SHERIFFDOM OF GRAMPIAN HIGHLAND AND ISLANDS AT ABERDEEN

[2026] FAI 11

ABE-B856-25

DETERMINATION

BY

SUMMARY SHERIFF RHONA WARK

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

into the death of

ANDREW ALEXANDER SOUTAR

ABERDEEN, 13 March 2026

Determination

The sheriff, having considered the information presented at the Inquiry, determines in terms of the Inquiries into Fatal Accidents and Sudden Deaths Etc (Scotland) Act 2016, (hereinafter referred to as the "2016 Act") that:

In terms of section 26(2)(a) of the 2016 Act (when and where the death occurred).

The late Andrew Alexander Soutar, born on 1 June 1970, died on 1 June 2023 in a field at Broomhill Farm, Lyne of Skene, Westhill, aged 53 years and was pronounced dead at 1854 hours.

In terms of section 26(2)(b) of the 2016 Act (when and where any accident resulting in death occurred).

The accident resulting in death took place after 1700 hours and before 1800 hours on 1 June 2023 at a field at Broomhill Farm, Lyne of Skene, Westhill**.**

In terms of section 26(2)(c) of the 2016 Act (the cause or causes of death).

The cause of death of the said Andrew Alexander Soutar was crush asphyxia caused by the compression of the chest by heavy agricultural equipment, namely a Major Equipment Limited MR180 Finishing Mower ("the Mower") sustained in an incident while at work.

In terms of section 26(2)(d) of the 2016 Act (the cause or causes of any accident resulting in the death),

The immediate cause of the accident resulting in the death of the said Andrew Alexander Soutar was the presence of Mr Souter lying under the Major Finishing Mower ("the Mower"), whereby he was exposed to the mower lowering and trapping his body beneath it.

In terms of section 26(2)(e) of the 2016 Act, any precautions which (i) could reasonably have been taken and (ii) had they been taken might realistically have resulted in death or any accident resulting in death being avoided.

No findings fall to be made.

In terms of section 26(2)(f) of the 2016 Act, any defects in any system of working which contributed to the death or accident resulting in death.

There are no defects in any system of working which contributed to the death or the accident which resulted in the death of the said Andrew Alexander Soutar.

In terms of section 26(2)(g) (any other facts which are relevant to the circumstances of the death).

There are no other facts relevant to the circumstances of the death of the said Andrew Alexander Soutar.

Recommendations

In terms of sections 26(1)(b) of the 2016 Act (recommendations if any) as to (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.

There are no recommendations made.

NOTE:

The legal framework of the Inquiry

[1] This Inquiry was held in terms of Section 1 of the 2016 Act and was governed by the Act of Sederunt (Fatal Accident Inquiry Rules) 2017 hereinafter referred to as ("the Rules"). This Fatal Accident Inquiry was presented by the Crown as a mandatory inquiry in terms of section 2 of the 2016 Act as Mr Soutar died as a result of an accident in the course of his employment or occupation.

[2] The purpose of this Inquiry is set out in section 3 of the 2016 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 exercise on fact finding not fault finding. The Inquiry process is an inquisitorial one in which the Procurator Fiscal represents the public interest.

[3] In terms of sections 26(1)(b) and 26(4), the Inquiry must determine certain matters, namely when and where the death occurred when any accident resulting in the death occurred, the cause or causes of death, the cause or causes of any accident resulting in death, any precautions could reasonably have been taken and might realistically have avoided the death or any accident resulting in the death, any defects in any system of working which contributed to the death and any other factors relevant to the circumstances of death. It is open to the sheriff to make recommendations in relation to matters set out in sub-section 4 of section 1 of the 2016 Act. The sheriff is not obliged to make recommendations, that is a discretionary power.

Introduction

[4] This Inquiry was held under section 1 of the Act. It was a mandatory Inquiry in terms of section 2(1) and (3) as Mr Soutar died because of an accident in the course of his employment or occupation. The Procurator Fiscal lodged a notice of the Inquiry on 8 October 2025. The Inquiry itself took place at Aberdeen Sheriff Court on 5 February 2026.

[5] Two parties were represented at the Inquiry. Ms L Duffus Procurator Fiscal Depute appeared for the Crown, Mr Allan Brownie was represented as a director of BA Events Limited which has subsequently been dissolved by Ms Z McDonnell, solicitor Parties lodged a joint minute. The narrative of facts listed at paras [8] to [13] are derived from the joint minute and productions.

[6] No oral evidence was led at the Inquiry hearing. A joint minute of agreement was entered into by all parties. All parties invited me to make formal findings only in respect of sections 26(1)(a) to (d) of the Act. Neither of the parties invited me to make any recommendations.

[7] The following productions were lodged and referred to in the joint minute.

a. Postmortem report

b. Toxicological report

c. Specialist inspector's report "Assessment of a tractor 3-point linkage and agricultural mower" by HM specialist inspector in mechanical engineering,

d. HSE guidance document AIS25: Safe use of agricultural mowers. 33 Crown Production 5 is a true and accurate copy of HSE Guidance Document INDG185: Using tractors safely.

e. Major Finishing Mowers Operator Manual and Parts List. 35 Crown Production 7 is a true and accurate copy of Major M180 Mower Specification

f. Witness statements:

Narrative of the facts

[8] Andrew Alexander Soutar (Mr Soutar) was 53 years old having been born on 1 June 1970. He formerly resided at 33 Gort Road in Aberdeen. Mr Soutar was an experienced groundsman having been employed by Aberdeen University as a groundsman for a period of 18 years before starting his own business and becoming self-employed. At the time of his death, Mr Soutar provided grass cutting services and general tidying to various clients including BA Events Limited at Broomhill Farm, Lyne of Skene, Westhill. He did so on a self-employed basis and had done so since around 2008. Over time he and Allan Brownie became good friends.

[9] At approximately 1230 hours on 1 June 2023, Mr Soutar attended at Broomhill Farm to cut the grass. He spoke with Mr Brownie. Mr Soutar was seen by Mr Brownie cutting grass at around 5 o'clock when the left the premises to go to a blacksmith. On his return at 1800 hours, Mr Brownie could see the tractor in which Mr Soutar was working with the mower up the hill. He could not see Mr Soutar. Mr Brownie went to

investigate and discovered Mr Soutar under the mower of the tractor with the mower on Mr Soutar's chest. Mr Brownie attempted to lift the mower with his hands but was unable to do so. He thereafter went into the cab of the tractor, turned on the engine, and used the hydraulic lift to lift the mower off Mr Soutar's body and move the tractor and mower away from Mr Soutar. Mr Brownie thereafter contacted his son and the emergency services for assistance. Mr Brownie's son alerted his nephew's wife who is a qualified nurse and who attended with a defibrillator from the local town hall and assisted in performing CPR. When he attended at the locus Mr Brownie noticed when he moved the tractor a small vice grip lying on the ground but not close to Mr Soutar. Mr Brownie summarised Mr Soutar must have been using it and thrown it away. Paramedics arrived at Broomhill at 1824 hours and took over attempts to save the life of Mr Soutar. They discontinued their efforts when they were deemed unsuccessful and Mr Soutar was pronounced dead at 1854 hours.

[10] Following an autopsy examination on 6 June 2023, Professor James Henderson Kerr Grieve and Doctor Allan Farnsworth certified that Mr Soutar had died as a result of crush asphyxia as a result of compression of the chest by heavy agricultural equipment sustained while he was at work. A toxicological examination was carried out by Doctor Duncan Stephen and Doctor Kevin Deans. No drugs were detected nor was alcohol found.

[11] An investigation carried out by the health and safety executive could find no definitive reason why Mr Soutar would be underneath the mower. They determined

that the premises were used solely for event and entertainment purposes and they did not identify any health and safety failing on the part of BA Events.

[12] A specialist inspector's report discloses that upon examination of the mechanism of the mower, the mower cutting blades were knocking against the blade guard. The noise of the knocking could be heard from the cab. It was further identified there was a fault within the hydraulic system which provided power to the 3-point linkage system connected to the mower, the result being that when the tractor engine was turned off the 3-point linkage dropped at approximate rate of 27 millimetres per minute.

[13] The mower itself appears to have been well maintained and within health and safety guidelines any maintenance of the "mower" was carried out using a prop. With the engine turned on the hydraulic 3-point linkage held the mower in the raised position. With the engine turned off the mower dropped approximately 270 millimetres at a rate of approximately 27 millimetres per minute. It was clear that had Mr Brownie been aware of any damage to the mower guard that would have been repaired by himself and Mr Soutar. Mr Soutar working on the mower alone was not the regular working practice for maintenance of the equipment he used. There is no evidence to suggest that any health and safety failing on the part of BA Events Limited or Allan Brownie caused Mr Soutar to complete or carry out the task which led to his death.

The evidence

[14] Miss Duffus intimated that all the evidence to be presented at the Inquiry was contained within the joint minute which she read out. The salient facts from the joint minute are noted above and the principal joint minute is lodged. The principal joint minute is admitted to evidence and is lodged with the Inquiry papers.

Submissions

[15] Both parties helpfully lodged written submissions.

The Crown

[16] Miss Duffus made formal submissions in relation to when and where Mr Soutar's death and the accident resulting in his death occurred based on the evidence contained in the joint minute. Likewise, her submissions make formal submissions in relation to the cause of Mr Soutar's death in accordance with the findings of the pathologist at autopsy.

[17] Ms Duffus submitted that section 26(2)(e), the act sets out a two-stage test. First the Inquiry required to be satisfied on the evidence that there was a precaution which could reasonably have been taken. Secondly that the Inquiry had to be satisfied on the evidence available or led that if the precaution in question had been taken then it might realistically have prevented the death.

[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 it might have done so.

[19] The Crown recognised that it is open to the court that to find that Mr Soutar could have taken a reasonable precaution of using a prop while working beneath the mower HSE guidance document AIS25 clearly states. "Always use a purpose-made prop or stand to carry out maintenance work safely beneath a mower. Do not rely on the tractor hydraulics alone." The Major Finishing Mowers Operator Manual similarly warns that hydraulics may leak even when the engine is off and that rigid supports must be used.

[20] However, the Crown further submitted that in considering whether to make a finding under 26(2)(e), paragraphs (f) and (g), that the court must do so with a view to furthering the purpose of the Inquiry, and must consider whether BA Events Ltd or Mr Brownie could reasonably have taken any precaution which might realistically have avoided the death.

[21] There were no health and safety failings found on the part of either BA Events or Mr Brownie which required or caused Mr Soutar to carry out the task which resulted in his death. In relation to 20(6)(2)(f), the Crown could identify no information suggesting a defect in the systems of work. The normal working practice for maintaining the mowers was within the guidance set out by in the documentation provided namely to support raised machinery with a prop before working beneath it. The equipment was maintained appropriately, and no hydraulic defect was known or reasonably detectable. The deceased was regarded as cautious and familiar with proper safe working methods.

The now dissolved BA Events Ltd and A Brownlie

[22] Ms McDonnell adopted the submissions of the Crown and in relation to paragraphs 26(2)(a) to (c), paragraph 26(2)(d).

[23] In relation to the immediate cause of the accident submitted that an inference could be drawn Mr Soutar's position beneath the mower he had heard knocking, which was identified on the mechanical investigation, had decided to investigate the knocking, and positioned himself below the mower. The guard, it may be inferred, had been dented sometime after Mr Brownie observed Mr Soutar mowing at approximately 1700 hours on 1 June 2021. That in investigating the knock Mr Soutar as a lone person was unable to lift the mower physically, had raised the mower into a position above the ground with the use of the hydraulics which then suffered a failure resulting in the loss of pressure to the 3-point linkage arm cylinder when the tractor engine was turned off which resulted in a gradual lowing of the 3-point linkage to the mower attached to it.

[24] When Mr Brownie found Mr Soutar trapped under the mower the tractor engine was off and he switched the tractor engine on to lift the mower and move the tractor away from Mr Soutar. Although the mower was found to lower to the ground very slowly at the rate of 27 millimetres per minute the reason why Mr Soutar did not or could not move out from under the mower to avoid being trapped could not be established from the evidence and ought not to be speculated upon.

[25] Ms McDonnell submitted that in terms of paragraph 26(2)(e) there was no evidence that there was any reasonable precaution could reasonably have been taken by

Mr Brownie or BA Events which had it been taken would have realistically resulted in the death being avoided. There is no suggestion the vehicle was not well maintained and the guidance within the HSE Guidance Document AIS25 paragraph 4.7 states clearly that "hydraulic circuits can fail unexpectedly at any time".

[26] Mr Brownie was unaware of any oil leak or loss of pressure within the hydraulics and the Health and Safety Executives opinion was that the hydraulic fault which resulted in a 3-point lowering was associated either with an internal or external leak. The local authority identified no health and safety failings.

Discussion and conclusions

[27] It is clear from the evidence presented to the inquiry that all possible steps were taken to assist Mr Soutar upon discovery of the incident, which resulted in the untimely loss of his life.

[28] On the available evidence at the inquiry I have determined that Mr Soutar died as a result of crush asphyxia, because of compression of the chest by a Major Finishing Mower, under which he had positioned himself thereby exposing himself to the risk of the mower lowering and trapping him beneath it.

[29] While the precise reason Mr Soutar placed himself under the mower cannot be established definitively, a reasonable inference, may be drawn from the evidence of HSE Specialist Inspector, and Senior Environmental Health Officer, that a knocking noise caused by a mower blade contacting a dented guard was heard by Mr Soutar. Mr Soutar then investigated the source of the noise, raising the mower blades to their upright

position to do so. He then started to work under the raised mower without additional support. A hydraulic fault developed, resulting in a loss of pressure in the 3-point linkage lift arm cylinder when the tractor engine was turned off which caused the mower to lower and trap him, resulting in fatal injuries. The use of a mechanical prop is recognised best practice. HSE Guidance AIS25 and the operator manual both warn against relying solely on hydraulics.

[30] Mr Soutar was described as experienced, safety conscious, and familiar with proper procedures, the decision to be beneath the raised mower without a prop was uncharacteristic. However, I find no reasonable precaution available to BA Events Ltd or Mr Brownie which, if taken, might realistically have prevented the accident.

[31] I have not identified any matter which would require a finding beyond the formal findings in terms of section 26(2) of the Act as set out above, in that I concur with the submissions of Ms Duffus and Ms McDonnell

[32] In closing I join with Ms Duffus in expressing my condolences to the family and friends of Mr Soutar, whose loss has been deeply and sincerely felt by all involved.