

Sheriffdom of Grampian, Highland and Islands at Peterhead

DETERMINATION

of

Philip Mann

**Sheriff of Grampian, Highland
And Islands at Peterhead**

in respect of

Fatal Accident Inquiry

relating to the Death of

Gordon Turriff

Peterhead 14 October 2009.

The Sheriff, having heard evidence on 09 October 2009 led by the Procurator Fiscal Depute and submissions by her, having made avizandum and now having resumed consideration of the matter Finds and Determines as follows:-

- (a) In terms of Section 6(1)(a) of the Fatal Accident and Sudden Deaths Inquiry (Scotland) Act 1976, Gordon Turriff, aged 58 years (date of birth 21.06.1949), who resided at 2 Moss Side of Strichen, Aberdeenshire AB43 7TU, died in the course of his employment at about 0615 hours on 27 December 2007 in a trailer attached to a lorry situated near the weighbridge of Northern Peat and Moss Company, Blackhills, St Fergus, Peterhead.
- (b) In Terms of Section 6(1)(b) of the said Act, Mr Turriff's death occurred as the result of a head injury sustained in a fall, described in the death certificate/ certificate as a "precipitate descent from height".
- (c) Being unable to determine the cause of Mr Turriff's fall, I am unable, in terms of Section 6(1)(c) of the said Act, to make a formal determination as to any precautions whereby Mr Turriff's death might have been avoided. I would, however, refer to my note hereto.
- (d) Being unable to determine the cause of Mr Turriff's fall, I am unable, in terms of Section 6(1)(d) of the said Act, to make a formal determination as to any defects in

any system of working which contributed to Mr Turriff's death. I would, however, refer to my note hereto.

- (e) Beyond the matters referred to in my note hereto there is nothing to add in terms of Section 6(1)(e) of the said Act.

Sheriff Philip Mann

Note

1. Representation

- 1.1 The Procurator Fiscal was represented by Mrs Porter, Procurator Fiscal Depute.
- 1.2 There was no representation for any other party although I was aware that Mr Turriff's widow and other members of his family were present in the public benches throughout the inquiry. At stages throughout the inquiry Mrs Porter fairly ascertained from Mrs Turriff and other family members whether there were any additional matters that they would wish her to canvass in evidence and this opportunity was taken up on at least one occasion.

2. Preliminary Matters

- 2.1 At the outset, as I did at the outset of the inquiry, I express my sympathy and condolences to Mrs Turriff and other family members in respect of Mr Turriff's tragic and untimely death.
- 2.2 At the outset of the inquiry I indicated that, in all likelihood, Mr Turriff's family would not get all of the answers that they might be looking for. I repeat that here with a reminder that the purpose of an inquiry such as this is to ascertain the facts surrounding the death, so far as possible, and not to apportion blame for the death.

3. Witnesses

- 3.1 The following witnesses gave evidence:
- John Nisbett Dingwall, Scenes of Crime Officer, Grampian Police, Force Headquarters, Queen Street, Aberdeen.
 - David Smith, Ambulance Technician, Scottish Ambulance Service, Damhead/Damhead Way, Peterhead.
 - David Burns Leiper, General Practitioner, G-Med, David Anderson Building, Foresterhill Road, Aberdeen.
 - Alistair McRobbie, 2 Kindrought Cottages, Strichen.

- George Andrew Noble, c/o Northern Peat and Moss Company, Blackhills, St Fergus.
- Eric Stewart Scott, E & J Scott, Mains of Kindrought, Strichen.
- Brian Kerr, c/o Les Taylor Contractors, Longside Road, Mintlaw.
- Alexander William Scott, 11 Knock View, Stuartfield, Peterhead.
- Alexander Thomson, Safety Officer, Les Taylor Contractors Ltd, Longside Road, Mintlaw.
- James Robb, Transport Manager, Mintlaw Transport Limited, Longside Road, Mintlaw.
- Douglas Alexander Connor, H M Inspector of Health and Safety, Lord Cullen House, Fraser Place, Aberdeen.

3.2 I found all of these witnesses to be credible and reliable and I record my gratitude to them for answering the call to give evidence in these proceedings.

4. Additional evidence

4.1 Mrs Porter lodged 3 Affidavits, namely

- Affidavit of Dr Duncan Stephen, Senior Clinical Biochemist, Department of Clinical Biochemistry, Aberdeen Royal Infirmary, Foresterhill, Aberdeen to which was attached the results of his analysis of various specimens.
- Affidavit of Dr Andrew George Colin Robertson, General Practitioner, Strichen Surgery, Strichen to which was attached his statement concerning Mr Turriff's general state of health.
- Affidavit of Dr James Henderson Kerr Grieve, Forensic Medicine Unit/ Unit, Department of Pathology, University Medical Buildings, Foresterhill, Aberdeen to which was attached the joint post mortem report prepared by him and Dr Paul Anthony James brown.

4.2 Various photographs were referred to in the course of oral evidence.

5. Findings in Fact

As a result of the oral and affidavit evidence presented at the inquiry and having regard to the submissions made by Mrs Porter I am able to make the following findings in fact:

- 5.1 At the date of his death Mr Turriff was engaged in his employment as a lorry driver with Mintlaw Transport Limited, Longside Road, Mintlaw, a subsidiary of Les Taylor Contractors limited of the same address.
- 5.2 In the course of his employment at or shortly before 6:00am on 27 December 2007 Mr Turriff arrived at the premises of Northern Peat and Moss Company, Blackhills, St Fergus, Aberdeenshire, driving a lorry to which was attached a trailer. The purpose of Mr Turriff's attendance there was to pick up a load of peat for transport to Fraserburgh.

- 5.3 The metal used for the construction of the trailer can be slippery in certain conditions.
- 5.4 The trailer was covered by a tarpaulin which was supported by a bar spanning the width of the trailer about half way along its length. The bar was hinged at one side and held in place at the other side by a pin. Removal of the pin enabled the bar to be swung back so as to lie against and parallel to the inside face of the trailer wall.
- 5.5 It was necessary to roll the tarpaulin cover to one side of the trailer to enable the peat to be loaded. The tarpaulin cover could be rolled aside from ground level outside the trailer but it was necessary to enter the trailer in order to throw out the ropes used to hold the rolled aside tarpaulin in place. In addition, it was standard practice within Mintlaw Transport/
Transport Limited when hauling peat that the employee driving the vehicle would swing the cover supporting bar against the side of the trailer so as to facilitate the loading operation and, at the same time, to avoid damage to the bar. This task could not be performed from ground level outwith the trailer and it was standard practice to enter the trailer in order to do so. More often than not it was necessary to use a hammer in order to dislodge the pin holding the bar in place.
- 5.6 Mintlaw Transport Limited had not instructed their drivers on any system of work to be employed when entering a trailer such as the one where the death occurred.
- 5.7 The only practicable means of entering the particular trailer being used by Mr Turriff on the day in question was to climb on to a platform at the front of the trailer and then to climb over the headboard and descend to the floor of the trailer. On the inside of the trailer there were pieces of metal protruding from the inside face of the headboard and one of the side walls of the trailer. These pieces of metal were part of the original construction of the trailer and were intended as footholds to facilitate the descent to the floor of the trailer. These footholds could accommodate only the ball of a person's foot. There was no ladder and there were no hand rails or grab rails on the inside of the trailer.
- 5.8 Mr Turriff and fellow employees had gained access to the inside of the trailer where the death occurred by the method detailed in finding in fact 5.7 on many previous occasions without incident.
- 5.9 Mr Turriff reported his arrival to the weighbridge attendant at Blackhills and indicated his intention to pull his vehicle aside and to roll aside the tarpaulin cover of his trailer preparatory to joining a queue of other vehicles to pick up his load of peat.
- 5.10 The ground in the vicinity of the parked trailer was muddy and wet. Mr Turriff would have walked on this ground when rolling aside the tarpaulin cover/
cover.
- 5.11 Having rolled the tarpaulin cover aside, Mr Turriff was in the process of entering the trailer, hammer in hand, by the means described in finding in fact 5.7 when he fell from a height to the floor of the trailer.

- 5.12 Mr Turriff struck his face and forehead, either during his descent or upon impact with the trailer floor, and suffered massive head injury involving a broken nose; extensive damage around the right orbit, including the maxilla and the supra-orbital ridge; and lacerations to the scalp.
- 5.13 Mr Turriff died within the trailer as a result of the head injury described in finding in fact 5.12.
- 5.14 Mr Turriff's lifeless body was discovered lying on its back by a colleague who, concerned that he could not find him anywhere else, investigated the inside of Mr Turriff's trailer. This was at about 06:15
- 5.15 Paramedics attended the scene at about 06:55 in response to an emergency call. There was no sign of life when they arrived. Dr Leiper attended at the scene at about 07:14 and confirmed that life was extinct.
- 5.16 At the date of his death Mr Turriff was apparently in good health. However, post mortem examination revealed that Mr Turriff had an enlarged heart with moderate coronary artery disease. Such disease can lead to cardiac dysrhythmia and collapse.

6. The Cause of Mr Turriff's Fall

- 6.1 It seems to me that there are two possibilities for the cause of Mr Turriff's fall from height to the floor of the trailer:

Either:

- 6.1.1 He lost his balance as he came over the top of the trailer headboard or lost his footing as he descended on the inside of the trailer using the footholds described in finding in fact 5.7.

or:

- 6.1.2 As he was in the process of climbing into the trailer he suffered a cardiac dysrhythmia, as a result of his pre-existing heart disease, and collapsed and fell.

- 6.2 It is not possible for me to determine with any certainty, on the evidence, which of the two possibilities was, in fact, the cause of the fall.

- 6.3 Having been unable to establish the cause of Mr Turriff's fall, I am unable to make any determinations under Sections 6(1)(c) and 6(1)(d) of the Fatal Accidents and Sudden Deaths Inquiry (Scotland) Act 1976.

7. Changes Since Mr Turriff's Death

- 7.1 Following Mr Turriff's death Mintlaw Transport Limited have carried out a health and safety review of the method of gaining access to the interiors of their trailers.
- 7.2 As a result of that review Mintlaw Transport Limited have modified each of their trailers so that the back door (or gate) of the trailer can be safely propped open, thus allowing access to the interior floor of the trailer by climbing upwards from ground level by means

of a short ladder. In my view, this is a much safer means of access than that hitherto generally employed and, in fact, employed by Mr Turriff on the morning of 27 December 2007.

7.3 Also as a result of that review Mintlaw Transport Limited have banned their employees from taking access to trailers by climbing over the headboard.

7.4 It seems to me that if, on the morning of 27 December 2007, Mr Turriff had been taking access to the interior of the trailer by the method that has now been made possible and even if he had at that time suffered a collapse brought on by his heart disease it is unlikely, though not impossible, that he would have suffered the massive head injury that caused/
caused his death.

7.5 In making the foregoing observations I acknowledge that they are made with hindsight and that the means of access described in finding in fact 5.7 had been used by Mr Turriff and fellow employees on many previous occasions without incident.

7.6 The manufacturers of the trailer in which the death occurred no longer provide footholds as part of the construction of their trailers.

8. Other matters

8.1 There was evidence from one witness during the inquiry that when a trailer is partially loaded it is not possible to enter the interior thereof by the method now made possible without losing part of its load by spillage from the open door (or gate).

8.2 It was thought that in the, albeit unlikely, event that it became necessary to sort out a problem with, say, the tarpaulin cover it might be necessary to gain access to the interior of the trailer and in such circumstances the only obvious means of access that would not result in spillage would be that which had been employed by Mr Turriff on the morning of 27 December 2007.

8.3 I was invited to recommend that consideration should be given to fitting every such trailer with a proper integral ladder on the interior face of the headboard with conveniently situated hand rails or hand grabs to assist in a safe descent from the headboard of the trailer. I do not make that recommendation because it seems to me on reflection, albeit that there was no evidence on the point, that any person entering a partially filled trailer, especially if its load is grain, could be placing himself in significant danger. That being the case, the ban referred to in paragraph 7.3 above seems/

seems to be a sensible one.

8.4 Instead I recommend that there should be a review by Mintlaw Transport Limited, in consultation with the Health and Safety Executive, as to the method by which any

problem which might arise with, say, the cover of such a partially filled trailer might safely be dealt with without resort to entering the trailer. Following that review the employees of Mintlaw Transport Limited should be instructed accordingly.

- 8.5 In response to a suggestion by a member of Mr Turriff's family Mrs Porter examined Mr Connor, the Health and Safety inspector, as to whether or not Mr Turriff's head injury might have been avoided if he had been wearing a hard hat such as that commonly used on construction sites. Mr Connor's evidence, which I accepted, was that the primary purpose of such a hat is to guard against injury from falling objects and that the wearing of such a hard hat by Mr Turriff would not have prevented the head injury which in fact occurred. I therefore make no recommendation in that regard.
- 8.6 Mintlaw Transport Limited are not the only operators of trailers such as the one in which Mr Turriff's death occurred. I recommend that steps should be taken by the Health and Safety Executive to publicise this determination within the haulage industry so that other operators may be aware of the dangers highlighted by this inquiry and may take steps, if need be, to guard against them.

In conclusion, I record my gratitude to Mrs Porter for the sensitive and comprehensive way in which she presented the evidence during this inquiry.