SHERIFFDOM OF NORTH STRATHCLYDE AT KILMARNOCK

[2026] FAI 45

KIL-B1099-25

DETERMINATION

BY

SHERIFF C J BISSETT

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

into the death of

JAMES STEEL

Kilmarnock, 18 August 2026

DETERMINATION

The sheriff, having considered the information presented at the inquiry, determines in terms of section 26 of the Act, that the late JAMES STEEL, born 14 September 1959, of Ballochmartin Farm, Millport, Isle of Cumbrae, died sometime between noon and 1.45pm on 25 September 2024 at Ballochmartin Farm, Millport, Isle of Cumbrae.

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

(i) Death occurred sometime between noon and 1.45pm on 25 September 2024 at Ballochmartin Farm, Millport, Isle of Cumbrae.

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

(ii) The death resulted from an accident at Ballochmartin Farm, Millport, Isle of Cumbrae, sometime between noon and 1.25pm.

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

(iii) The cause of death was: a motorised wheel loader crushed the deceased against a metal cattle feeder. Mr Steel died of asphyxia due to chest compression by a motorised wheeled loader.

RECOMMENDATIONS

No recommendations are made in terms of section 26(1)(b) of the Act.

NOTE

Introduction

[1] The inquiry was held under the Act into the death of James Steel.

[2] The Procurator Fiscal was the sole participant in the inquiry.

[3] The representative of the participant in the inquiry was Ms Lewis, Procurator Fiscal Depute.

[4] Preliminary hearings took place on 16 February, 11 March and 1 May 2026. The inquiry hearing took place on 20 July 2026.

[5] The preliminary hearing of 16 February was continued as the documentary productions were lodged with insufficient time for them to be considered before the hearing. The preliminary hearing of 11 March was continued for the Procurator Fiscal to lodge the witness statements of three police (CID) officers who had attended the scene of the death and to obtain a supplementary statement from Mr Robert Steel, in order to clear up matters which appeared ambiguous; also, for the Procurator Fiscal to obtain an explanation from Police Scotland for the absence of a vehicle examination report and a scene examination report. At the preliminary hearing on 1 May 2026, the Procurator Fiscal was directed to lodge a notice to admit information, in terms of Rule 4.12 of the Act of Sederunt (Fatal Accident Inquiry Rules) 2017 ("the Rules").

[6] The Procurator Fiscal lodged an inventory of documentary productions as follows: -

1. Intimation of death to Procurator Fiscal
2. Death certificate
3. Post-mortem report
4. Medical records of James Steel
5. Correspondence between Police Scotland and COPFS
6. Photographs of locus
7. Witness statement of Robert Steel, dated 25 September 2024
8. Witness statement of Alyson Shaw, dated 15 April 2025
9. Witness statement of Jacqui Gourley, dated 25 September 2024
10. Witness statement of John Horn, dated 25 September 2024

11. Witness statement of PC Lewis Reaney, dated 14 October 2024

12. Witness statement of Robert Steel, dated 28 April 2025

13. Witness statement of DS Peter Sweeney, dated 29 March 2026

14. Witness statement of DC Danielle Keyes-Parkinson, dated 5 April 2026

15. Witness statement of DC Lorna Kerr, dated 5 April 2026

16. Witness statement of Robert Steel, dated 13 May 2026

[7] The Procurator Fiscal invited the court to make formal findings only in terms of subsections (a), (b) and (c) of section 26(2) of the Act; to make no findings in respect of subsections (d), (e) and (f) of the Act; and to decline to make any recommendations in terms of subsection (b) of section 26(1) of the Act.

[8] On 13 May 2026 the Procurator Fiscal lodged a notice to admit information in terms of Rule 4.12 of the Rules, setting out facts and productions it sought to present at the inquiry. No witnesses were cited to attend the inquiry hearing. On the same date, a note of written submissions on behalf of the Procurator Fiscal was lodged.

[9] At the inquiry hearing on 20 July 2026, there being no party to object, I deemed it unnecessary for the Procurator Fiscal to present information to the inquiry concerning the facts or productions set out in the notice to admit. I accepted the facts set out in the notice to admit as uncontroversial. The terms of the notice were narrated into the record by Ms Lewis. This formed the entirety of the information before the inquiry hearing. No parole evidence was led. Thereafter, the written submissions on behalf of the Procurator Fiscal were narrated into the record by Ms Lewis. I then made avizandum.

The legal framework

[10] This inquiry was held in terms of section 1 of the Act and was governed by the Act of Sederunt (Fatal Accident Inquiry Rules) 2017. This fatal accident inquiry was a mandatory inquiry in terms of section 2 of the Act as the death of Mr Steel occurred while he was acting in the course of his occupation.

[11] In terms of section 26(2) of the Act, the inquiry must determine certain matters, where applicable, namely:

(a) where and when the death occurred,

(b) when and where any accident resulting in 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 defects in any system of working which contributed to the death, or any accident resulting in the death, and

(g) and any other factors relevant to the circumstances of the death.

[12] It is open to the Sheriff to make such recommendations as are appropriate in relation to matters set out in section 26(4) of the Act, namely:

(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) and the taking of any other steps,

which might realistically prevent other deaths in similar circumstances.

[13] The Procurator Fiscal, represents the public interest. The purpose of this inquiry is set out in section 3 of the Act as being to establish the circumstances of the death and to consider what steps, if any, might be taken to prevent other deaths in similar circumstances. It is not intended to establish liability, either criminal or civil. The inquiry is an inquisitorial process and the manner in which evidence is presented is not restricted. The determination must be based on the evidence presented at the inquiry.

Summary

The facts

James Steel

[14] James Steel ("the deceased") was born on 14 September 1959 and was 65 years old at the date of his death on 25 September 2024. He resided alone at Ballochmartin Farm, Millport, Isle of Cumbrae, where he was a self-employed farmer. He didn't employ anyone to assist him although his brother, Robert Steel, worked on the farm every day.

[15] The deceased rarely attended his GP practice. At the time of his death, he took no prescribed medication apart from Simvastatin tablets, to manage his cholesterol.

Events immediately preceding the death

[16] On the morning of 25 September 2024, Robert Steel arrived at Ballochmartin Farm to begin work. The deceased advised Robert Steel he intended to distribute feed for his calves. This involved filling the bucket at the front of a motorised wheel loader by hand from a tonne bag of feed he had purchased the previous day. The feed would be transported in the loader bucket to be deposited in calf feeding hoppers ("feeders").

[17] The loader was a Matbro TR200 Turbo, vehicle registration mark L410 TSL, described (confusingly) by some witnesses as either a "forklift" or a "tractor". It has four wheels and a rear-mounted diesel engine. The driver's cab is enclosed. At the front is a hydraulic arm upon which a scooping bucket is mounted. It was approximately 20 years old at the time.

[18] Robert Steel worked elsewhere on the farm whilst the deceased carried out this work. He last saw the deceased alive around noon. At this time, the deceased had returned to refill the bucket on the loader with feed before heading back out to fill the feeders. After a time, Robert Steel felt the deceased had been away for longer than expected, so he went to look for him.

His death discovered

[19] He located the loader in a field around a quarter of a mile from the farmhouse and noted that the engine was still running. As he drew near, he saw the deceased trapped between the loader's bucket and the feeder. The deceased was standing facing the feeder, although slumped over it with his arms inside it. The bottom edge of the

bucket was pressing on the deceased's lower back. Robert Steel supposes it was necessary for the deceased to go between the loader and the feeder to open the lid of the hopper, to allow the feed to be deposited inside. Mr Steel got into the loader and reversed it away from the feeder, resulting in the deceased's body falling to the ground, face up. The deceased's face was seen to be blue at this time.

[20] Robert Steel phoned his ex-wife, Alyson Shaw, to tell her what had happened and ask that she contact the emergency services. He told her the deceased was dead, having become trapped between the "feeding trailer" and the "tractor". Alyson Shaw then called 999 to report the incident to police.

[21] At 1.25 pm, Police Constable Lewis Reaney was on uniformed mobile patrol in Cumbrae when he was instructed by the area control room to attend at Ballochmartin Farm. He did so immediately.

[22] At 1.29pm, Jacqui Gourlay and John Horn were on duty as ambulance technicians with the Scottish Ambulance Service, when they were actioned to attend Ballochmartin Farm. The call came through as a "purple call" making them aware that someone had sustained a crushing injury resulting in asphyxiation. On attending Ballochmartin Farm they were met by PC Reaney.

[23] They observed Robert Steel within one of the fields, calling to them. They went to meet him and found him to be in a hysterical state, crying and repeating the words "he's died". All three observed the wheeled loader, stationary before a large, red feeder stand, between one and two metres apart. The deceased was lying face up on the ground between them. His lips were blue and he appeared lifeless. Post-mortem

lividity was evident, and rigor mortis had set in. At 1.45pm, Jacqui Gourley pronounced life extinct.

[24] PC Reaney was apprised of the circumstances by Robert Steel. At this time, PC Reaney observed the loader's engine to be switched off. The feeder had a dent in it just above chest height. Marking on the ground suggested it had been moved out of position with a degree of force. CID officers were requested to attend, to photograph the scene and examine the deceased. PC Reaney secured the area until their arrival. The ambulance crew covered the deceased's remains with a blanket.

[25] Detective Sergeant Peter Sweeney and Detective Constables Danielle Keyes-Parkinson and Lorna Kerr attended at the scene at approximately 5pm. The ambulance crew, PC Reaney and Robert Steel were still present. Mr Steel was visibly upset and he was asked to return to the farmhouse before the police examined the deceased's remains.

[26] The CID officers noted the deceased to be lying on his back on the ground between a "tractor" and a large red metal cattle feeder. The engine of the loader was switched off and the bucket of the tractor was level to the ground. The officers observed damage to the side of the feeder and marks on the ground where the feeder had been pushed back about 10 inches. There was a slight decline in the ground between the loader and the feeder.

[27] The deceased was noted to have an indent line across the front of his chest and a slight indent line on his lower back, consistent with him having been crushed between the loader's bucket and the feeder.

[28] In their witness statements, the officer state that a scene examiner was unable to attend to photograph or carry out a forensic examination of the scene, due to the ferry timetable. DC Kerr resorted to taking photographs of the locus and the deceased on her Pronto mobile device.

[29] In photographs taken by DC Kerr, the loader can be seen sitting with the lower edge of the front bucket approximately two to three metres away from a red Portequip feeding hopper. The deceased's remains are between the two, immediately before the feeder, oriented face up with the legs bent at the knee and the feet on the ground. The front of the loader is facing the hopper at a slight angle (which I estimate from the photographs to be around 20degrees). The front bucket is around three quarters full of what one may presume to be animal feed. The feeder lid has been slid back and appears empty inside apart from traces of the substance pictured in the loader's bucket.

[30] Road traffic police officers were requested to attend the following day to mechanically examine the loader. They failed to attend on the day following or on any subsequent day. No examination of the machine was ever carried out. Police Scotland have failed to provide any explanation for this to the Procurator Fiscal.

[31] The CID officers then spoke with Robert Steel. He was still upset but confirmed that when he discovered the deceased, he immediately got into the loader and reversed it. This was an automatic response. He could not recall whether the handbrake was on at the time. He told them he may have lowered the bucket to the ground after moving the vehicle. He found it difficult to remember the exact details due to the upsetting nature of the incident.

[32] The police officers were satisfied that there were no suspicious circumstances surrounding the death. The deceased's remains were then conveyed to Crosshouse Hospital.

[33] The Health and Safety executive (HSE) were made aware of the circumstances but declined to investigate as they claimed to be without statutory obligation to do so because James Steel being self-employed and having no employees. This overlooked the fact that Robert Steel worked there on a daily basis.

[34] Robert Steel, in his second witness statement, explained that the deceased "never" used the handbrake on the loader. As the ground around the farm was "fairly flat" he normally jumped in and out of the machine without engaging the handbrake. At the time, the handbrake was functional.

Post mortem analysis

[35] On 2 October 2024, Dr Derek Leitch, pathologist, conducted a post-mortem examination on the deceased at Crosshouse Hospital mortuary. The cause of death was recorded as:-

> "1a. Asphyxia
>
> 1b. Chest compression by tractor"

Submissions

[36] Only formal findings in terms of section 26(2)(a) and (c) of the Act are required. These should reflect the information contained in the notice to admit.

[37] In terms of Section 26(2)(d), the Procurator Fiscal submitted that it is unknown what caused the accident resulting in James Steel becoming trapped between the loader and the feeder trough. There is no direct evidence available. No one witnessed the accident, nor was it captured on CCTV. No forensic examination of the scene of the accident was carried out. No vehicle examination of the loader was ever carried out. Therefore, no cause of the accident can be identified.

[38] Accordingly, in terms of sections 26(2)(e) and (f), no precautions which might realistically have avoided the death of Mr Steel are identifiable; nor are any defects in any system of working which contributed to his death identifiable.

[39] The Procurator Fiscal made no submissions in terms of section 26(2)(g).

[40] Given the circumstances of the death, and the information available to me, I was invited to decline to make any recommendations in respect of the matters mentioned at Section 26(4) of the Act.

Discussion and conclusions

[41] I am grateful to Ms Lewis for her diligence in pursuing important missing information, following my direction. Also, for her preparation of a detailed notice to admit which allowed the attendance of witnesses to be dispensed with. Her well-focussed submissions upon the evidence have assisted me in making my determinations in this matter.

[42] I accept the submissions made anent making formal findings in terms of section 26(a), (b) and (c). All of the evidence supports the conclusion that the deceased

became trapped between the Matbro loader and the feeder whilst he was readying the latter to receive a load of feed from the loader's bucket.

[43] I concur with her submission that I am unable to make any findings in terms of section 26(d), (e) and (f) due to having insufficient information before me to do so. It is possible that the deceased omitted to engage the handbrake when he alighted the machine. Equally, he may have engaged the handbrake, and it failed on this occasion. Or, he may accidentally have left the machine in a low gear when he alighted, causing it to creep forwards. Whilst the first of these scenarios seems the most likely on the information before me, that information is incomplete. It is unsatisfactory that I am unable to make a finding as to the cause of the accident which led to James Steel's death where, had more care been taken by Police Scotland in ingathering evidence, additional information might have been available to the inquiry to allow one or more of these scenarios to be ruled out, or otherwise allow one of them to be identified as the probable cause of the accident.

[44] Without being able to establish the cause of the accident I am unable to make any findings in terms of section 26 (e) and (f).

[45] I agree that the evidence does not suggest any other facts which are relevant to the circumstances of James Steel's death.

[46] Having carefully considered all of the evidence before the inquiry, I conclude that formal findings in terms of sections 26(2)(a) and (c) of the Act only are justified and no recommendations are to be made in terms of section 26(1)(b).

Other observations

[47] James Steel was a hard-working man in a difficult and demanding occupation. His death as a result of an accident in the course of his work is a tragedy for his family and friends, to whom I express my sincere sympathies.

[48] The quality of the statements initially obtained from witnesses by Police Scotland is poor. Beyond the many typographical and grammatical errors, they omit to record essential information about the circumstances of the accident which, presumably, would have been fresh in the minds of those witnesses at the time; and might have been obtained by careful, focussed questioning.

[49] Surprisingly, none of the three CID officers in attendance thought to obtain a statement from Robert Steel themselves. In his case, two supplementary witness statements were taken (the latter on my direction) due to the poor quality of the first. The second statement left some matters still ambiguous. By the time a third statement was taken, earlier this year, Mr Steel's recollection of events was, he said, impaired due to the passage of time. He found it upsetting to be contacted to provide another statement about the circumstances of his brother's death.

[50] It also to be regretted that no forensic examination of either the scene or the machine involved was ever carried out.

[51] The only explanation for the failure to send a scenes of crime officer to the locus is given in the witness statements of DS Sweeney and DC Keyes-Parkinson, thus: "due to the ferry timetable". Given that those officers were themselves able to attend the scene by ferry, it is not obvious why a scenes of crime officer could not.

[52] None of the CID officers explained in their statements, prepared some months after the event, why road traffic policing officers did not attend to examine the loader on 26 September as arranged. No answer was given to the Procurator Fiscal when they sought an explanation from Police Scotland on my direction.

[53] It is concerning that the mechanical condition of the machine on the date of the accident was never ascertained. The lack of such an examination also leaves open the question of whether it presents an ongoing danger to anyone, given it is still used on the farm.

[54] The decision by the Health and Safety Executive not to investigate the circumstances of James Steel's death appears to have been taken in haste. While Mr Steel did not have any known employees, it is clear that Robert Steel worked on the farm every day. The decision to not investigate might ultimately be in keeping with the HSE's statutory obligations (I do not offer any opinion on its correctness) but it is surprising that more care was not taken to ascertain the exact circumstances of Robert Steel's daily work on the farm.

[55] The information before the inquiry is that no one in the locality was employed on the farm. Also, that the farm belonged to the deceased. It is however unknown whether Robert Steel and the deceased were partners together in any business which used the farm as its base of operations; whether Robert Steel was remunerated in any way for his work on the farm; or whether he worked under the direction of the deceased on the farm. It is surprising that the HSE were able to decide not to investigate James Steel's death without clarity on these points.