

**SHERIFFDOM OF GRAMPIAN, HIGHLAND AND ISLANDS AT
STONEHAVEN**

**UNDER THE FATAL ACCIDENTS AND SUDDEN DEATHS INQUIRY
(SCOTLAND) ACT 1976**

2010 FAI 22

DETERMINATION

by

PATRICK PROTHEROE DAVIES,
Sheriff of Grampian, Highland and
Islands at Stonehaven

In

FATAL ACCIDENT INQUIRY
into the death of
IAN MORRISON

STONEHAVEN, 17th May 2010

Having heard the evidence led, considered the affidavit lodged along with the Joint Minute for the parties and both heard and considered the submissions of the parties thereon, I determine, in terms of Section 6(1) of the Fatal Accidents and Sudden Death Inquiry (Scotland) Act 1976:

1. In terms of Section 6(1)(a), that
 - (a) at about 08.20 hours on 7th June 2008, Ian Morrison, born on 2nd May 1957 who normally resided at 4 Newbigging Farm Cottages, Montrose, DD10 9LF died as the result of an industrial accident within the Smiddy at the premises of Ross Agri Services, Invergarry, St Cyrus, near Montrose, DD10 0DE;
 - (b) That the death resulted from a necessarily and instantaneously fatal head injury sustained in the accident;
2. In terms of Section 6(1)(b), that

- (a) Mr Morrison was acting in the course of his employment with Ross Agri Services as a Blacksmith Foreman at the time of the accident;
 - (b) the accident occurred when Mr Morrison was seeking to cut a used steel drum with an angle grinder. It was caused when flammable waste paint thinners contained within the drum were ignited by the grinding process and exploded;
3. In terms of Section 6(1)(c), that
- (a) the accident and resulting death might have been avoided had the management responsible for the Smiddy and the staff who worked in the Smiddy, in particular those staff who engaged in “hot work”, been familiar with and adhered to the terms of the Leaflet prepared by the Health and Safety Executive entitled “Hot work on small tanks and drums or with similar guidance;
 - (b) The accident and resulting death might have been avoided had Ross Agri Services had in place a system whereby any potential order for work of an unfamiliar, non-routine nature, was reviewed and a risk assessment carried out by a member of the senior management having an appropriate understanding of health and safety issues and, in particular, an awareness of the hazards of working with a drum that had contained an inflammable substance;
 - (c) the accident and resulting death might have been avoided had a complete and correct risk assessment been carried out by an appropriate party so as to identify the hazards presented by the work which the deceased was to undertake and the steps required to mitigate those hazards, particularly the need to thoroughly clean and then vent the drum, before any grinding work commenced;

Note

At this Inquiry, the only party to be represented was the deceased’s employer, Ross Agri Services. They were represented by Miss Henry.

I was assisted throughout this Inquiry by the clear manner in which the Procurator Fiscal Depute, Mr Gavin Callaghan, advanced the evidence led for the Crown and his submissions. His thorough examination was such that no cross-examination was required by Miss Henry. My task was also eased by the fortitude shown by those witnesses most closely involved in this matter in the giving of their evidence. One particular witness clearly found the giving of his evidence a distressing task. All

those whose lives have been touched by the tragic events about which I heard, have my sympathy.

The evidence

Ten witnesses were called to this Inquiry on behalf of the Crown. I heard from the deceased's son, also Ian Morrison and then from the party who had ordered the barbecue upon which the deceased was working at the time of his death. I heard from two of the deceased's immediate colleagues, an apprentice, Steven MacPherson, who had been engaged to a limited extent in relation to the "barbecue project" and from a very young blacksmith (an apprentice at the material time), John Sinclair, who had witnessed the immediate aftermath of the accident. I then heard from Martin Ross, the partner in Ross Agri Services directly in charge of the firm's Smiddy and from his father, the senior partner. Detective Inspector Neil Cameron spoke to the police investigations and John Radcliffe and David Richardson spoke to the investigations and findings of the Health and Safety Executive.

The evidence of Dr Grieve who had undertaken a post-mortem was introduced by way of affidavit evidence and a Joint Minute was lodged wherein the parties agreed a number of issues and helpfully limited the amount of evidence that required to be heard.

Save in one respect, I had no concerns with regard to the credibility of any of the witnesses or in relation to the reliability of the evidence that they gave. The evidence before me was such that I have been unable to determine the issue of credibility that caused me some concern. There was no evidence to directly contradict what I was told in relation to that issue but the evidence did not "ring true".

With regard to my determinations:

Section 6(1)(c) findings:

Finding (a)

This finding is along the lines of a finding which the Procurator Fiscal Depute invited me to make. I conclude that it is an appropriate finding. I have considered whether it would be appropriate to make a broader finding to the effect that those in the Smiddy should have had a proper understanding of the hazards of working with tanks, drums or other containers that contained or had contained flammable substances. I have not, however, felt able to make such a finding because of the doubt that surrounds the deceased's own understanding of these hazards. On any reasonable view of the evidence, however, what is clear is that no one had seen the Health and Safety Executive Leaflet dealing with such work and that there was certainly no adherence to its provisions.

I have considered whether or not there was a lack of understanding of the hazards involved in working with tanks, drums or other containers that contained or had contained flammable substances on the part of management. Whilst not explaining the basis for his knowledge, Mr Martin Ross suggested that he had an understanding of the risks inherent in this sort of work. While acknowledging that he was "no expert

in the field”, he said that, had the deceased come to discuss the work with him, he would not have let him use the barrel that was used – or certainly not to use it without cleaning. This evidence, I have to say, leaves me questioning whether or not Mr Martin Ross fully appreciated that a seemingly clean barrel might still be a very dangerous barrel. But he had earlier suggested that, had he been consulted, he would have told the deceased to “leave the barrel alone” as the contents would be very difficult to clean out. So, in the absence of any contradictory evidence and judging the matter on the balance of probabilities, I have felt bound to proceed on the basis that Mr Martin Ross had some understanding of the dangers of hot work with drums prior to this accident.

I have accepted, on the basis of the evidence that I heard, that the deceased also had some understanding of the hazards of the type of work on which he was engaged. In particular, the witness Steven MacPherson said that the deceased had told him that he, the deceased, had worked on diesel tanks in his past employment and had been involved in hot work on such tanks. Witness John Sinclair said that the deceased had told him something of the hazards of working with flammable substances. So, he had a level of knowledge about these hazards. But his level of knowledge had never been formally “examined” by his employers and an adequate level of knowledge had just been assumed. Such assumptions will, I accept, be made by employers – one cannot “examine” everything. That said, however, witness David Richardson made the very valid point that age does not necessarily bring an understanding of the hazards of one’s work and such an understanding should not be assumed just because of an employee’s age.

The circumstances of the accident suggest that the deceased may have lacked an adequate understanding of the hazards of the work upon which he was embarked. The mere fact that he asked for the barrel to be washed out demonstrates that he wanted a clean barrel to work on; but the events leading up to this accident do not suggest that he had a full awareness of the extent to which the barrel, having contained flammable substances, would require to be cleaned, the need to vent the barrel and so on. On the available evidence, no one will ever know for certain whether he had an inadequate knowledge of the risks or just overlooked known hazards in seeking to get this job finished. Had he been made aware of the terms of the Health and Safety Executive’s Leaflet “Hot work on small tanks and drums or received similar guidance, however, then that might have heightened his awareness, if it needed heightening, and thus prevented this accident.

What is clear is that the witness Steven MacPherson, who selected the drum from which a barbecue was to be made, had no understanding of the hazards involved in the undertaking of this the job in hand. He demonstrated some understanding of the hazards when giving his evidence but only, I concluded, because of what he had learned in the wake of this accident. In giving his account of events, he said that he had been unaware of the risk of an explosion at the time; he knew nothing of the need to vent the barrel; he did not know that it had been wrong to put the “bung” back into the barrel after washing it. This witness was, of course, a young man in the early stages of his apprenticeship as a welder/blacksmith at the time of the accident. It is not surprising that he did not know of these hazards if no one had told him of them. He had no health and safety guidance in relation to such hazards. But, had he been made aware of the terms of the Health and Safety Executive’s Leaflet in relation to

such hazards, then he may well have adopted a different approach to his selection or cleansing of the barrel. The accident might thereby have been avoided.

Witness John Sinclair spoke to being a time served welder/fabricator. He was, at the time of this accident, an apprentice with Ross Agri Services and he remains in their employment. He was not directly involved in events leading up to the accident and his state of knowledge of the above-mentioned hazards could have had no bearing on the outcome in this case. He spoke, however, to having received all his safety training at Angus College. He had also received a measure of safety training in the course of his work. He had been told, he said, something by the deceased of the risks involved in working with flammable liquids. His safety training at Angus College had not, however, covered the hazards of working with small tanks and drums and flammable substances. What was significant about his evidence was that neither at College or at his place of employment had his attention been drawn to the Health and Safety Leaflet dealing with this subject. Indeed, his employers had only given him a copy of it about a week before he gave his evidence. At the time of the accident he did not know that if drums were heated or cut there was a risk of explosion. I would perceive some merit in everyone who is trained to do “hot work” also being taught something of the hazards referred to in the Leaflet.

In making this determination, I am conscious of the fact that the Smiddy at Ross Agri Services did not routinely deal with hot work on small tanks or drums, let alone those that contained or had contained flammable substances. But, as this accident demonstrates, there was an ever present risk that such work might be undertaken.

Finding (b)

The Procurator Fiscal Depute invited me, in broad terms, to make a determination to this effect under Section 6(1)(d). I have concluded that there is a basis for making such a finding – but I make it under Section 6(1)(c). I do not think that the evidence is sufficiently compelling for me to find a clear system failure under Section 6(1)(d).

Mr Richardson expressed the view that, given the proposed work was outwith the normal line of business, a manager should have considered the risk. One cannot be confident that that would have made a difference to the outcome of this matter – but it might well have done so. It is an open question as to just how thorough a knowledge the deceased had of the hazards of the work upon which he was embarked. Mr Martin Ross, however, gave evidence – as mentioned above – as to his awareness of the hazards of hot work with drums. He said that, had he been aware of the circumstances in this instance, he would have told the deceased to “leave the barrel alone”. So, had he – as representing senior management – been consulted then the outcome may have been different.

Finding (c)

During the course of evidence, the question was raised as to the need for a written risk assessment for the sort of job which the deceased was to undertake. The Procurator Fiscal Depute asked me to find that, had a risk assessment been carried out in conformity with published Health and Safety Executive guidance, allowing for proper cleaning and venting of the drum to mitigate the risks, the accident might have been

averted. When I reflect upon what was asked of me, I am unsure as to whether the Procurator Fiscal Depute was suggesting that there should have been a written risk assessment or merely a complete and correct assessment. I conclude that he meant the latter – a complete and correct assessment, whether written or otherwise, might have avoided this accident. On the evidence, it is reasonable to infer from the deceased's actions that any risk assessment that he had personally carried out was, either because he was unfamiliar with the potential hazards or because he overlooked them, less than complete. In any event, I consider that on the evidence before me a finding as sought by the Procurator Fiscal is appropriate.

Although my determination does not turn upon the point, I conclude, having regard to the evidence that I heard, that a written risk assessment was not required for the sort of small job on which the deceased was engaged. To have prepared a written assessment for every small job of this sort would not have been practicable. That said, to have a written assessment where it is practicable to prepare one is clearly to be preferred. A written assessment provides a potentially valuable “audit trail” if things “go wrong”. Whether the assessment is a written one or a “mental” one, however, the key to securing a proper and meaningful assessment is to ensure that the person conducting it is aware of the hazards involved in the type of work in contemplation. A proper awareness of those hazards is the key to a complete and correct assessment.

General

The Procurator Fiscal Depute invited me to determine in terms of Section 6(1)(c), that the accident might have been avoided had the drum been better cleaned out or a clean drum used. I have not done so. It was clear from the evidence that, had the drum been further cleaned, then this would have involved nothing more than it being washed out again with hot soapy water. Taking the evidence of Mr Radcliffe and Mr Richardson together, the drum would have required to be steam cleaned, brushed strongly and then properly vented - or cleaned at a cleaning plant – and then perhaps vented. There does not appear on the evidence to have been any real prospect of that being done. There was no clean drum to use. So, in the circumstances in which the deceased found himself, there was no real possibility that, by seeking to further clean the drum, the accident might have been avoided. I cannot exclude the possibility that further washing may have made a difference, but I do not think that the level of possibility is such as to justify a finding under this sub-section. The precaution of getting a clean drum was not a precaution that was, in a practical sense, open to the deceased at the material time.

The evidence of Mr Radcliffe did cause me to consider whether it would be appropriate to make a determination under Section 6(1)(c) to the effect that “The accident and resulting death might have been avoided had Ross Agri Services had in place a system to control the use and disposal of containers that contained, or had contained, flammable substances”. Mr Radcliffe suggested that, because of the interface between the “Smiddy” and the “paint shop” and the presence of flammable substances in the latter, a system should have been in place to ensure that no drum passed from the paint shop to the Smiddy in other than a safe condition. He cast the paint shop in the role of the “supplier” of the drum and said that the supplier was responsible for the drum's state. I conclude, however, that there is insufficient

evidence before me on the basis of which I could make such a determination. I do, however, record Mr Radcliffe's evidence in order that Ross Agri Services and other businesses carrying out similar "interfacing operations" can give consideration to his views when assessing the systems that they require to put in place.

Section 6(1)(d) findings

I do not identify any failure of any system of working such as would justify my making a finding under Section 6(1)(d).

The Procurator Fiscal Depute submitted, as I summarise his position, that a system should have been in place that would have ensured that there was greater supervision of incoming work by management; that would have ensured that, where necessary and particularly in the case of unusual jobs, a proper risk assessment was undertaken.

Given the experience of the deceased and the nature of the business in which he was employed, I am not persuaded by the evidence that there was anything untoward or unusual in his taking instructions direct from customers of the business. I do not think that that this practice, in itself, demonstrates a "systems failure". Mr Radcliffe accepted that this sort of practice was not unusual in small rural communities. But, with the benefit of hindsight - and as dealt with above - it would have been a good idea had there been in place a practice whereby the deceased liaised with Mr Martin Ross before accepting any unusual, non-routine work. That may, dependent upon the nature of the work, have led to a more thorough risk assessment of the work proposed. But, to day that it would have been a "good idea" is not to categorise it as a "systems failure".