing much of the risk. The report also states that it was apparent that Mr Chalmers was the controlling mind of the company and as the senior partner would not take advice from his juniors.

[22] The terms of the HSE report are consistent with the witness statements and photographs produced for this inquiry and I have no difficulty in accepting its findings. I have therefore made the determination that a precaution which could reasonably have been taken and had it been taken, might realistically have resulted in the death or the accident resulting in the death, being avoided would have been for Mr Chalmers, while engaged in the task of sorting cattle into groups to have been separated from the cattle by a gate.

[23] I did not consider there were any defects in a system of working which contributed to the death or the accident resulting in the death. The HSE noted that the race and crush were adequately set up but that Mr Chalmers was in the collecting area with nothing to separate him from the cattle. It would appear from the evidence that this was how Mr Chalmers preferred to carry out this task. It was possible that the work could have been carried out from behind a gate. I agree with the Crown submission that it was therefore a matter of Mr Chalmers preferred way of working rather than any

defect in a system of work. I therefore did not consider it would be appropriate to make a determination in terms of section 26(2)(f).

[24] I did not consider there were there any other facts relevant to the death, and it was therefore not necessary for me to make any determination in terms of section 26(2)(g).

Concluding remarks

[25] I am grateful to Ms Stewart for her helpful and respectful presentation of evidence, for her submissions and for her assistance in this inquiry.

[26] Finally, I would wish to extend my sincere condolences to the family of the late Mr Chalmers for their sad loss as a result of this tragic accident.