SHERIFFDOM OF TAYSIDE, CENTRAL AND FIFE AT FALKIRK

[2026] FAI 62

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DETERMINATION

BY

SHERIFF KEITH O'MAHONY

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

into the death of

ALAN BRISBANE, CHARLES EMSLIE, COLIN GIBSON, DALE PATTINSON, HUGH MACPHAIL AND JAMES SMITH

FALKIRK, 25 November 2026

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PART I – STATUTORY FINDINGS

The sheriff, having considered the evidence 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:

A. In relation to the death of ALAN BRISBANE

1. In terms of section 26(2)(a) - when and where the death occurred:

Alan Brisbane, born 6 February 1963, died at 0027 hours on 18 September 2023 at the Queen Elizabeth University Hospital, Glasgow.

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

The fall from height resulting in the death of Mr Brisbane occurred at approximately 1627 hours on 15 September 2023 in a grain storage barn at Westwood Lane Farm, Stirling.

3. In terms of section 26(2)(c) - cause of death:

The cause of death was:

1a. Blunt head injury.

4. In terms of section 26(2)(d) - cause of accident resulting in death:

At the time of the accident Mr Brisbane was either on, or accessing by means of a ladder, a pallet which had been raised on the forks of a forklift from which he subsequently fell. The precise movement leading to the fall cannot be determined on the evidence.

5. In terms of sections 26(2)(e) - precautions which (i) could reasonably have been taken, and (ii) had they been taken might realistically have resulted in the death being avoided:

Had the following reasonable precautions been taken they might realistically have avoided the death:

i. Use of a properly positioned and secured ladder;

ii. the use of a stable and guarded working platform, such as a tower scaffold or scissor lift.

6. In terms of section 26(2)(f) - any defects in any system of working which contributed to the death or any accident resulting in the death:

The system of work offered no protection from the possibility of a fall. There were no safety measures in place to minimise the risks associated with working at height.

7. In terms of section 26(2)(g) - any other relevant facts:

No additional finding is necessary on the evidence.

B. In relation to the death of CHARLES EMSLIE

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

Charles Emslie, born 19 May 1953, died at 1720 hours on 7 September 2024 at Law Farm, Insch, Aberdeenshire.

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

The fall from height resulting in the death of Mr Emslie, occurred shortly before 1649 hours on 7 September 2024 at the grain store on Law Farm.

3. In terms of section 26(2)(c) (cause of death):

The cause of death was:

1a. Head and chest injuries;

1b. precipitate descent from height;

1c. incident at workplace.

4. In terms of section 26(2)(d) (cause of accident resulting in death):

Mr Emslie was carrying out repair work to the roof of the grain store located on his farm. He stepped on a fragile roof surface and fell approximately 5.6 metres to the ground.

5. In terms of sections 26(2)(e) (precautions which (i) could reasonably have been taken, and (ii) had they been taken might realistically have resulted in the death being avoided):

Had the following reasonable precautions been taken they might realistically have avoided the death:

i. Use of proprietary crawler boards properly spanning the structure;

ii. use of a suitable internal working platform or closely stacked hay bales beneath the immediate work area. This would have allowed work to be

carried out from beneath where possible and had the dual benefit of reducing the distance of any fall from above the roof.

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

The system of work offered no protection from the possibility of a fall. There were no safety measures in place to minimise the risks associated with working at height.

7. In terms of section 26(2)(g) (any other relevant facts):

No additional finding is necessary on the evidence.

C. In relation to the death of COLIN GIBSON

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

Colin Gibson, born 23 July 1959, died at 2030 hours on 12 April 2022 at Peterhead Community Hospital.

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

The fall from height resulting in the death of Mr Gibson occurred between 0815 and 0849 hours on 7 October 2020 at Littlehill of Knaven Farm, Maud, Peterhead.

3. In terms of section 26(2)(c) (cause of death):

The cause of death was:

1a. Lower respiratory tract infection;

1b. severe brain injury;

1c. fall from height.

4. In terms of section 26(2)(d) (cause of accident resulting in death):

Mr Gibson was making roof repairs to the cattle court at Littlehill of Knaven Farm. He fell through the fragile roof there after moving off wooden boards (being used as crawler boards) onto the purlins, before hay-bale protection had been placed beneath the work area.

5. In terms of sections 26(2)(e) (precautions which (i) could reasonably have been taken, and (ii) had they been taken might realistically have resulted in the death being avoided):

Had the following reasonable precautions been taken they might realistically have avoided the death:

i. Remaining on the wooden boards rather than stepping on to the purlins;

ii. deferral of entry onto the roof until the planned stacked hay bales were in position; or alternatively, use of an appropriately sited internal work platform beneath the area of work, such as a tower scaffold, to reduce the distance of any fall.

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

Failure to implement the agreed fall-mitigation elements of the intended system before roof work commenced. These agreed elements comprised the use of wooden boards on the roof in conjunction with hay bales positioned within the cattle court. To be clear, this relates to the implementation of the intended system of work and does not relate to a design defect attributable to Ms Forbes.

7. In terms of section 26(2)(g) (any other relevant facts):

No additional finding is necessary on the evidence.

D. In relation to the death of DALE PATTINSON

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

Dale Pattinson, born 1 May 1987, died at 1530 hours on 26 August 2023 at the Royal Infirmary in Edinburgh.

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

The fall from height resulting in the death of Mr Pattinson occurred between 1520 hours and 1543 hours on 25 August 2023 in the cattle shed at Bassendean Farm, Gordon.

3. In terms of section 26(2)(c) (cause of death):

The cause of death was:

1a. Blunt force head injury;

1b. fall from height.

4. In terms of section 26(2)(d) (cause of accident resulting in death):

Mr Pattinson was carrying out roof repairs to the cattle sheds at Bassendean Farm. He slipped and fell through a fragile fibreglass skylight, falling approximately 4.9 metres to the ground.

5. In terms of sections 26(2)(e) (precautions which (i) could reasonably have been taken, and (ii) had they been taken might realistically have resulted in the death being avoided):

Had the following reasonable precautions been taken they might realistically have avoided the death:

i. Suspension and reassessment of the work to be carried out when the cherry picker could not be used as intended;

ii. the use of fall protection nets attached to load bearing elements of the structure or a free-standing scaffold located inside the building;

iii. suspension of the work following heavy rain until drier conditions prevailed.

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

The work continued without sufficient fall through protection or a revised safe method of working after the intended use of the cherry picker (which would have allowed work to take place from underneath the roof) was frustrated, and heavy rainfall occurred creating slippery conditions. The work methodology was controlled by Mr Pattinson.

7. In terms of section 26(2)(g) (any other relevant facts):

No additional finding is necessary on the evidence.

E. In relation to the death of HUGH MACPHAIL

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

Hugh MacPhail, born 27 October 1947, died at approximately 1457 hours on 6 July 2023 at Callachally Farm, Glen Forsa, Isle of Mull.

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

The fall from height resulting in the death of Mr MacPhail occurred between 1400 and 1423 hours on 6 July 2023 at the sheep shed, Rhoal Fank, on Callachally Farm.

3. In terms of section 26(2)(c) (cause of death):

The cause of death was:

1a. Neck injury;

1b. fall from height.

4. In terms of section 26(2)(d) (cause of accident resulting in death):

While repairing a leak on the roof of a sheep shearing shed, Mr MacPhail stepped on a fragile roof surface and thereafter fell to the ground.

5. In terms of sections 26(2)(e) (precautions which (i) could reasonably have been taken, and (ii) had they been taken might realistically have resulted in the death being avoided):

Had the following reasonable precaution been taken it might realistically have avoided the death:

i. The use of a proprietary crawler board system appropriately located and secured.

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

The system of work did not include any suitable safety measures to minimise the risks associated with working at height.

7. In terms of section 26(2)(g) (any other relevant facts):

No additional finding is necessary on the evidence.

F. In relation to the death of JAMES SMITH

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

James Smith, born 29 May 1950, died at approximately 1938 hours on 22 August 2024 at Bowhouse Farm, Dunlop, Kilmarnock.

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

The fall from height resulting in the death of Mr Smith occurred between 12 noon and 1920 hours on 22 August 2024 at a shed on Bowhouse Farm.

3. In terms of section 26(2)(c) (cause of death):

The cause of death was:

1a. Head injury;

1b. fall from height.

4. In terms of section 26(2)(d) (cause of accident resulting in death):

While carrying out repairs to the roof of a shed, Mr Smith fell through the fragile roof surface to the ground. The precise movement or precipitating event cannot be determined on the evidence.

5. In terms of sections 26(2)(e) (precautions which (i) could reasonably have been taken, and (ii) had they been taken might realistically have resulted in the death being avoided):

Had the following reasonable precautions been taken they might realistically have avoided the death:

i. The use of a proprietary crawler board system;

ii. the use of internal measures such as the positioning of a platform beneath the work area or stacked hay bales to reduce the distance of any fall.

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

The system of work did not include any suitable safety measures to minimise the risks associated with working at height.

7. In terms of section 26(2)(g) (any other relevant facts):

No additional finding is necessary on the evidence.

G. RECOMMENDATION

In terms of section 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), the following recommendation is made:

Recommendation - Effectiveness of communication and engagement

The inquiry recommends that the Health and Safety Executive review how it currently communicates the risks of working at height to those working in Scotland's agricultural sector. The primary purpose of the review is to assess how effective these methods are in raising awareness of those risks. Particular regard should be had to self-employed farmers, small farming businesses and those undertaking maintenance of agricultural buildings. The review should specifically consider:

- whether different or additional approaches, including more direct engagement with rural farming communities, could improve awareness of the risks and encourage greater compliance with established safety precautions; and
- whether online information could be simplified to assist rural farmers understanding of the available material; and
- whether webinars and in-person training seminars could be arranged for farmers in rural Scotland to attend.

I further recommend that the review specifically takes the views both of NFU Scotland and the No Falls Foundation. They are both uniquely well placed to comment with authority on effectiveness of current methods of communication and the potential for improvement.

PART II – NOTE

A. Introduction

[1] An inquiry was held into the deaths of Alan Brisbane, Charles Emslie, Colin Gibson, Dale Pattinson, Hugh MacPhail and James Smith. For ease of reference, I undernote a table outlining critical dates and places.

Name	**Date of Birth**	**Date of Accident**	**Date of Death**	**Location of Accident**
Alan Brisbane	6/2/63	15/9/23	18/9/23	Westwood Lane Farm, Stirling
Charles Emslie	19/5/53	7/9/24	7/9/24	Law Farm, Insch, Aberdeenshire
Colin Gibson	23/7/59	7/10/20	12/4/22	Littlehill of Knaven Farm , Maud, Peterhead
Dale Pattinson	1/5/87	25/8/23	26/8/23	Bassendean Farm, Gordon
Hugh MacPhail	27/10/47	6/7/23	6/7/23	Callachally Farm, Glen Forsa, Isle of Mull
James Smith	29/5/50	22/8/24	22/8/24	Bowhouse farm, Dunlop, Kilmarnock

B. The inquiry

[2] COPFS gave notice of their intention to hold a joint Fatal Accident Inquiry into these deaths on 25 September 2025.

[3] Preliminary hearings were held on the:

- 19 November 2025;
- 26 January 2026;
- 29 May 2026; and

- 12 June 2026.

[4] The court heard evidence on 22 June 2026. The court heard final submissions from parties on 25 August 2026. The court had the benefit of a large volume of statements and productions which were adopted into evidence, and an extensive joint minute of agreement. The court heard evidence from witnesses Wendy Forbes, owner of Littlehill of Knaven Farm, and Hazel Dobb, principal inspector of the Health and Safety Executive ("HSE"), who gave evidence in an expert capacity.

[5] Ms Webb, procurator fiscal depute, represented the Crown. Mr Scullion, advocate, represented Littlehill of Knaven Farm. Ms Watt, solicitor, represented George McDougal (Bassendean) Ltd.

[6] I make no adverse findings in relation to the credibility of either of the witnesses who gave evidence. I am satisfied they were doing their best to assist the inquiry in their evidence.

C. Legal framework

[7] The inquiry was held in terms of section 2(3) of the Inquiries into Fatal Accidents and Sudden Deaths etc (Scotland) Act 2016 (the Act) on a mandatory basis as all the deaths occurred during the course of employment or occupation. The inquiry is governed by the Act of Sederunt (Fatal Accident Inquiry Rules) 2017.

[8] In terms of section 1(3) of the Act, the purpose of this inquiry is to establish the circumstances of the deaths and to consider what steps, if any, might be taken to prevent other deaths in similar circumstances.

[9] Section 26 of the Act sets out the matters to be covered in the determination. These include setting out findings on the following: (a) when and where the death occurred; (b) when and where any accident resulting 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. They also include setting out such recommendations (if any) in relation 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.

[10] The procurator fiscal represents the public interest in investigating, arranging and conducting an inquiry. It is not the purpose of an inquiry to establish civil or criminal liability. Fatal Accident Inquiries are an inquisitorial and not an adversarial process.

[11] Section 26(2)(e) sets out a two-stage test. Firstly, the court requires to be satisfied on the evidence that there was a precaution which could reasonably have been taken. Secondly, the court must be satisfied on the evidence that if the precaution in question had been taken, that it might realistically have avoided the death. Unless both criteria are met, no finding should be made in terms of section 26(2)(e).

[12] A finding as to a reasonable precaution whereby the death would have been avoided is not required. The wording of the provision instead refers to reasonable precautions which, if taken, might have resulted in the death being avoided. The explanatory notes to the 2016 Act provide that the use of the word "reasonably" relates to the reasonableness of taking the precaution rather than the foreseeability of the death or accident. They further provide that "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." It follows, therefore, that certainty as to avoidance of death is not required.

PART III – CIRCUMSTANCES OF EACH DEATH

A. Alan Brisbane

[13] Mr Brisbane owned and ran Westwood Lane Farm in Stirling with his family. He lived on the farm with his wife and daughter.

[14] There is a barn on the farm which is used for grain storage. A grain dryer is attached to the exterior of the barn with a chute that transfers the dried grain into the barn.

[15] During the afternoon of 15 September 2023 Mr Brisbane was working on his farm. At around 1625 hours that afternoon Mr Brisbane received a telephone call from one of his neighbours. Approximately 2 minutes into the telephone call the neighbour heard a loud bang and then breathing. The neighbour attended the farm and found Mr Brisbane lying on his back on the floor of the barn. Lying next to Mr Brisbane was a

ladder, his phone and a spanner. A forklift with its arm raised and a pallet on the forks was also within the barn. The pallet was approximately eight feet above the floor. The neighbour assumed from the positioning of the various items that Mr Brisbane had been intending to move the grain chute.

[16] There were no signs of any specific measures having been put in place to protect against a fall.

[17] At approximately 1633 hours that afternoon an emergency telephone call was made to the Scottish Ambulance Service. An ambulance arrived at Westwood Lane Farm at approximately 1646 hours. The trauma team arrived at approximately 1705 hours.

[18] Mr Brisbane was conveyed to Queen Elizabeth University Hospital, Glasgow and arrived there at approximately 1817 hours. A CT scan was performed which confirmed Mr Brisbane had suffered multiple injuries including a catastrophic brain injury. The clinicians assessed him as unsuitable for neurosurgical intervention and he was given a poor prognosis for recovery.

[19] Life sustaining treatment was subsequently withdrawn, and Mr Brisbane was pronounced dead at 0027 hours on 18 September 2023.

[20] The police measured the height of the mobile grain dryer chute to be approximately 2.4 metres.

[21] The evidence disclosed that Mr Brisbane had various medical conditions. Pathologists could not exclude the possibility of an undiagnosed heart condition, however there was no evidence of significant natural disease in any of his organs to

account for the fall. Mr Brisbane previously suffered from tumours within his head and had undergone surgery in connection with that. Evidence disclosed that it is conceivable that such a tumour could affect an individual's balance.

[22] To draw any firm conclusion that the cause of the fall was related to a medical condition would be speculative. The pathological evidence does not confirm that any pre-existing condition contributed to the fall. Equally the evidence does not confirm that his use of the phone played any causative part in the fall. What is clear from the evidence is that no precautions appear to have been taken against the possibility of a fall.

[23] Hazel Dobb, principal inspector with the Health and Safety Executive, gave helpful evidence to the inquiry in relation to all these cases. Ms Dobb has over two decades experience with the Health and Safety Executive. She has taken on leadership and investigatory roles as inspector and principal inspector across sectors including agriculture, manufacturing and major events. She has experience of many workplace safety investigations, enforcement and regulatory compliance.

[24] Ms Dobb explained that in Mr Brisbane's case the pallet was not secured to the forks. That of itself presents a risk of falling. Furthermore, pallets do not have any edge protection, such as a secured barrier, to prevent someone falling over the edge.

Ms Dobb noted that factors which were important to determining the safest method of work here remained unclear. For example, the expected duration of the work, whether access to tools was required, and whether both hands needed to be used to complete the work. The evidence suggested that Mr Brisbane was attempting to gain access to the grain dryer. In those circumstances Ms Dobb was of the view that reasonable

precautions could have been taken to establish a safe system of work. These would have included the use of a fully enclosed working platform, such as a tower scaffold, or a properly secured ladder. Alternatively, other fully enclosed work platforms, such as a scissor lift, could have been used and may realistically have prevented the fall.

B. Charles Emslie

[25] Mr Emslie owned and ran Law Farm in Aberdeenshire with the assistance of his family. He lived there with his wife.

[26] On the morning of 7 September 2024, Stuart Emslie, son of the deceased, arrived on the farm to assist his father. At approximately 1300 hours that day, the pair attended at the grain store to carry out repair work to the roof. This was a job that they had both carried out many times in the past.

[27] A pallet was placed on the forks of a telehandler (also known as a reach forklift) which was raised towards the roof of the grain store. Stuart Emslie was positioned on the pallet. Mr Emslie senior was positioned outside on top of the roof which he had accessed by ladder. Stuart Emslie could hear his father walking on the roof.

[28] Stuart Emslie saw his father fall through a skylight in the roof onto the floor of the grain store. Mr Emslie landed on his back.

[29] Stuart Emslie commenced CPR. At approximately 1649 hours that day the Scottish Ambulance Service received an emergency phone call. An ambulance attended there at approximately 1708 hours. Mr Emslie was assessed as having no signs of life. He was pronounced dead at 1720 hours.

[30] Ms Dobb noted in her evidence that profiled fibre cement roofs, such as the one found here, are commonly found on agricultural buildings. They are known to be fragile, particularly the perspex roof lights used to allow natural light into the building. Perspex roof lights can degrade over time. They can also be similar in appearance to the roof sheets.

[31] Mr Emslie did not use a crawler board system when carrying out repairs. Nor were any other protective factors taken against falling, such as an internal platform or hay bales being positioned beneath the work area.

[32] Ms Dobb explained that crawler boards are designed to span the roof beams and distribute weight across fragile roof sheets, thereby reducing the risk of an individual falling through the roof. They are long, narrow, flat platforms designed to be laid across a roof. They spread a worker's weight over a larger surface area preventing concentrated pressure being placed on fragile roofing materials. Crawler boards can be fitted with guardrails to reduce the risk of individuals inadvertently stepping off the board. Ms Dobb's view is that, given the frequency with which agricultural roofs require repair and maintenance, investment in a proper crawler board system is clearly worthwhile.

[33] Ms Dobb also identified additional measures that could have been taken to reduce the risk of a fall. The first of these was the use of hay bales, tightly packed beneath the work area to reduce the distance of any potential fall. They would also serve a dual purpose of acting as a working platform to allow work to be carried out from beneath. A scissor lift was also identified as a measure which could have been

used to provide protection from falling. Ms Dobb acknowledged the potential cost of hiring or purchasing such equipment. By contrast, a tower scaffold potentially could have a variety of uses on a farm and could therefore represent an appropriate and reasonable investment. That would have allowed work to be carried out safely from beneath while reducing the risk of any fall through the roof.

C. Colin Gibson

[34] Colin Gibson operated his own property maintenance company, Colin Gibson Property Maintenance.

[35] Littlehill of Knaven is a farm in Maud, Peterhead. The owner is Ms Wendy Forbes. She has owned the farm since inheriting it from her partner following his death in July 2019.

[36] Prior to his death, Ms Forbes partner would attend to all maintenance work with local contractors and neighbours assisting. After his death, Ms Forbes set about a maintenance and buildings improvement programme on the farm. Mr Gibson was recommended to her as a local handyman. She engaged him to carry out general jobs including repair work around the farm on several occasions.

[37] In October 2019 Ms Forbes decided to have work undertaken to repair the roof of the cattle court. Some of the roof sheets had cracked and required replacement. She asked Mr Gibson for a recommendation, and he said that he himself could carry out the necessary repairs. He had experience of working on roofs and had appropriate insurance.

[38] On 26 October 2019 Mr Gibson carried out the repairs. He purchased replacement sheets and hired a telehandler to help him complete the work. The work was completed without incident.

[39] Mr Gibson again worked on the farm in July and August 2020. During that time Ms Forbes asked him to look again at the cattle court roof and provide an opinion on whether further sheets required to be replaced. He told her that multiple sheets needed replacement.

[40] Mr Gibson provided her with an estimate of cost and duration of the job. He asked if Mr Andrew Connon, a self-employed farm worker in the local area, could assist him. Ms Forbes agreed to that request.

[41] Mr Gibson told Ms Forbes that he intended to stack the cattle court with hay bales prior to commencing work on the roof. These were to be tightly packed to the edge of the building. They were to serve a dual purpose, those being to allow access to the underside of the roof while simultaneously acting as a cushion in the event of a fall. He said that crawler boards would be used whilst on the roof, but he intended that as much of the work as practicable was to be carried out on the underside of the roof.

[42] Ms Forbes felt comfortable and satisfied with those arrangements. She regarded Mr Gibson as well respected and experienced. His plan for the method of working seemed clear. She had previously observed his work which she considered was completed to a good standard. She had never previously been given any reason for safety concerns around his work.

[43] Mr Gibson ordered the replacement roof sheets which were delivered to the farm on the 6th of October 2020.

[44] On 7 October 2020, at approximately 0815 hours Mr Gibson attended at the farm to carry out repair work on the roof of a cattle court. Andrew Connon was also in attendance. Mr Gibson and Ms Forbes briefly chatted before the work started. Mr Gibson had brought equipment with him, including wooden boards to act as crawler boards. Mr Gibson began to remove the equipment from his trailer. Ms Forbes went away to check on cows elsewhere on the farm although she intended to return shortly thereafter.

[45] While Mr Connon was moving hay bales into the cattle court Mr Gibson accessed the roof via a ladder leaning against one of the outside walls of the cattle court. Mr Connon left the cattle court and began to climb the same ladder Mr Gibson had used. The bale stacking exercise, intended to precede the roof work, had not been completed at that stage. Only two hay bales had been moved into the shed, and they had been left on the tractor stacker.

[46] Mr Connon saw Mr Gibson standing upright on top of a wooden board he had brought with him. Mr Gibson passed one of the old roof sheets to Mr Connon. He climbed down with it and put the old sheet in the digger bucket.

[47] Mr Gibson then walked higher up the roof, moving his weight from board to board. Mr Connon observed Mr Gibson walk on to the purlins and crouch to measure one of the existing roof sheets. As he stood up, he fell through the roof of the cattle court onto the concrete floor below.

[48] Mr Connon entered the cattle court and found Mr Gibson breathing but otherwise unresponsive. He placed Mr Gibson into the recovery position and sought help from Ms Forbes.

[49] At approximately 0849 hours Ms Forbes phoned the emergency services. A trauma team arrived at the farm at approximately 0916 hours. Mr Gibson was conveyed to Aberdeen Royal Infirmary arriving there at approximately 1101 hours.

[50] On admission Mr Gibson was assessed as having suffered multiple injuries, including a severe traumatic brain injury. No operative intervention was performed. After spending time in intensive care, he was transferred to a hospital ward. He was unable to communicate and required care for all basic functions.

[51] On 9 March 2022 Mr Gibson was transferred to the Summers Ward at Peterhead Community Hospital. On 6 April 2022 he developed a lower respiratory tract infection and was prescribed antibiotics. On 12 April 2022 Mr Gibson's National Early Warning Score (NEWS) had increased to nine. NEWS is a standardised clinical tool used to detect and monitor the severity of acute illness and clinical deterioration in patients. A score of nine indicates high risk, critical care issues.

[52] At around 0820 hours that day Advanced Nurse Practitioner (ANP) Amanda McKandie assessed Mr Gibson. It was suspected that Mr Gibson had developed sepsis. Following discussion with a General Practitioner, Mr Gibson's Amoxicillin was increased, and he was prescribed Clarithromycin. The antibiotic required was not in stock on the ward but was available in the pharmacy adjoining the ward. ANP McKandie did not have prescribing rights for Mr Gibson as he was not

registered to her practice. A request was sent to Mr Gibson's GP practice, Aden Health Centre, to prescribe Clarithromycin at around 0955 hours. A GP within the practice prescribed Erythromycin at 1155 hours. A further request was sent to Mr Gibson's GP practice to prescribe Clarithromycin. This was prescribed by a GP at 1627 hours. Mr Gibson was given Clarithromycin at 1640 hours. Mr Gibson continued to deteriorate and was pronounced dead at 2030 hours on 12 April 2022 at Peterhead Community Hospital.

[53] Peter Bodkin, consultant neurosurgeon was advised by Police Scotland that there had been a delay in obtaining Mr Gibson's prescription. Peter Bodkin opined that on the balance of probability this would not have played a major factor in the death and his overall condition was such that sepsis and rapid clinical deterioration would not be unexpected. There is no evidence that the delay in provision of antibiotics played any causative role in the death.

[54] Ms Forbes was never charged with any offence, and no enforcement action was taken against her by the HSE. Following engagement with the HSE the necessary roof works were carried out at a later stage.

[55] In October 2020, and of her own volition, Ms Forbes consulted with a health and safety consultant, Mr Steven Anderson, to review and improve the farm's health and safety measures. She has frequent meetings with Mr Anderson who visits on multiple occasions each year. A comprehensive health and safety management system was implemented which has various components. Mr Anderson describes Ms Forbes as

showing exemplary adherence to the health and safety measures now implemented, including proactive monitoring of contractors' compliance.

[56] There is no evidence to show why Mr Gibson decided to begin the work on the roof before the hay bales had been stacked as planned.

[57] In relation to the wooden boards which Mr Gibson was using as crawler boards, Ms Dobb gave evidence that it was unclear how thick these boards were and whether they were suitable for that use. There was no evidence to confirm their condition and whether they might crack. She recommended using a proprietary crawler board system rather than the wooden boards being used by Mr Gibson.

[58] Nonetheless, there was no evidence to suggest that the boards being used had in some way failed, resulting in the accident. On the contrary, the evidence was that Mr Gibson had stepped off the boards entirely before he then fell through the roof. It is therefore speculative to suggest that a bespoke crawler board system would have resulted in a different outcome.

[59] The essential problem was that the work on the roof began before the planned hay bales were in position. The evidence did not disclose why Mr Gibson chose to take that path. There was no evidence of any urgency or pressure from any individual to complete the work as quickly as possible.

[60] Ms Forbes was credible and reliable in her evidence. Understandably she questioned whether she could have done more to avoid the accident. She was clearly shocked and upset that the work had begun without the necessary precautions being put in place. It was clear from her evidence that safety was a matter of considerable

concern to her, both before and after the accident. The measures agreed upon by her and Mr Gibson were proportionate to the task in hand. As regards designing a safe system of work, it was entirely reasonable for her to take the lead from Mr Gibson. He was the one to carry out the work and had carried out similar work in the past. It was entirely reasonable for Ms Forbes to proceed on the basis that the safety measures which Mr Gibson outlined would be put in place. I agree with submissions made by counsel on her behalf; it cannot be the case that a self-employed farmer is required to stand over and supervise works being carried out by a specialist contractor for their entire duration. Such an obligation would be entirely unrealistic and onerous. In most cases, the expertise lies with the specialist contractor, not the self-employed farmer.

[61] In any event this inquiry's task is not to assess whether there was any breach of health and safety legislation. It is to identify whether there were any defects in the system of working and whether precautions could have been adopted which might have prevented the death. If the precautions identified by Mr Gibson and Ms Forbes had been acted upon the accident would likely not have taken place. The failure is in the implementation of the system, not in its design.

D. Dale Pattinson

[62] Dale Pattinson operated his own roofing company as director of DWP Roofing and Cladding Ltd.

[63] In August 2023 he was contracted to carry out roof repair work to the cattle sheds at Bassendean Farm in Gordon. These are of concrete construction with asbestos

sheeting. James McDougal is farmer and director of George McDougal (Bassendean) Limited. Bassendean Partnerships owns the farm and rents it to George McDougal (Bassendean) Limited. James McDougal runs the farm with his two sons and another employee. It was agreed by way of joint minute that Mr Pattinson had full control over the way those works were planned, organised and executed.

[64] Mr Pattinson advised Mr McDougal that a cherry picker and forklift would be required to complete the job. A cherry picker is a mobile lifting machine with a hydraulic boom and a work platform or bucket which is used to raise workers to high places. It was arranged that a cherry picker would be hired, however it had not arrived before work began. Mr Pattinson was given access to the farm's telehandler for use during the works.

[65] The work to be undertaken was to strip and reclad the roofs. Existing roof sheets were to be removed by grinding off the bolts. Once loose, the sheets would be lifted, carried to the gutter line, and stacked on a pallet which was to be mounted on the telehandler. Access to the roof was gained either by a ladder positioned on hay bales or by using the telehandler.

[66] Mr Pattinson had two assistants in conducting the work, Brennan Bryan and Ryan McQuillan. They commenced repair work on 24 August 2023.

[67] The following day they began work at approximately 0800 hours. During that afternoon it began to rain heavily. Work was suspended for a period and then commenced again once the rain had stopped. Mr Pattinson himself repeatedly warned both of his assistants that they were working in slippery conditions.

[68] The cherry picker had arrived on site approximately 1 hour before the fall occurred. Mr Bryan stated that they had planned to carry out work from underneath the roof once the cherry picker was delivered. They had moved the cherry picker to the middle of the barn where they intended to use it, but they could not get it to level off so did not use it again and continued the work without it.

[69] At around 1520 hours all three of them were working on the roof of one of the cattle sheds. Mr Pattinson was positioned at the top of the roof, the other two were positioned close to the valley gutter. Mr Bryan saw Mr Pattinson lift off a roof sheet, slip, lose his footing and fall through the fibreglass skylight onto the concrete floor below.

[70] No safety precautions had been put in place to protect against a fall.

[71] At the time he fell Mr Pattinson was wearing trainers.

[72] At approximately 1543 hours a call was placed to the Scottish Ambulance Service. At approximately 1601 hours the first ambulance arrived at the scene with a second ambulance arriving around 1604 hours. The critical care team arrived at approximately 1654 hours. Mr Pattinson was conveyed by helicopter to the Royal Infirmary at Edinburgh, arriving there at approximately 1820 hours.

[73] A CT scan was performed which confirmed that Mr Pattinson had suffered multiple injuries including a traumatic brain injury. He was not considered suitable for neurosurgical intervention. Mr Pattinson clinically deteriorated and was pronounced dead at 1530 hours on 26 August 2023.

[74] An HSE inspector attended at Bassendean farm on 26 August 2023. Various items of equipment commonly used for work at height were present within the cattle sheds at the time. These included a cherry picker situated within the middle of the cattle shed, a telehandler which was positioned outside the cattle shed at the edge of the cattle shed roof, and sets of ladders within the cattle shed.

[75] Following post-mortem examination, toxicology analysis revealed the presence of cocaine metabolites in the bloodstream of Mr Pattinson. Other drugs were also detected consistent with admission to the intensive care unit. No hospital admission blood samples were retained during investigations, and no further analysis was carried out. There is no evidence that intoxication played any part in the fall which led to the death.

[76] Ms Dobb gave evidence that these works were more significant than those being carried out in the other cases. Accordingly, consideration had to be given to putting in place significant safety measures. She reasoned that the presence of the cherry picker demonstrated a degree of planning. It was reasonable to conclude that it had been hired because it was considered necessary to safely carry out the work. In her view a sizeable proportion of the work could have been carried out from below the roof utilising the cherry picker. Any method of work that minimised the time spent on the roof reduced the risk associated with the work. The cherry picker therefore served an important safety purpose. Her view was that when it became apparent that the cherry picker could not be operated in the manner required work should have been stopped.

[77] Given the scale of the work to be carried out, Ms Dobb also reasoned that roof safety nets could have been utilised for any work that required to be undertaken on top of the roof. These nets act as a fall prevention system. They are rigged beneath the working level to catch falling workers and dropped materials during roof maintenance. They are attached to load bearing parts of the structure or a specially designed scaffold. Ms Dobb would have expected safety nets to be in place, especially if it had been assessed that most of the work had to be carried out above the roof itself. Ms Dobb also suggested that she would have expected scaffolding to be on the outside of the building to act as suitable edge protection. She acknowledged that this would not have avoided Mr Pattinson's death given that he fell through the roof rather than from its edge.

[78] Under cross-examination Ms Dobb confirmed that she would have expected Mr Pattinson, as the contractor, to determine how the work was to be carried out and satisfy himself that the proposed method of work was safe. If the cherry picker could not be operated in the manner required, the decision on how to proceed would have been one for Mr Pattinson. However, she would also have expected the farmer to exercise oversight in relation to the work being undertaken on his farm.

E. Hugh MacPhail

[79] Hugh MacPhail owned and ran Callachally Farm on the Isle of Mull. He became the tenant farmer there in 1977 and purchased the farm in 2018. He was an equal partner in the farming business with his wife and two adult sons.

[80] On the morning of 6 July 2023, Colin MacPhail, the son of Hugh MacPhail, attended at the farm to assist with work. At around 1400 hours the pair attended at the sheep shed known as Rhoal Fank where Mr MacPhail senior decided to carry out repairs to the roof. The Rhoal Fank is a large shed used for sheep handling and shearing. It contains numerous sheep handling pens of both timber and stone construction. It was described in evidence as requiring regular maintenance, especially due to storm damage. The shed was partially congested with other farmyard related equipment and tools. On that day there was evidence of a leaking skylight.

[81] A ladder was placed outside the door. Mr MacPhail senior used it to climb onto the roof. His son was assisting him from below by passing him a piece of iron to fix the leak. Mr MacPhail then advised his son that he was going to fix another leak further towards the middle of the roof. His son told him to be careful as the roof was rotting.

[82] No specific measures were put in place to protect against a fall.

[83] Colin MacPhail heard a crash and observed his father fall through the roof, striking his head on the ground below. He did not put his hands out in front of him to protect himself. He placed his father into the recovery position and thereafter placed a call to the Scottish Ambulance Service at approximately 1423 hours.

[84] Paramedics arrived at the farm at approximately 1440 hours. They assessed Mr MacPhail and found that there were no signs of life. CPR was commenced.

[85] Mr MacPhail was pronounced dead at 1457 hours that day.

[86] Ms Dobb gave evidence that, in this case, access to the shed was restricted due to the presence of existing pen walls and the fact that the inside of the shed was congested

with other farm related items. While those materials could potentially have been cleared to improve access, her view was that many of the items were fixed in position or otherwise difficult to move, thereby limiting options available for implementing precautions against falling. Her view was that the primary focus in this case should have been on prevention of a fall in the first place. This could potentially have been achieved with an appropriate crawler board system.

[87] Ms Dobb emphasised that in the agricultural sector roofs require repair and maintenance on a regular basis. Therefore, investment in a proper crawler board system is clearly worthwhile.

[88] Ms Dobb also gave evidence that appropriate edge protection could have been implemented. This would involve the installation of a physical barrier system along the perimeter of a roof to prevent people or materials from falling over an exposed edge. This acts as collective protection, safeguarding everyone working at height about the same time without requiring specialist user training. The value of that is self-evident as a safety measure and best practice. However, given the location of the fall in this case was through the middle of the roof that evidence has only limited value here.

F. James Smith

[89] James Smith owned and ran Bowhouse Farm in Kilmarnock. This was a family run business, and he and his wife were equal partners.

[90] On 22 August 2024 Mr Smith was undertaking repair work to the roof of the barn on the farm. He was working alone. He was last seen by his wife around lunchtime.

[91] At approximately 1820 hours Mr Smith's wife went to look for him as he had not returned home for his evening meal. She contacted her sister and brother-in-law to assist her in the search.

[92] Her brother-in-law found Mr Smith lying face down on the concrete floor of the barn. There was a hole in the roof directly above Mr Smith and pieces of corrugated roofing were on the ground. A set of ladders was leaning against the outside of the barn. There was no evidence of any protective measures against a fall.

[93] A call was made to the Scottish Ambulance Service at approximately 1920 hours that day. An ambulance arrived at approximately 1934 hours. Paramedics assessed Mr Smith as having massive head trauma. He was cold to the touch and had no signs of life. He was pronounced dead at 1938 hours.

[94] The precise circumstances of the fall remain unclear given the absence of eyewitness evidence. However, Ms Dobb gave evidence that reasonable precautions could have been taken to establish a safe system of work which might realistically have prevented the fall. These included the use of a proprietary crawler board system and the use of a tower scaffold or hay bales beneath. That would have allowed work to be undertaken from below or to minimise falling distance from above.

PART IV – COMMON FACTORS

The prevalence of work at height on agricultural premises

[95] The common feature of all six deaths is that they arose during work at height on agricultural premises, principally involving the repair or maintenance of farm buildings.

Five involved falls through fragile roof surfaces, while the sixth exposed the dangers of improvising access equipment when working at height. These circumstances demonstrate that work at height presents a recurring and foreseeable hazard within the agricultural sector, including during relatively routine maintenance activities. In considering recommendations, this inquiry emphasises to farmers, agricultural workers and contractors that work at height undertaken in an agricultural setting, requires the same careful assessment of risk and safety precautions as equivalent work carried out in any other industry.

The identification and assessment of foreseeable risks

[96] A further common feature is the failure to identify, assess or respond to the risks associated with the work being undertaken. In several cases, the fragile nature of roofing materials presented an obvious danger. In others, the proposed means of access or changed working conditions created risks which were not sufficiently addressed. The evidence demonstrated the importance of undertaking a suitable assessment of the risks before work commences and reviewing that assessment where circumstances change. The inquiry recognises that such assessments must be practical and proportionate to the task, but they must identify the precautions necessary to prevent a fall or minimise its consequences.

The absence or ineffective implementation of protective measures

[97] In all these cases, the accidents occurred in circumstances where appropriate measures to prevent or mitigate a fall were either entirely absent or had not been effectively implemented. The evidence identified a range of reasonably practicable precautions. Most commonly these were proprietary crawler boards, secured ladders, suitable and stable working platforms, and safety nets. The particular measures required necessarily depend upon the nature and location of the work. Several of these deaths illustrate that the identification of suitable precautions is insufficient, unless those precautions are actually in place before work begins, and they remain effective throughout its duration.

Familiarity with maintenance work and the perception of risk

[98] Several of the deceased were experienced farmers or tradesmen who were familiar with the work they were undertaking and had carried out similar tasks successfully many times before. Such experience does not provide protection against the risks associated with working at height. The danger of familiarity with routine maintenance activities may result in insufficient attention being paid to hazards which are well recognised and capable of causing fatal injury. This is especially true when the work to be undertaken is small scale but nevertheless to be completed at a height from which, if a fall occurred, has the potential to result in fatality.

The availability and practical application of existing safety guidance

[99] Finally, the evidence demonstrates that established guidance concerning work at height was available at the time of these accidents. One of the issues disclosed by the evidence was not necessarily an absence of guidance but the mechanism by which it is provided to the agricultural sector. The circumstances of these deaths suggest that consideration should be given to how existing guidance might be more effectively communicated.

PART V – RECOMMENDATIONS

[100] Section 26(1)(b) of the Act requires this inquiry to set out such recommendations as it considers appropriate. The making of recommendations is a discretionary matter for the court. The purpose of recommendations is forward-looking.

[101] I have carefully considered all the submissions made on behalf of parties. The Crown submitted that the risks associated with working at height, particularly on fragile agricultural roofs, are already well recognised and the subject of extensive guidance from the HSE and other organisations. It nevertheless acknowledged there might be value in encouraging the dissemination of this determination to agencies with some reach in the agricultural sector, such as the National Farmers Union for Scotland or the No Falls Foundation. Other parties to the inquiry were of the view that any recommendations should be directed to the HSE and their further dissemination and implementation would be their responsibility. As I understood it, during the hearing on submissions the Crown came to agree with that viewpoint.

[102] There is force in the Crown submission that the risks highlighted by these deaths are already well known and understood, and that the measures required to address them are also well established. The evidence of Ms Dobb established that recognised precautions and guidance were already available from the HSE. If these had been followed, they might realistically have prevented the deaths. The evidence does not demonstrate a deficiency in the nature of the guidance which is available.

[103] There would be no value in directing recommendations towards the individual farms concerned. That will not serve any useful preventative purpose. I am satisfied that the wider lessons arising from these deaths are more appropriately addressed through recommendations directed toward the improvement of awareness of established safety precautions.

[104] The circumstances of these deaths disclose matters of wide concern. Each involved a foreseeable risk associated with working at height. In each case the well-known safety precautions that could have addressed those risks were either not considered or were not implemented. These deaths tragically demonstrate that the existence of guidance does not necessarily result in the adoption of safe working practices.

[105] I have considered the evidence of Mr Wayne Owen concerning the activities already undertaken by the HSE within the agricultural sector. That evidence describes a substantial programme of guidance, awareness campaigns, and engagement. It also indicates that fatal injury rates within agriculture have remained broadly unchanged. I recognise that the persistence of fatal accidents does not necessarily establish that the

HSE's existing initiatives are ineffective. But it does provide a legitimate basis for considering whether the methods currently employed to communicate safety information are being engaged with by those most at risk within the agricultural sector.

[106] The evidence of Ms Forbes is relevant here. She described difficulty in navigating the available guidance and a lack of opportunities for direct engagement with the HSE in her location. She described never having been sent any guidance or pamphlets by the HSE until after Mr Gibson's accident. She took steps at her own cost to educate herself on health and safety matters. When she began her own research, she described being overwhelmed by the number of HSE documents and briefings, all of which were cross referred to technical legislation which she found difficult to follow. There was no evidence of any ongoing training workshops and seminars being provided to farmers in rural Scotland. She was not aware of any in-person safety and awareness campaigns ever having been run by the HSE in the Aberdeenshire area. Ms Forbes presented as diligent and doing her best to educate herself on the health and safety aspect of matters. It is reasonable to conclude that if she was unaware of any ongoing HSE in-person safety and awareness campaigns in her local area the same is likely to be true of other farmers in that area. That evidence illustrates a practical issue which merits consideration.

[107] Against that background, I consider it appropriate to make a recommendation in terms of sections 26(1)(b) and 26(4)(d) of the Act. It is directed towards the HSE, which is clearly the body best placed to consider the matters identified and to determine how they might most effectively be addressed.

RECOMMENDATION - Effectiveness of communication and engagement

[108] The inquiry recommends that the Health and Safety Executive review how it currently communicates the risks of working at height to those working in Scotland's agricultural sector. The primary purpose of the review is to assess how effective these methods are in raising awareness of those risks. Particular regard should be had to self-employed farmers, small farming businesses and those undertaking maintenance of agricultural buildings. The review should specifically consider:

- whether different or additional approaches, including more direct engagement with rural farming communities, could improve awareness of the risks and encourage greater compliance with established safety precautions; and
- whether online information could be simplified to assist rural farmers' understanding of the available material; and
- whether webinars and in-person training seminars could be arranged for farmers in rural Scotland to attend.

I further recommend that the review specifically takes the views both of NFU Scotland and the No Falls Foundation. They are both uniquely well placed to comment with authority on effectiveness of current methods of communication and the potential for improvement.

[109] I make this recommendation because the evidence in this inquiry demonstrates a recurring failure to implement precautions against well recognised risks. This

recommendation is not intended as a criticism of the work the HSE already undertakes in this area, or as a finding that its existing arrangements are deficient. Rather, it is directed towards evaluating whether those arrangements might be improved. Given the common circumstances of these deaths as outlined above, I am satisfied that a review capable of identifying more effective methods of engagement might realistically contribute to preventing further deaths in similar circumstances.

PART VI - POSTSCRIPT

[110] While the inquiry makes the above recommendation directed towards the HSE, it is important to emphasise the responsibility for improving safety is not a one-way street. Those working within the agricultural sector must themselves recognise and act upon the risks associated with working at height. If there is one message which this inquiry seeks to convey in the clearest possible terms, it is that the agricultural sector is not an exception to the fundamental principles of health and safety. Simply because work is undertaken on a farm, often by experienced individuals carrying out familiar tasks, does not diminish the risks involved nor the need for appropriate precautions. Before undertaking work at height, agricultural workers and contractors must give careful consideration to the hazards involved and ensure that appropriate safety measures are in place before that work commences. Familiarity with the task or the fact that similar work has been completed successfully in the past without incident, are not substitutes for a safe system of work. The deaths considered in this inquiry demonstrate, in the most tragic terms, the potentially fatal consequences of failing to take such precautions.

This inquiry urges all those working within the agricultural sector to ensure the considerations of health and safety remain at the forefront of their thinking whenever work at height is contemplated.

[111] On behalf of the inquiry and all of those who participated, I offer sincere condolences to the families of the six men who lost their lives.