

SHERIFFDOM OF GRAMPIAN HIGHLAND AND ISLANDS AT PETERHEAD

B175/11

DETERMINATION

by

SHERIFF WILLIAM H. SUMMERS ESQ.

**in the Inquiry under the Fatal Accidents &
Sudden Deaths Inquiry (Scotland) Act 1976**

into the Death of

HARRY WILLIAM EMSLIE

PETERHEAD, 17th January 2012

The Sheriff, having resumed consideration of the evidence, affidavits, productions and submissions, Determines:-

1. In terms of Section 6(1)(a) of the Fatal Accidents & Sudden Deaths Inquiry (Scotland) Act 1976 ("the Act") that Harry William Emslie (who was born on 6th September 1940) and resided at Brae of Coynach, Clola, Mintlaw, Aberdeenshire died between 5 pm on Sunday 8th June 2008 and 9.30 am on Monday, 9th June 2008. Mr Emslie died in a barn at Brae of Coynach, Clola, Mintlaw, Aberdeenshire as a result of injuries sustained by him in an agricultural accident.
2. In terms of Section 6(1)(b) of the Act that the death of Harry William Emslie was due to chest, abdominal and pelvic injuries. These were a rapidly fatal

consequence of Mr Emslie being crushed against a wall by the bucket attachment of the Manitou vehicle he had been using.

3. In terms of Section 6(1)(c) of the Act, while he was using the vehicle Mr Emslie parked it perpendicular to a wall in the barn. He exited the cab of the vehicle. In doing so he did not engage the handbrake. He left the vehicle in gear with the engine running. He left a dog in the cab of the vehicle. Reasonable precautions that might have been taken and that might have avoided the accident are

- 3.1 Parking the vehicle parallel to, rather than perpendicular to the wall.

- 3.2 Engaging the handbrake of the vehicle.

- 3.3 Leaving the vehicle in neutral rather than in gear.

- 3.4 Switching off the engine of the vehicle

- 3.5 Removing the dog from the cab of the vehicle.

4. In terms of 6(1)(d) of the Act, there was no evidence of any defect in any system of working that contributed to the accident or the death.

5. In terms of Section 6(1)(e) of the Act, there are no other facts that are relevant to the circumstances of Mr Emslie's death.

Sgd Sheriff W H Summers

NOTE:

Introduction

1. This is a mandatory Fatal Accident Inquiry held in terms of Section 1(1)(a)(i) of the Fatal Accidents & Sudden Deaths Inquiry (Scotland) Act 1976. The Inquiry is in relation to the death of Harry William Emslie following an agricultural accident on 8th or 9th June 2008.

The application for the Inquiry was warranted on 8th November 2011. The date allocated for the Inquiry was 19th December 2011. I heard evidence and submissions on that day.

2. The Inquiry was presented on behalf of the Crown by Mr Fay, Procurator Fiscal Depute. Mr Emslie's immediate family were represented by Mr Gibb, Solicitor. No other party was represented at the Inquiry.

3. Some of the evidence at the Inquiry was presented through affidavits. Those were

3.1 An affidavit of Doctor James H.K. Grieve speaking to the post-mortem examination of Mr Emslie.

3.2 An affidavit of Mr Eugene Wilfred Norman. Mr Norman was a near neighbour of Mr Emslie. He spoke to a statement he had given to the police largely in relation to events on 8th June 2008.

3.3 An affidavit of William John Service. Mr Service is the son-in-law of Mr Emslie. He spoke to a police statement in which he dealt with background circumstances, events on 8th and 9th June and his discovery of Mr Emslie's body.

4. I heard evidence from two witnesses at the Inquiry. Those were

4.1 Sergeant Colin Houston. Sgt Houston is a police officer with Grampian Police. He attended the scene and investigated the circumstances surrounding Mr Emslie's death.

4.2 Doctor Harris Cooper. Dr Cooper is an occupational health and environmental safety lecturer at Robert Gordon's University. He was formerly employed by the Health & Safety Executive. In that capacity he was involved in investigating Mr Emslie's death.

5. In the course of giving evidence the witnesses referred to a number of productions. Those included photographs taken at the scene, correspondence passing between Dr Cooper

and the Procurator Fiscal's Office and a DVD of the Manitou vehicle taken some time after the accident.

Harry William Emslie

6. The deceased, Harry William Emslie, was born on 6th September 1940. At the time of his death he was 67 years of age. Mr Emslie was a farmer. He farmed 650 acres at Brae of Coynach. For some time prior to his death he worked the farm himself. Mr Emslie was very hard working and it was not unusual for him to be working in the evening.

7. Mr Emslie was survived by his wife, Mrs Kay Emslie, from whom he had recently separated. He was survived by his son, Harry and his daughter, Jacqueline. She is married to Mr William John Service, one of those who gave evidence by affidavit.

Sunday, 8th June 2008

8. At around 5 pm on Sunday, 8th June Mr Eugene Norman saw Mr Emslie drive into the farm yard at Brae of Coynach. In the course of the evening of 8th June, Mr Norman heard an engine running in the farm yard. That was not unusual.

9. A meeting had been arranged to take place on 9th June 2008. The meeting was to be attended by Mr Emslie, his wife and children. Mr Service and his wife, Jacqueline (the deceased's daughter) lived in the South of Scotland. They travelled north to Aberdeen on the evening of 8th June. Mrs Service tried to speak to Mr Emslie by telephone in the course of the evening but was unable to do so.

Monday, 9th June 2008

10. Mr Service and his wife travelled from Aberdeen to Brae of Coynach on the morning of 9th June. Mrs Service tried again to contact Mr Emslie with no success. They arrived at the farm at around 8.40 am. There was no immediate sign of Mr Emslie. Mr & Mrs Service went to look for him. Mr Service spoke to walking to the big shed. He looked inside and saw a Manitou vehicle (SP05 DKL). It has a bucket on the front. He saw the deceased's body slumped into the bucket. Both of the deceased's feet were on the ground. The bucket had crushed Mr Emslie against the wall of the shed. Mr Service concluded immediately that he was dead.

11. The Manitou vehicle was cold. The engine was not running. There was no smell of diesel. Mr Service concluded that the accident had happened some time previously.

12. Mr Service found a Collie type dog in the vehicle cab. His wife let the dog out. It ran off. Mr Service took steps to contact Mr Emslie's immediate family and to call the emergency services.

Investigation – Sergeant Houston

13. Sgt Houston gave evidence in relation to his investigation. He arrived at the farm at about 11 am on 9th June. He described the circumstances in which he found Mr Emslie's body. He did so largely by reference to the photographs in Crown production 1. Those photographs show the scene Sgt Houston found at Brae of Coynach.

14. Sgt Houston was not able to trace anyone who had witnessed the accident. He could not readily ascertain what had caused the accident. He was able to identify someone who knew about the operation of the vehicle and was assisted in his examination of it.

15. When Sgt Houston initially saw the vehicle, the ignition was turned on. The internal dashboard lights on the vehicle were on although they went out in the course of the day. There was no diesel in the vehicle. It had run dry. The vehicle was in third gear. The handbrake was off and the drive lever was in the forward position.

16. Sgt Houston concluded that the vehicle must have moved forward somehow and pinned Mr Emslie against the wall of the barn. It was not immediately obvious how that had happened.

17. Sgt Houston identified some animal food in the bucket of the vehicle. There was some animal food lying on the ground underneath the bucket. The blade of a shovel was lying on the ground. The handle was lying in the bucket. It appeared as if Mr Emslie had been using the shovel. It seemed to Sgt Houston that Mr Emslie had used the bucket of the Manitou vehicle to lift up the bulk of the food stuffs and had then emerged from the vehicle and used the shovel to pick up what remained.

18. On the basis of the evidence that I heard from Sgt Houston in relation to the subsequent investigations, it is clear that the vehicle operates in a way that is markedly different from a car. It has a number of features with which Mr Emslie will have been familiar and which are worthy of note.

19. The vehicle is driven hydraulically. The vehicle has a handbrake but that does not operate in the same way as the handbrake on a conventional vehicle. When the handbrake is engaged it brakes the wheels on the vehicle. More significantly at the same time it operates a micro switch, the effect of which is to isolate the drive mechanism of the vehicle. That prevents the wheels being driven and the vehicle moving under power. If the handbrake is not engaged the vehicle is capable of moving forward. As previously noted, when the vehicle was found in the morning of 9th June, the handbrake was not engaged.

20. The vehicle has a gear lever but again that does not operate in a conventional way. There is no requirement to change gears when the vehicle is moving. A gear is selected while the vehicle is stationary. When the vehicle is then operated it will attain the speed attributable to that gear without the necessity of further gear changes. Again, as previously noted, when the vehicle was found on the morning of 9th June the gear lever was in the position for third gear.

21. On the left of the steering column of the vehicle there is a lever which was described as the drive lever. This vehicle has three positions. Those are neutral, forward and reverse. If neutral is selected, the vehicle will not move. If the forward position is selected the vehicle is capable of moving forward. If reverse is selected the vehicle is capable of moving in reverse. The vehicle will move in either forward or reverse in which so ever gear is selected. Again, and as previously noted, when the vehicle was found on the morning of 9th June 2008, this lever was in the forward position.

22. For the vehicle to move forward under power a number of factors must be present. Firstly, the engine has to be running. Secondly, the handbrake must be off. Thirdly, a gear must be selected. Fourthly, the drive lever must be in the forward position.

23. Sgt Houston was able to get the vehicle going on 9th June by replacing the battery and filling it with diesel. On the basis of his investigations, he came to understand how the

vehicle could have started moving while in gear. Even if it encountered an obstacle it would not stall. It would continue to run, applying constant pressure, until either it was switched off or it ran out of fuel.

24. On the basis of his investigations on the day, Sgt Houston was satisfied that if the engine of the vehicle was running, third gear was engaged and the handbrake was engaged, if the drive lever was moved forward the vehicle would not move. Conversely if the engine was running, third gear was engaged, the handbrake was not engaged and the drive lever moved forward the vehicle would move forward.

25. There was no evidence of any third party involvement and Sgt Houston did not think that this is an accident that Mr Emslie could have caused to himself. The vehicle had not travelled any significant distance and did not hit the wall of the shed with any significant momentum. It would not have been possible for Mr Emslie to emerge from the cab, move the drive lever forward and position himself in front of the vehicle. There was nothing to suggest that Mr Emslie had any suicidal intention. Sgt Houston was aware that there had been a dog in the cab. Sgt Houston came to wonder whether the dog in the vehicle might have been responsible for knocking the drive lever

26. The vehicle was sold after Mr Emslie's death. Some months later Sgt Houston tracked the vehicle down. He carried out further investigations into its operation and had a DVD made in relation to those investigations. Two things of significance emerged from that DVD. The first is if the engine is running, third gear engaged and the handbrake off, the drive lever can be engaged in the forward position without any definite movement. This was illustrated in the DVD by the simple expedient of the drive lever being hit with the back of the driver's hand. Secondly, when engaged in that way the vehicle moves off very quickly.

27. On the basis of his initial and subsequent enquiries, Sgt Houston's conclusion was that Mr Emslie had been got out of the vehicle leaving the engine running with third gear engaged and without setting the handbrake. Mr Emslie did that to use the shovel to put what remained of the animal feed into the vehicle bucket. He concluded that the dog in the cab had struck the drive lever. That caused the vehicle to move forward and pinned Mr Emslie against the wall.

28. It was difficult to be precise about the time of Mr Emslie's death. It was clearly at some point between the late afternoon of Sunday 8th June and 9.30 in the morning of Monday 9th June. It appeared from the post-mortem report as if Mr Emslie had died within one or two hours of eating what seemed to be an evening meal.

Investigation - Doctor Harris Cooper

29. Dr Cooper was involved in investigating Mr Emslie's death. He attended the farm on the morning of 9th June, arriving at about 11.30am. He did a visual inspection of the vehicle. He described it as a Manitou reach truck with a shovel attachment. He observed Mr Emslie's body pinned between the shovel and the wall of the barn. He had access to inspect the vehicle. He looked at it and he confirmed that the engine was not running, the key was in the ignition and the ignition was turned on. The engine was cold, the handbrake was off and third gear had been engaged.

30. The vehicle has two separate hydraulic systems, one for operating the boom, the other for operating the drive system. It has a hydrostatic drive. If the vehicle meets an obstruction it will not stall, it will continue to try to move forward. Dr Cooper spoke to Crown Production 1 and in particular to the photographs showing what appeared to be patches of oil underneath the vehicle. He explained that this appeared to be oil that had leaked from the boom system and the drive system of the vehicle. Those leakages were consistent with the vehicle having been operated for some time under stress. He explained that if the vehicle's drive system was engaged but it was effectively stuck in forward position for a sustained period of time, the oil would heat and would leak out of the vehicle's systems.

31. Dr Cooper spoke to the letters that he had written to the procurator fiscal's office, Crown productions 3 and 4. He spoke to the safety features of the vehicle including the drive lever and the handbrake. He referred to the gear lever as being a safety feature in the sense that it could be left in neutral.

32. Dr Cooper explained that he had been in touch with the vehicle's manufacturers. He had established that some two months after this vehicle had been manufactured, a new feature had been incorporated into subsequent models. That was a seat sensor that operated in such a way that the vehicle would not move forward unless the weight of a driver was detected on the seat.

33. Dr Cooper spoke to the DVD Crown label 1. He explained that with use and the passage of time the drive lever becomes easier to move. He did not regard this degradation as a fault. It was natural wear and tear. It would only be hazardous if the lever reached a state where it was possible to move it into forward or reverse without any positive action by the driver. He was satisfied that in June 2008 the drive lever in this vehicle still required a positive action for it to be engaged. Dr Cooper gave detailed evidence in relation to his letters dated respectively 20th October 2008 and 30th July 2009, Crown productions 3 and 4. He set out in Crown production 3 his assessment of the probable scenario leading to Mr Emslie's death.

34. Dr Cooper was reasonably satisfied that Mr Emslie had been working in the barn with the machine. He had used it to clear some food stuffs. He had then parked the vehicle perpendicular to the wall, a metre to a metre and a half from the wall. He then left the vehicle to use a shovel to lift the remainder of the material into the bucket.

35. Dr Cooper believed that when he emerged from the vehicle, Mr Emslie left the engine running and in third gear. The drive lever was in the neutral position. He did not engage the handbrake and he left his dog in the cab.

36. When Mr Emslie was standing between the bucket blade and the wall, the drive lever was moved into the forward position and the vehicle moved forward. In Dr Cooper's assessment the likelihood is that the dog in the cab knocked the lever into the forward position. The vehicle moved forward suddenly and too quickly for Mr Emslie to get out of the way.

37. Dr Cooper was satisfied that the accident could have been avoided. In his assessment the working method used by Mr Emslie was very unsafe. He could have done any one of a number of things that would markedly have improved his safety. Those things were

- 37.1 Parking the vehicle parallel to the barn wall rather than perpendicular to it.
- 37.2 Engaging the handbrake.
- 37.3 Putting the vehicle into neutral rather than leaving it in third gear.
- 37.4 Switching off the engine of the vehicle.

37.5 Removing the dog from the cab.

38. The witnesses who gave evidence to the Inquiry were very helpful and I am grateful to them.

Submissions

39. Mr Fay invited me to make findings broadly in line with the findings that I have made. The place of Mr Emslie's death was clear. There was an issue in relation to the time of death. The window was between 5 pm on 8th June and 9.30 am on 9th June. The evidence pointed to Mr Emslie's death having occurred the previous evening. In his affidavit, Mr Norman spoke to hearing machinery on 8th June but not on 9th June. The vehicle was cold when it was found. The battery failed in the course of the police investigations and the post-mortem findings pointed to death having occurred in the evening of the 8th.

40. The cause of Mr Emslie's death was fairly clear but the cause of the accident was not. The police investigation had ruled out third party involvement. Suicide seems very unlikely because of the speed at which the vehicle moved off and the deceased's frame of mind. The significant issue was the question of how the vehicle came to move forward. By far the most likely scenario is that the drive lever was knocked by the dog left in the cab.

41. In relation to reasonable precautions that might have been taken to avoid the accident, Mr Fay invited me to make a determination referring to the five points in Dr Cooper's letter, Crown production 3.

42. There was no evidence in relation to any particular system of work. In relation to other factors, Mr Fay suggested that I might refer to the inclusion of a seat sensor in newer models of the vehicle.

43. Mr Gibb on behalf of the family largely echoed what Mr Fay had said. The family had come to accept the tragic circumstances in which Mr Emslie had died and took no issue with the submission made by Mr Fay.

Decision

44. On the basis of the evidence I heard, I had little difficulty in making the determination in this Inquiry. I am reasonably satisfied that Mr Emslie's death happened on the evening of

8th June rather than the morning of 9th June. I say that for a number of reasons, again, all as largely rehearsed in the evidence. An engine was heard running in the farm on the evening of 8th June but not the following morning. Mr Emslie's daughter was not able to contact him by telephone on the evening of 8th June. The post-mortem report indicates that Mr Emslie died within one or two hours of what appeared to be an evening meal. The engine of the vehicle was cold when it was found. The battery went flat in the course of the morning of 9th June. Having said that, I cannot exclude the possibility that Mr Emslie worked late and that the accident happened in the early hours of 9th June. I have declined to speculate as to the precise time of death.

45. I am satisfied that the accident that caused Mr Emslie's death happened in the way described by Sgt Houston and by Dr Cooper. That is to say he was working on his own in the barn at the Brae of Coynach. He was using the bucket of the vehicle to pick up some food stuff lying immediately adjacent to the barn wall. He had his dog in the vehicle cab.

46. After Mr Emslie had picked up as much of the material as it was possible to pick up using the vehicle's bucket, he parked the vehicle a metre to a metre and a half away from the wall of the barn. He parked the vehicle perpendicular to the wall. He got out of the vehicle cab. He left the engine running. He left it in third gear. He did not engage the handbrake. When he got out of the cab he closed the cab door leaving his dog in the cab.

47. Mr Emslie then moved round to the front of the vehicle. He had a shovel that he intended to use to pick up the remainder of the material. He placed himself between the bucket and the wall. When he was in that position, the dog in the cab hit the drive lever on the steering column of the vehicle. That engaged the vehicle's drive mechanism. The vehicle moved forward very quickly. The vehicle moved forward so suddenly and at such a speed that Mr Emslie had no time to move out of the way of the bucket. The bucket pinned Mr Emslie against the barn wall by the abdomen.

48. That caused the catastrophic injuries described in the post-mortem report. In consequence of those injuries, Mr Emslie lapsed into unconsciousness within a matter of seconds and died shortly thereafter.

49. I am entirely satisfied on the basis of the evidence that Mr Emslie could not have engaged the drive lever in the forward position, closed the door of the cab and then positioned himself in front of the bucket between the wall before the vehicle moved forward.

50. I am entirely satisfied on the basis of the evidence that no third party was involved in this incident.

51. On the basis of the evidence I heard the reasonable precautions that Mr Emslie might have taken to prevent this accident are largely self-evident. If Mr Emslie had done any of parking the vehicle parallel to the wall rather than perpendicular to it, switching the engine off, engaging neutral gear, engaging the handbrake or taking the dog out of the cab, this accident would not have occurred.

52. After the accident the vehicle engine carried on running until eventually the diesel tank in the vehicle ran dry. At that point the engine stopped. The ignition, of course, remained on. That is the position in which the vehicle was found on the morning of 9th June.

53. I was invited by Mr Fay to make a finding in terms of Section 6(1)(e) of the Act. That is to say a finding in relation to other facts that are relevant to the circumstances of the death. Mr Fay invited me under this heading to refer to the inclusion of a seat sensor in newer models of this forklift truck. I am not satisfied that it is appropriate to do that. It does not seem to me to be relevant to the circumstances of Mr Emslie's death that subsequent models of this vehicle were fitted with a seat sensor. There were a number of other safety features present in the vehicle which if utilised would have prevented the accident.