SHERIFFDOM OF SOUTH STRATHCLYDE, DUMFRIES & GALLOWAY AT LANARK

[2025] FAI 17

LAN-B215-24

DETERMINATION

BY

SHERIFF SIOBHAN CONNELLY

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

into the death of

JORDAN LITTLE

Lanark, 19 March 2025

DETERMINATION

The Sheriff having considered the information presented at the inquiry determines in terms of Section 26 of the Inquiries into Fatal Accidents and Sudden Deaths etc. (Scotland) Act 2016 ("the Act") that:-

(1) In terms of Section 26(2)(a) of the Act Jordan Little, born 16 January 1997, died on 25 April 2022 at Craighead Farm, Craighead Road, Abington, Biggar. His life was formally pronounced extinct at 11.00 hours.

(2) In terms of Section 26(2)(b) of the Act the accident resulting in the death took place within a workshop at Craighead Farm between approximately 10:00 hours and 10:30 hours on 25 April 2022.

(3) In terms of Section 26(2)(c) of the Act the cause of death was:

1a: Crush asphyxia due to

1b: Crushed under HGV.

(4) In terms of Section 26(2)(d) of the Act the cause of the accident resulting in the death of Jordan Little was Jordan Little attempting to replace or repair an air bellows in the tractor unit (or cab) of Volvo Heavy Goods Vehicle ("HGV"), registration number X600 XXL. He had not been instructed by his employer to carry out the repair. Such repairs were ordinarily done by a licensed garage or dealer. The relevant Volvo manual states that any repair to an air bellows should be done by a technician and the vehicle chassis should be supported by appropriately rated jack stands. The air bellows in such a vehicle ought to be capable of repair or replacement without the necessity of working underneath the vehicle. Jordan Little attempted to carry out the repair from underneath the tractor unit of the vehicle which he had propped up on wooden blocks. The wooden blocks were not sufficient to support the weight of the tractor unit and the tractor unit fell onto the torso of Jordan Little while he was lying underneath it and caused the injuries he sustained.

(5) In terms of Section 26(2)(e) of the Act there were no precautions identified which could reasonably have been taken which might realistically have resulted in the death, or any accident resulting in the death, being avoided.

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

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

RECOMMENDATIONS

There are no recommendations in terms of section 26(1)(b) of the Act.

NOTE

Introduction

[1] This inquiry was held into the death of Jordan Little under Section 1 of the Act. It was a mandatory inquiry in terms of Section 2 (3) of the Act as it occurred while Mr Little was acting in the course of his employment. The death was reported to the Crown Office and Procurator Fiscal Service. The Procurator Fiscal issued a Notice of Inquiry on 17 December 2024 and a preliminary hearing was held by Webex video conference on 7 February 2025.

[2] Mr Speed, Procurator Fiscal Depute, appeared for the Crown. Mr Smith, KC, Senior Counsel, appeared for the employer, Hodge Specialist Transport Limited ("HST"). There was no other appearance. The Crown advised that intimation of the Inquiry had been made to the Health and Safety Executive ("HSE") and to Mr Little's family. The HSE did not take part. Mr Little's family did not formally take part in the proceedings, or attend the preliminary hearings, but his mother did attend the hearing of the inquiry to observe same.

[3] The preliminary hearing of 7 February 2025 was continued until 24 February 2025 for clarification of certain matters and further information to be produced at my request. Statements of additional witnesses and a revised and comprehensive draft joint minute was prepared and lodged with the court.

[4] The inquiry took place on 6 March 2025 within Lanark Sheriff Court. The signed Joint Minute of the parties was formally lodged in process and at their invitation, I interponed authority thereto. I was grateful to parties for the care with which they prepared the comprehensive joint minute which meant there was no requirement to hear parole evidence, which would most likely have been a source of considerable distress to the witnesses and to the family.

[5] A number of productions were before the inquiry, the contents of which were agreed in the Joint Minute, namely:-

a . The Hodge Policies Handbook, a copy of which was provided to Jordan Little when he commenced employment with HST.

b. Jordan Little's HR and Training file with HST.

c. Volvo driver's handbook manual.

d. A Volvo workshop manual in relation to the repair and replacement of an air bellow (also known as an airbag) located at the front of a Volvo vehicle.

e. Four images taken by Robert Graham, Senior Forensic Scene Examiner, Scottish Police Authority, on 25 April 2022 at the company's premises which show general views of the external workshop and its interior showing various items contained there.

f. A series of eighteen images taken by Shauna Halstead, HM Inspector of Health and Safety on 25 April 2022 at the company's premises which show various views of wooden blocks.

[6] Parties agreed the statements of:

a. Duncan Hodge Senior, Director of HST, dated 6 February 2025 (with accompanying documentation including (i) a copy of HST's contract for 6 weekly maintenance inspections of all HGV's operated by them with T French & Son Ltd and (ii) an inspection report from 11 November 2021 confirming T French & Son replaced an airbag on Volvo HGV X600 XXL on that occasion)

b. Duncan Hodge Junior, Director of HST, undated, but lodged on 20 February 2025.

c. James Murdoch, HGV driver employed by HST, taken at 13:00 hours on 28 April 2022 by Inspector Ashley Fallis, HM Inspector of Health and Safety.

d. Leslie Anne Hodge, office manager/administration officer taken at 13:00 hours on 28 April 2022 by Inspector Shauna Halstead, HM Inspector of Health and Safety

e. Leslie Anne Hodge (2) taken at 11:25 hours on 13 June 2023 by Linda Aitken, official of the Health and Safety Executive.

f. Scott Henderson, HGV driver employed by HST, taken at 11:00 hours on 28 April 2022 by Inspector Ashley Fallis, HM Inspector of Health and Safety.

The Legal Framework

[7] This inquiry was held under Section 1 of the Act. The inquiry is governed by the Act of Sederunt (Fatal Accident Inquiry Rules) 2017 ("the Rules"). The inquiry is an inquisitorial process. The Crown represented the public interest. The purpose of an inquiry is not to establish civil or criminal liability. The purpose of the inquiry under Section 1(3) of the Act was to establish the circumstances of the death of Mr Little and to consider what steps, if any, might be taken to prevent other deaths in similar circumstances. Section 26 of the Act prescribes what must be determined by the inquiry and is in the following terms:

> "**Section 26 - The Sheriff's determination**
>
> (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 (2), and
> b. such recommendations (if any) as to any of the matters mentioned in subsection (4) as the sheriff considers 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 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,

(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.

(5) A recommendation under subsection (1)(b) may (but need not) be addressed to—

(a) a participant in the inquiry,

(b) a body or office-holder appearing to the sheriff to have an interest in the prevention of deaths in similar circumstances.

(6) A determination is not admissible in evidence, and may not be founded on, in any judicial proceedings of any nature."

SUMMARY

Agreed Facts

[8] Jordan Little was born on 16 January 1997 and resided in Dumfries and Galloway.

Occupation

[9] Jordan Little was ordinarily employed as a HGV driver by Hodge Specialist Transport Limited ("HST"), a company incorporated under the Companies Act with registration number SC504231 and whose registered office is Craighead Farm, Abington,

Biggar, South Lanarkshire. The premises are shared between Hodge Specialist Transport Limited and a separate farming business operated by a partnership.

Location, date and time of death

[10] At 11:00 hours on 25 April 2022 at Craighead Farm, Craighead Road, Abington, Biggar the life of Jordan Little was pronounced extinct.

Circumstances of the death

[11] On the morning of 25 April 2022 Jordan Little was instructed by Duncan Hodge Junior to wash a telehandler. This task would be undertaken at the front of the workshop where the pressure washer is located and is a task that has a two hour estimate to complete.

[12] At approximately 09:15 hours on 25 April 2022 the witness Leslie Anne Hodge, a subcontracted administrator then engaged as the office manager by HST, arrived at work at Craighead Farm, Craighead Road, Abington, Biggar, South Lanarkshire and spoke to Jordan Little and another member of staff briefly before going upstairs to the office area.

[13] At approximately 10:00 hours Jordan Little was seen by a colleague, Scott Henderson, an HGV driver, in the workshop. Jordan Little indicated to Scott Henderson that HGV tractor unit, namely, Volvo HGV registration number X600 XXL was sitting lower than normal at the front. This vehicle was that which Scott Henderson ordinarily drove. Scott Henderson went upstairs to the office area.

[14] An expulsion of air from the workshop area attracted the attention of both Scott Henderson and Leslie Anne Hodge. Leslie Anne Hodge looked out of the internal office window and saw Jordan Little walking in the workshop area below. Scott Henderson then left the office and walked downstairs into the workshop area. As he walked closer to the front of the vehicle, he saw that Jordan Little was trapped underneath the tractor unit of the HGV.

[15] Scott Henderson alerted Leslie Anne Hodge to what had happened. He also telephoned Duncan Hodge Senior, director of HST, for assistance.

[16] On being alerted to the accident by Scott Henderson, Leslie Anne Hodge immediately called the emergency services seeking the attendance of an ambulance as she ran downstairs to the workshop to assist. The call was made at 10:30 hours. All three emergency services attended the incident.

[17] Duncan Hodge Senior then arrived at the workshop and with the use of jacks successfully managed to raise the vehicle sufficiently to enable Scott Henderson to pull Jordan Little out from underneath the vehicle.

[18] Michael McLaughlin, a paramedic with the Scottish Ambulance Service attended in response to the emergency call. On examination he found that Jordan Little had sustained injuries that were incompatible with life. Michael McLaughlin applied a defibrillator to Jordan Little which confirmed that there were no signs of life.

Pronunciation of life extinct

[19] At 11:00 hours on 25 April 2022 at Craighead Farm, Craighead Road, Abington, Biggar Michael McLaughlin, paramedic, Scottish Ambulance Service pronounced Jordan Little's life as being extinct.

Details of employment

[20] Jordan Little was employed by HST at the time of his death. Between 22 June 2020 and 17 March 2022, both dates inclusive, he was employed as an HGV driver.

Employment duties

[21] From 18 March 2022 the said Jordan Little was employed as a general work member, a capacity which he held at the time of his death.

[22] The role of general work member involved carrying out tasks such as; tidying up the yard and workshop; washing farm machinery; basic maintenance like greasing the farm machinery and the trailers; topping up oil and checking the tyre pressure of agricultural vehicles; sweeping up; and painting gates, barriers and fences.

[23] Employees of HST were not expected to undertake maintenance of their vehicles. Drivers completed daily checks of their vehicles and completed logbooks. Any defects identified were to be reported to Duncan Hodge Senior, Duncan Hodge Junior or employee James Murdoch immediately in order that the vehicle could be booked in for repair.

[24] HST had a contract with the garage operated by T French & Son Limited, Cumnock, for safety inspections and maintenance. In November 2021, previous work carried out at this garage on Volvo HGV registration number X600 XXL included the repair of an air bag (or bellows) which was the same type of mechanical work Jordan Little appeared to have attempted on 25 April 2022.

[25] In addition, the company also used Volvo in Carlisle, the specialist dealer, for maintenance and repairs.

[26] Lorries operated by the company were inspected every 5-6 weeks at the garage operated by T French & Son Limited. The Driver and Vehicle Standards Agency ("DVSA") carry out annual inspections on these vehicles.

[27] Duncan Hodge Junior observed after the accident that the telehandler remained unwashed.

[28] Jordan Little had also been given the task of re-painting the chassis of a vehicle in the week prior to his death, which had not yet been completed.

[29] The vehicle repair undertaken by Jordan Little on Volvo HGV registration number X600 XXL was carried out of his own volition and was outside the scope of his employment duties.

Mechanical examination

[30] On 16 May 2022 Volvo HGV registration number X600 XXL was examined by, Colin Dunn, HM Specialist Inspector of Health and Safety who did not find any

significant faults that would have contributed to the incident. Colin Dunn observed a degree of corrosion in places that were commensurate with the age of the vehicle.

[31] The instructions in the Volvo Workshop Manual require a technician to raise and support the vehicle chassis. However, according to the Manual, it should have been possible to replace the bellows without working underneath the vehicle.

Pathology

[32] On 5 May 2022, Dr Esther Youd, Consultant Pathologist and Dr Margaret Balsitis, Locum Consultant Pathologist both of the department of Forensic Medicine and Science, University of Glasgow, undertook a post mortem examination of Jordan Little. In summary the significant findings from the examination are as follows: (a) Petechiae on the chest and in the face; (b) Minor injuries to the front of the chest; (c) Left-sided rib fractures; (d) Lung contusions; (e) Small amount of blood in the pleural cavities; and (f) Congestion and haemorrhage in the neck soft tissues and thyroid gland

[33] The traumatic injuries sustained by Jordan Little were in keeping with the circumstances of death, due to the pressure from the vehicle on his chest but would not account for death; death occurred due to the restriction of breathing because of the heavy weight of the vehicle on his chest.

[34] The medical certificate of cause of death was completed as follows: 1a: Crush asphyxia Due to 1b: Crushed under HGV

Toxicology

[35] On 5 May 2022 Claire Parks, Forensic Toxicologist and Dr Hazel Jennifer Torrance, Forensic Toxicologist, both of the department of Forensic Medicine and Science, University of Glasgow received two samples of blood and one sample of urine each collected post mortem from Jordan Little.

[36] The toxicology results showed a trace of alcohol in the urine, likely due to post mortem production. There is no evidence of any drug or alcohol cause for or contribution to the death of Jordan Little.

SUBMISSIONS

[37] Written submissions were lodged in advance of the hearing. I was invited by the Crown to make formal findings in respect of paragraphs 26(2)(a), (b) and (c). The Crown made no submission in respect of paragraphs 26(2)(e), (f) and (g). In respect of paragraph 26(2)(d) the Crown's submission, in summary, was that the accident was caused by Jordan Little attempting a repair of the vehicle which he was not asked to do, and which was outwith the scope of employment for all employees of HST.

[38] Senior Counsel for the employer adopted the Crown's submissions in respect of paragraphs 26(2)(a) to (d). In respect of paragraph (e) it was submitted that there was no evidence of any reasonable precaution, which could reasonably have been taken by Hodge Specialist Transport Ltd, which, had it been taken, might realistically have resulted in the death, or the accident resulting in the death, being avoided. In respect of paragraph (f) it was submitted that there was no evidence of any defect in any system of

working employed by Hodge Specialist Transport Ltd which contributed to the death, or the accident resulting in the death. In respect of paragraph (g) no submission was made.

DISCUSSION AND CONCLUSIONS

[39] The findings in terms of sections 26(2)(a), (b) and (c) were formal, there being no dispute about the date, place or time of death and the cause of death was clearly as determined at the post mortem examination.

[40] In connection with section 26(2)(d) the evidence before me sadly showed that the accident was due to Jordan Little making the decision to attempt to repair the Volvo HGV. I accepted the unchallenged evidence from the agreed witness statements that HST did not ask employees to undertake mechanical repairs of the vehicles. They had a contract with a specialist garage, T French & Son Limited, for regular safety inspections, maintenance and repairs. Inspection records required to be retained for inspection by an officer of the DVSA. Any repair work would be done by the garage or at the licensed Volvo dealership in Carlisle. The HGV involved in the accident had been inspected by T French & Son in November 2021 and they had replaced an airbag (or bellows) on that occasion. Repairs done by the garage would have the benefit of a warranty and a full inspection report which would be available for production to the DVSA.

[41] From the statements of the witnesses, it is clear that Mr Little was a well-liked and valued colleague and that he was keen to be busy. He had other tasks to do that day, which he could have safely completed without supervision, but it seems he decided

that he would attempt the repair of the HGV in question. It can only be a matter of speculation, but from the evidence before me I can only assume that he may have thought he was helping by doing the repair, and also that he believed he was capable of doing the repair safely.

[42] None of the witnesses actually saw the accident happen but from the observations of the witnesses in the aftermath of the accident and from the findings of the mechanical examination it appears Mr Little approached the task in an unsafe way, which was not in accordance with the Volvo manual instructions. There was no workshop manual on HST's premises, as they did not carry out such work, but if Mr Little had consulted the manual, he would have been able to see the safety warnings regarding the work he was planning to undertake. Sadly, it appears from the manual that Mr Little ought to have been able to repair or replace the air bellows without actually having to work underneath the tractor unit.

[43] It appears that the decision to work underneath the vehicle while it was propped up on wooden blocks was ultimately Mr Little's fatal mistake. Wooden blocks were available in the workshop but, according to the witness statements, were predominantly used for packing loads on the trailers. The Volvo workshop manual states that a vehicle chassis must be supported by jack stands with an adequate rating. The mechanical examination carried out after the accident found that there were no significant faults or defects in the vehicle relevant to the occurrence of the incident. It was inappropriate to use wooden blocks at all to support the vehicle, but it appears that the position and orientation of the blocks relative to the chassis of the vehicle may have made it more

likely that the blocks would fail to support the weight of the tractor unit, as happened here. As the blocks failed the vehicle has descended and landed on Mr Little, fatally injuring him.

[44] Given the circumstances of the accident I accepted the submission of behalf of HST that there was no reasonable precaution, which could reasonably have been taken by Hodge Specialist Transport Ltd, which, had it been taken, might realistically have resulted in the death, or the accident resulting in the death, being avoided. Unfortunately, it seems that HST could not have predicted that Mr Little would attempt this repair as they had given him other tasks to complete which he could have done safely and without supervision. I accepted that if those in HST responsible for arranging maintenance and repair of the vehicle had been made aware of the apparent fault in the Volvo HGV they would have booked the vehicle in to the garage.

[45] Likewise, given the circumstances of the accident, I accepted the submission that there was no evidence of any defect in any system of working employed by Hodge Specialist Transport Ltd which contributed to the death, or the accident resulting in the death.

[46] Having considered all the evidence before the inquiry I am compelled to conclude that this was tragic accident and there are no other facts relevant to the determination.

[47] I do not consider that it is appropriate to make any formal recommendations in terms of section 26(1)(b). I do understand from the witness statements that HST are winding down the haulage part of the business and the company no longer has any

employees. The directors intend to focus on other business interests in the future. This accident has clearly been a cause of significant concern to HST and the directors thereof and I trust that they will reinforce to all employees of any business operated by them, now and in the future, the dangers inherent in attempting mechanical repairs of any vehicle.

[48] In concluding this determination, I wish to extend my sincere condolences in particular to Mr Little's family and also to his friends and colleagues.