

SHERIFFDOM OF NORTH STRATHCLYDE AT PAISLEY

2013 FAI 5

Case ref: B78/11

FATAL ACCIDENT INQUIRY

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

**DETERMINATION BY SHERIFF DEREK D
LIVINGSTON**

**Sheriff of North Strathclyde following an inquiry
held at Paisley**

into the death of

DARREN TAYLOR (D.O.B. 15/10/85)

PAISLEY 14th February 2013. The Sheriff, having resumed consideration of the cause, DETERMINES that in terms of Section 6(1) of the Fatal Accidents and Sudden Deaths Inquiry (Scotland) Act 1976 that;

- a) Darren Taylor born 15th October 1985 residing formerly at 62 Drumpellier Avenue, Glasgow, G69 7DW died in the yard at the rear of North Kirktonmoor Farm, Eaglesham on 8th January 2009 at approximately 15.10 hours. On the same date he was taken by ambulance from North Kirktonmoor Farm, Eaglesham to Hairmyres Hospital, East Kilbride at approximately 16.30 hours and was pronounced dead on the same date at 17.26 hours by Doctor Jean Mellor.
- b) The post mortem which was carried out on 16th January 2009 found no natural disease which would have caused or contributed to the death and that the toxicology was negative for the presence of alcohol and drugs within his system. The cause of Darren Taylor's death was electrocution caused

by an accident at work. The cause of that accident was the crane boom which was being used by Mr Taylor to offload a container touching overhead electricity wires causing the electricity to flow to the ground through the crane jib and down via the controls which Mr Taylor was using and ultimately through Mr Taylor himself.

- c) The death of Darren Taylor might have been avoided had the following reasonable precautions been taken namely:
 - i) Clear and visible signs to have been erected at the entrance to the yard at North Kirktonmoor Farm in Eaglesham warning of the danger from the overhead power lines.
 - ii) Eaglesham Industrial Services Limited should have liaised through their employee regarding the date and time of delivery of the container with the Sawers family and should have ascertained that delivery was to be made to a safe place.
 - ii) Darren Taylor ought to have carried out his own risk assessment of the site i.e. the yard at North Kirktonmoor Farm Eaglesham and following upon doing that to have avoided his equipment coming within fifteen metres of the overhead wires in the said yard.

The Sheriff finds the following facts admitted or proved.

1. On 8th January 2009 a storage container was ordered from R B Farquhar (Farquhars). That company leases out containers. The order came from a company, Eaglesham Industrial Services Limited (EIS). The container was to be delivered to North Kirktonmoor Farm in Eaglesham. The container in question was a shipping container. The person to be contacted regarding the container was Jordan of EIS. There was no indication given when the order was placed that there were any hazards in delivering the container.

2. North Kirktonmoor Farm is jointly owned by Matthew Sawers and his wife Margaret Sawers. Mr Matthew Sawers and his wife Mrs Margaret Sawers are the infert proprietors of the land at North Kirktonmoor Farm and have been so since 14th August 1998 and at all material times. being the subjects described in the Property Section to Land Certificate Title Number REN95908; having been registered as proprietors on 14th August 1998 and retaining title thereafter. On 8th January 2009 Matthew Sawers was the managing director of EIS.
3. On 3rd August 1998 company number SC188158 was incorporated; it was incorporated under the name Millbry 99 Ltd; but changed its name to EIS Eaglesham Industrial Services Ltd on 26th August 1998; and again changed its name to EIS Limited on 8th February 2007; the company was subject to a winding up order dated 5th August 2011.
4. Between 19th August 1998 and date of liquidation on 5th August 2011, (i) Mrs Margaret Sawers was company secretary and also direct of company number SC188158; and (ii) Mr Matthew Sawers was director of company number SC188158.
5. As at date of death, the business carried on by company number SC188158 had two divisions (1) a cleaning business and (2) a construction business.
6. As at date of death, although formally a director and thereby responsible for corporate governance of the company, Matthew Sawers did not manage the day to day business of EIS Limited either in relation to its cleaning division or its construction division. Notwithstanding that his designation was that of managing director.
7. Farquhars, at the time in question, sub-contracted delivery of containers. This particular delivery was sub-contracted to Morrison (Dalmarnock) Ltd, (Morrison's), who instructed their driver, Darren Taylor to attend at Farquhars' premises to uplift the container in question. Mr Taylor was given a

delivery sheet which had been completed by the office at Farquhars, production number 7, giving details of the premises to which delivery should be made and the contact being Jordan. He took the container on a flatbed lorry with a hydraulic crane. The vehicle driven by Darren Taylor was a Scania 310 Tractor Unit and 2-axle flatbed trailer registration number D11 LEX.

8. Gordon Kirkcaldy, the operations supervisor at Farquhars at the time, contacted EIS and spoke with Jordan. He asked if there was any hazards at the site and was told that there were not.
9. Whatever information is given to a driver regarding the existence or otherwise of hazards is at best an unreliable indicator. All drivers are expected to carry out their own site specific risk assessment when arriving at the delivery locus.
10. The container earmarked for delivery was a lockable hijack store, similar to a ship container but with legs and a door which opens out to give access to the whole container. It was a standard ISO container also known as a shipping container having a dimension of 20 feet in length by 8 feet in width and by 8 feet in height.
11. The container, although ordered by EIS, was for the personal use of William Sawers' sister, Katy.
12. A properly trained driver is required to check that the ground to which they are making a delivery is level and firm, check for overhead electrical cables and for gas and water pipes with a view to ensuring that the delivery operation is safe. It was made clear to all drivers that if coming within 15 meters of overhead electrical wires then delivery was unsafe.
13. The Bridgend Training Facility, a reputable training company, which provided training to Mr Taylor *inter alia* instructs drivers to check proximity hazards. Its guidance refers to BS7121 which provides, "Under no circumstances should a lorry load or travel under live overhead cables with its jib raised or extended. Regular travel under cables should only be by a route with goal posts". It is

also stated there, "The operator and other persons nearby can be killed if the lorry loader or its load touches or comes too close to overhead electrical cables. An operator controlling the crane from a position on the ground is particularly vulnerable."

"The local electricity authority or, if the appropriate the generating authority, should be consulted if the lorry loader is to be used within a distance of 15 meters plus the maximum jib length from overhead lines which are supported on steel towers, or within a distance of 9m plus the maximum jib length from overhead lines which are supported on wood, concrete or steel poles."

14. It is rare that a banksman signaller i.e. someone who assists in the safe navigation of a crane is used.
15. Darren Taylor was a capable, obliging and conscientious employee who had been trained at Bridgend Training Facilities, had a SVQ for driving goods vehicles, had passed the Young LGV driver test and had Freight Association training. He had completed his training in February 2008 and had been employed by Morrisons for about 5 or 6 years prior to the accident and was experienced and well aware as to how to use a lorry with a crane. He had been externally assessed as being competent in the operation of a lorry load or crane.
16. When the Sawers refurbished the farmhouse shortly after first buying the property in 1998, there were three containers brought to the yard referred to in finding in fact 18 at the back of the property and left there. Since about 1998, there have been three containers situated within that yard.
17. As at the date of death, the layout of the farmhouse and its curtilage and its immediate vicinity was as illustrated in Map 1 of the report prepared by CW Stewart of Hayes Macfarlane.
18. As at the date of death, (i) part of the land owned by the Sawers had been enclosed to form a separate area, described by the Sawers as a yard; and (ii) the yard was as illustrated in Map 2 of the report prepared by CW Stewart of Hayes Macfarlane.

19. Overhead power cables cross the yard as illustrated in Map 2 of the report prepared by CW Stewart of Hays Macfarlane; Map 2 illustrates the overhead power cables where reference is made to “overhead electric wires”; the overhead power cables are supported by poles which are situated outwith the yard, but within land owned by the Sawers (as illustrated by black dots at the end of the graphics on Map 2 illustrating the “overhead electric wires”); the overhead power cables and the supporting poles (i) have been situated where illustrated in Map 2 since the Sawers bought their house; and (ii) have not been altered physically at any time by the Sawers.
20. On 8th January 2009 Darren Taylor arrived at North Kirktonmoor Farm at about 2.50pm where he met the owners’ adult son outside the farmhouse. When asked as to where the container should be delivered the son, William Sawers, stated, “The only place I can think of is up the back of the farm” and directed Darren Taylor to the yard at the back of the farm which was part of the farm property. Darren Taylor followed that instruction. At the time Darren Taylor arrived at North Kirtonmoor Farm and whilst carrying out his attempted unloading of the container it was still daylight and the electricity wires were clearly visible both from ground level in the yard and from the top of the container which was situated on the truck when parked inside the yard.
21. There were three containers already sitting in the yard in question two of which were under the power lines which were in the airspace above the yard. There is a warning on the gates coming into the yard about the existence of dangerous overhead wires. However when the gates of the yard are open that sign cannot be seen. The gates were open at the time of Darren Taylor’s arrival. There is also a sign on each of the poles supporting the wires about half way up stating “Danger of Death”.
22. EIS carried out both construction and demolition work in January 2009. The yard in question is used for storage of surplus building materials owned by EIS which are from time to time used at the farm

itself, on occasions are uplifted and used at other sites where EIS are working and sometimes the yard is simply a dump for waste materials. The materials delivered included slates, timber, bricks, yellow piping, blue piping and steel beams and general building materials. The regular delivery of building materials and the uplift of same was known to Matthew Sawers. Matthew Sawers had been present on a number of occasions when materials had been delivered by EIS to the yard at the back of the farmhouse. Some of the materials which were brought to the farm were stored in the containers at the back of the farmhouse and in particular in the blue container. When goods were delivered to the yard by EIS this was done without prior notification. Those carrying out the deliveries were provided with the four digit code required to enter the farm. No selection process took place regarding delivering material that might be useful to a farm.

23. No risk assessment was ever carried out upon the farm premises by Mr and Mrs Sawers or by EIS.
24. Neil McMenemy and Robert Brown who at the time were both employed by EIS arrived at the entrance to the yard shortly after Mr Taylor at around 15.20 hours. They were there for the purpose of leaving surplus timber building materials from EIS which they intended depositing in the blue container. They were unable to access same in their vehicle due to the lorry driven by Darren Taylor blocking the entrance.
25. They discovered Darren Taylor lying on the ground unconscious. Robert Brown went for assistance to the Sawers' farmhouse whilst Neil McMenemy attempted resuscitation. Mr Taylor had no pulse. He was grey with a small amount of blood coming from his mouth.
26. Resuscitation was also attempted by the neighbouring farmer, Robert Bauld. An ambulance was called by either Matthew Sawers or William Sawers. The ambulance was called within a few minutes of Robert Brown drawing the accident to the attention of the occupants of the farmhouse.

Matthew Sawers and William Sawers were present in the farmhouse with a male friend of William's at the time of Robert Brown's arrival.

27. The ambulance service arrived about 20 minutes after they had been called and placed an oxygen mask over Mr Taylor's head whilst resuscitation was attempted by Mr Bauld and by Mr McMenemy. Neil McMenemy carried out CPR by way of chest compressions and mouth to mouth resuscitation.
28. On at least five occasions during the time that Matthew Sawers was joint owner of the farm, flatbed trucks with mobile cranes were used at the yard at the back of the farm. The first three of these was to deliver the three containers which were in the yard at the time of the accident. In addition a similar type of vehicle had been used to clear up the yard about two years prior to the accident and Darren Taylor also used such a truck when he met with the accident which is the subject of this Inquiry.
29. Prior to standing on the ground, immediately before taking to the steps referred to in the findings of fact below, Darren Taylor had stood on top of the container which was on the truck, using a ladder to access it, and had attached the slings to the container and the crane hook for lifting. At that point, standing erect, he would have been 5.5 metres high and only about a metre or so below the overhead wires above his head. They should have been obvious to him.
30. The accident took place at about 3.10pm on 8th January 2009. It happened when Darren Taylor was using a hydraulically-powered crane mounted behind the cab of his tractor unit. He was operating the crane whilst standing on the ground using levers located behind the tractor cab on the left hand side of the vehicle. Whilst using the "raise jib" operating lever to lift the container off the trailer one

of the crane's hydraulic hoses came into contact with of the wires of an 11,000 volt overhead power line underneath which Mr Taylor had parked.

31. The overhead power line belonged to Scottish Power Energy Networks and was higher above the ground level than the minimum statutory height. The minimum height of the span of the overhead lines crossing the yard was 6.55 meters which was well above the minimum statutory height of 5.2 meters set out in Schedule 2 of the Electricity Safety Quality and Continuity Regulations 2002. The overhead line complied with the requirements of the Electricity Safety, Quality and Continuity Regulations and in particular Regulations 3 (1), and 17-19 and Schedules 1 and 2 and was in good order. The circuit breaker attached to the line operated properly and effectively and could not have prevented the accident.
32. Once contact was made with the overhead high voltage wire electrical current flowed between the conductor and the earth through the vehicle's tyres and outriggers, and through Mr Taylor while he was holding the metal operating lever. This current caused Mr Taylor to suffer fatal injuries.
33. The pole-mounted reclosing circuit breaker protecting the overhead line automatically tripped and reclosed twice and then locked out in the open position after the third trip.
34. The Health and Safety Executive provide guidance on how to avoid danger from overhead power lines in Guidance Note GS6. The document recommends a preferred hierarchy of precautions based upon an interpretation of the relevant legislation as follows (i) find out if the work has to be carried out under or near the overhead lines or if it can be avoided altogether – if the work cannot be avoided; then (ii) divert all overhead lines clear of the work area or, if it is not reasonable for this to be done; then (iii) make the lines dead while the work is in progress or, if this cannot be done; (iv) work around the live overhead lines using the precautions outlined in the guidance note.

35. GS6 suggests that there should be various precautions taken including erecting barriers around the overhead lines, goalposts made from rigid, non-conducting material and distinctively marked with warning notices on or near the goalposts giving the crossbar clearance height and instructing drivers to lower jibs, tipper bodies etc. and keep below this height whilst crossing. These type of precautions depend upon the frequency at which loading and unloading operations are expected to take place with the more frequent the activity the greater the need to implement these types of precautions.
36. The overhead power lines at the locus have three conductors horizontally offset from each other supported on insulators mounted on metal cross-arms and cross-arms on the top of wooden poles. The voltage between any two of the three conductors is 11,000 volts and the voltage between each conductor and the earth is 6,350 volts.
37. The power lines are suspended between wooden poles on the west and eastern side of the yard at the farm. They have a barbed wire and declining guard and two "Danger of Death" notices attached to the poles. At the top of the western pole three insulators are mounted each of which supports one of three conductors of the overhead line.
38. The hydraulically powered crane was immediately behind the cab of the vehicle and there was a yellow danger notice at the crane's operating levers warning about the danger from contact with overhead power cables. At the nearside controls where Darren Taylor had been operating the crane there was a sign stating, "Beware of electric power cable".
39. The crane could be operated by either the left or right hand of the vehicle by a person standing on the ground using a set of levers that operated valves in the hydraulic system. Darren Taylor used the levers on the left hand side of the vehicle immediately before the accident.

40. When the vehicle which Darren Taylor had been driving was examined by John Madden on 21st January 2009 a deep pit was found in the pipe on the upper boom of the crane where the rubber insulation had melted. This was the point at which the vehicle had touched the overhead wires and the melting had been caused by around 6,350 volts causing an electric current to flow from the wire down to the earth.
41. There were signs of electrical arcing activity on the central lever near its black plastic handle. This lever operated the hydraulic valve that caused the cranes boom to raise and lower. Arc marks could be seen on the central lever comprising small craters where the surface metal of the operating handle had melted. In addition there was blackening where the vaporised metal had been deposited on the surface.
42. A deep circular notch in the hydraulic pipe running along the length of the boom of the crane on its upper surface was also seen. The pipe had a rubber outer layer and inner steel reinforcement.
43. The evidence of electrical arcing activity on the central valve lever is consistent with Darren Taylor having been operating that lever to lift the cranes boom. The notch in the hydraulic pipe on the upper surface of the boom was consistent with an overhead line wire having come into contact with the pipe. The electrical current would then have flowed between the wire and earth through the pipe and the vehicles' tyres. That in turn would have heated the pipe at the point of contact allowing the wire to melt into the pipe creating the notch.
44. The hydraulic hose on the top of the boom came into contact with one of the outer head overhead wires, creating a voltage of about 6,350 volts between the point of contact and the earth on which both the vehicle and Mr Taylor were standing. The current would have flowed to earth through the

hose, the vehicle, the vehicles tyres, the vehicle's outriggers (if they had been deployed), and through Mr Taylor to the footpath.

45. Mr Taylor was holding the valve lever at the time of the initial contact causing him to be fatally injured at the instant that contact was made. The amount of current was many times higher than that needed to cause cardiac failure. The cause of death was electrocution. In being electrocuted he also suffered charged blistering burns to the left hand and to both feet typical of entry and exit electrocution burns.
46. If Darren Taylor carried out a risk assessment at the yard the risk assessment he carried out was wholly inadequate in that he either failed to note the overhead wires, assumed they were safe or miscalculated believing that his equipment would not touch the wiring. Further he failed to take account of the fact that within the yard itself the container could have been deposited other than underneath the overhead wires. There was sufficient space in the yard for the container to be offloaded in an area distant from the overhead power cables so as to avoid the risk of contact with the overhead power cables.
47. The placing of containers under overhead electrical wires constitutes a risk in view of the operation that is required to place these there and also to remove them.
48. Scottish Power carry out inspections of overhead electrical wiring such as that at the locus approximately once every 10 years. The inspection is to ascertain foreseeable risk. They did not consider there was an unusual risk here and categorised the risk as normal.
49. The lorry and equipment used by Darren Taylor were all in good working order immediately prior to the accident. .

50. Number 5/6 of process is a letter written to the Health and Safety Executive by Stewart Henderson dated 27th April 2009 who was then Facilities Director of EIS. The letter stated, “that the container ordered on 8th January 2009” was ordered by the administration department of EIS, “to replace the container that was already on sight (sic) at (North Kirktonmoor Farm) the home of the owner of our business”. The information contained in that letter was untrue. The container in question ordered was not for that purpose. In addition Mr Henderson stated “The purpose of the container was to use as storage of household goods whilst there (sic) home was being decorated.” Again there was no truth in this.
51. Darren Taylor born 15th October 1985 and formerly of 62 Drumpellier Avenue, Glasgow, G69 7DW was taken by ambulance from North Kirktonmoor Farm, Eaglesham to Hairmyres Hospital, East Kilbride at approximately 16.30 hours on 8th January 2009.
52. That Darren Taylor’s life was pronounced extinct at 17.26 hours on 8th January 2009 by Dr Jean Mellor, at said Hairmyres Hospital.

NOTE

INTRODUCTION

1. It may be helpful to make some introductory comments so that, on the one hand, the objectives and purpose and, on the other the limitations of a Fatal Accident Inquiry are understood. An essential feature of the procedure is that evidence is given in public so that the knowledge of those of responsible for investigation of the death and the accident leading to the death is shared with the public and in particular with legitimately interested parties, including of course the relatives of the deceased. The inquiry therefore fulfils the important purpose of enlightening those with a legitimate

interest as to a cause of death. It also serves the purpose of ascertaining whether any reasonable steps could or should have been taken whereby the death or the accident might have been avoided, whether any defects in any system of work contributed to the death or the accident and allows the sheriff to describe any other facts relevant to the circumstances of the death.

2. The responsibility and powers of the sheriff in respect of the determination following the inquiry are set out in Section 6 of the Fatal Accidents and Sudden Deaths Inquiry (Scotland) Act 1976 ("the Act" or "the 1976 Act"). Section 6(1) is in the following terms:

"At the conclusion of the evidence and any submissions thereon or as soon as possible thereafter, the sheriff shall make a determination setting out the following circumstances of the death so far as they have been established to his satisfaction: -

Where and when the death and any accident resulting in the death took place;

The cause or causes of such death and any accident resulting in the death,

The reasonable precautions, if any, whereby the death and any accident resulting in the death might have been avoided;

The defects, if any, in any system of working which contributed to the death or any accident resulting in the death; and

Any other facts which are relevant to the circumstances of the death."

3. However the limitations of the Fatal Accident Inquiry should also be noted. A Fatal Accident Inquiry is an exercise in fact finding, not in fault finding and it is not the function of the court to make findings or express opinions on questions of fault or liability, to attempt to apportion blame. This does not mean, of course, that the evidence led at an inquiry may not disclose fault. In that event a finding implying or imputing fault is competent. However the whole object of impartial

public inquiry is to get at the truth and to see to it so far as humanly possible that any mistakes discovered, whether they arise through fault or some other reason are not made in the future.

4. The very wide power given to a sheriff in a Fatal Accident Inquiry must also be exercised with caution, bearing in mind the summary nature of the pleadings and the lack of formal written pleadings. It is no doubt partly at least for this reason that Section 6(3) of the Act provides that the sheriff's determination in a Fatal Accident Inquiry may not be founded upon in any subsequent proceedings.
5. As I have indicated above Darren Taylor died on 8th January 2009 when the equipment he was operating touched overhead electric wires causing him to be electrocuted.

EVIDENCE

6. In this case I heard evidence from a substantial number of witnesses. The witnesses who gave oral evidence, in the order in which they gave their evidence were as follows:

Gordon Kirkcaldy, formerly operations supervisor of RB Farquhar,

Alexander Morrison, manager at Dalmarnock Transport Ltd,

William Sawers, son of the joint owners of North Kirktonmoor Farm,

Neil McMenemy, formerly labourer/driver for EIS,

Matthew Sawers, joint proprietor of North Kirktonmoor Farm and formerly managing director of EIS,

John Madden, HM Principal Specialist in Electrical Engineering,

Dr William Arnold, Principal Specialist Inspector with the Health and Safety Executive in mechanical engineering,

Robert Brown, formerly general labourer with EIS,

Stewart Henderson, formerly facilities director with EIS,

Michael Hutt, Chartered Engineer, Consultant to Strange, Strange and Gardner,

Robert Bauld, farmer, South Kirktonmoor Farm.

Generally I found the witnesses I heard from to be credible and reliable with a few exceptions. The main exceptions related to the evidence given by Matthew Sawers, the joint owner of North Kirktonmoor Farm and former managing director of EIS, his son William Sawers and Stewart Henderson also of EIS. In relation to the first two of these three their evidence was of some importance but I could place little reliance upon it. I was of the view that much of their evidence was quite simply unreliable and incredible regarding what they knew of what was going on at the site at North Kirktonmoor Farm in relation to there being overhead electrical wires and regular deliveries and uplifts by employees of EIS. The evidence of Mr Henderson was less important but I found his letter, which I have referred to in my findings in fact, to be redolent of at least a lack of reliability and quite possibly candour. I also had some difficulty with parts of Mr Hutt's evidence which I felt was overly defensive of Mr Sawers but generally accepted his evidence.

7. In terms of Section 6 of the Fatal Accidents and Sudden Deaths Inquiry (Scotland) Act 1976 I require to make a determination setting out various circumstances of the death so far as they have been established to my satisfaction. Section 6 sets out the various issues in which I am required to make a determination.
8. In terms of Section 6 (1) (a) I have a joint minute and in any event it is clear from the evidence before the Inquiry that Mr Taylor died in the yard at the rear of North Kirktonmoor Farm, Eaglesham,

sometime around 15.10 hours on 8th January 2009. Mr Taylor's life was pronounced extinct at Hairmyres Hospital, East Kilbride at 17.26 hours that day.

9. Equally in terms of Section 6 (1) (b) of the 1976 Act I require to determine the cause or causes of death and any accident resulting in death. Again this is not in any way controversial in that the cause of death was electrocution due to an accident at work. That is set out in Crown production number 9 being a post mortem report conducted by Marjory Black and Julie McAdam, forensic pathologist, into the death of Darren Taylor and the terms of that report are agreed to be true and accurate and so form sole cause of Darren Taylor's death. The immediate circumstances which led to that death were that Mr Taylor was driving a lorry with a mounted crane attachment at North Kirktonmoor Farm, Eaglesham. He was off loading a container from the lorry using the crane which he operated from the controls fixed to the left hand side of the truck. In the course of lifting the container from the flatbed of the truck the crane boom touched overhead electricity wires. The electricity flowed to the ground through the crane jib and down via the controls which Mr Taylor was using, and ultimately through Mr Taylor himself.
10. As this case continued it appeared to me that some aspects became reasonably clear e.g. that the yard at North Kirktonmoor Farm was being used for storage of work materials which were not placed there for the benefit of the farm but were present to be used in the future, if required, for EIS's building work and as a convenient place to dump materials.
11. What however we can only guess at is what was in Darren Taylor's mind after he arrived at North Kirktonmoor Farm. Having heard all of the evidence it seems to me that this can only be a matter of speculation. Did he see the overhead wires? His training and the warning signage on his vehicle was very much to the effect that he should look out for such wiring. It was clear from all of the

evidence that it was up to him to carry out a risk assessment. Did he simply miss the wires? It is difficult to see how he could do this particularly when the evidence was that in order to carry out the unloading of the container he would have climbed upon the container leaving him less than 5 feet below the wires. Alternatively did he see the wires but for some reason assume that they were not electrical wires but instead telephone wires? Again it is difficult to see why he should have reached that conclusion. There were warning signs on the poles and in any case it is difficult to see why knowing the dangers from electrical wires Mr Taylor would have taken such a risk without being quite clear. In passing I would have thought that had the crane touched non electrical wires it would still have created difficulties for the operation with possible damage to the crane and/or the wires. Alternatively did he simply miscalculate believing that his crane would avoid the wires? Or did he wrongly believe that having been directed to the yard by William Sawers that the yard must be safe? Having heard all of the evidence I am no clearer about which of these is the answer. The clear evidence given in particular by Mr Morrison was that Darren Taylor was an extremely conscientious worker who was always keen to get the job done. On the one hand such a worker would presumably take care to avoid risks. Or did he, in his desire to be helpful and not delay matters, take a risk which would prove to be fatal? Standing my finding that there was room in the yard to place the container safely that theory could only be applicable if either he was unclear about that or having realised the danger decided not to delay things by starting again. It has to be speculation and I am unclear that in any case why starting to unload in a slightly different part of the yard should delay things significantly. There is no doubt however in my opinion that had a risk assessment been properly carried out by Mr Taylor and then acted upon the accident would not have occurred since he would not have let his equipment go within fifteen metres of the overhead wires within the yard

12. As I have indicated I am satisfied that the farm and in particular the yard was a work site. It was a work site for EIS who used it for storage of and disposal of building materials. EIS therefore should have carried out a risk assessment which would have recognised the risk from overhead lines where there was activity that might create a risk of contact. It was clear from the evidence I heard that such activities took place from time to time albeit those in which lifting operations by high vehicles were probably relatively few and perhaps only took place on average about once every two years. It seems to me that at the very least there should have been very clear signage placed at the entrance to the yard, and not simply on the gates where such signs could not easily be seen if the gates were open, warning of the dangers of overhead wires. This would have been easy and might have prevented the accident although it is extremely difficult to say without knowing what was in Darren Taylor's mind at the time. It did also seem to me however that with other containers under the wires there was certainly a risk when containers were either delivered or uplifted and there should certainly have been warnings.
13. I am by no means certain that goalposts i.e. metal frames in the shape of goalposts being the height of the hazard would have been proportionate standing the relative infrequency of operations and taking into account the property was partly a residential one, provided there were these signs I have come to the conclusion that any precautions taken by Scottish Power would most likely have been of little consequence here. In the first place Matthew Sawers' attitude that the wires were safe and he could not recall whether or not he had been given Form GS6 did rather indicate to me that he was not particularly concerned about the situation and he would have been highly unlikely to have taken any action. Secondly even had Matthew Sawers taken action here I think it an even more remote possibility that William Sawers would have shown any more interest than he did when Darren

Taylor arrived at the property and in particular warned him about the overhead wires. It is also fair to say that I simply did not accept Mr Matthew Sawers' evidence that he was not aware of there being danger from the overhead wires, albeit his evidence was by no means consistent on this point. It should also be borne in mind that there was already signage on the poles within the yard which stated, "Danger of Death" and again I am of the view that further education, if indeed any was missing, would in all probability have made no difference.

14. Equally it does seem to me that any precautions which are to be taken have to be proportionate to the frequency of operations in the vicinity and indeed this was emphasised by a number of witnesses. On that basis I do not consider that it would have been a reasonable precaution to have permanently established barriers running down the middle of the yard.
15. On the basis that this was a construction storage site for EIS it appears to me that when EIS ordered the container they would normally have been expected to have identified a safe and suitable place for it to be delivered. However I have no doubt that EIS assumed their managing director or his family were taking responsibility for the delivery but I am of the view there should have been liaison regarding the delivery to what I have found to be work premises. Since I accept that Jordan of EIS was contacted by Mr Kirkcaldy regarding the delivery date and time that information should have been provided to those at the locus i.e. Mr & Mrs Sawers, so that consideration could have been given in advance to proper instructions being given to Darren Taylor particularly when EIS must have known that part of the premises to where the container could potentially have been delivered were used for work purposes.
16. Contrary to what is submitted on behalf of EIS I am of the view that EIS have to accept some responsibility for the safe delivery of this container. They had previously carried out business with

R B Farquhar. The fact that the container was being utilised for personal rather than company purposes does not seem to me to be of any consequence. If they were going to order a container to be delivered to a workplace, which is what they did here, then it appears to me that ultimately they have responsibility for the workplace being safe. If they did not wish to assume such responsibility they should not have let their name be used to obtain the container.

17. It was suggested on behalf of the family of Darren Taylor that a remote control device for the operation of the crane jib might have avoided the accident. I am of the view however that this is not really a "lively possibility" bearing in mind there is every indication that Mr Taylor had an excellent view of the overhead wires both whilst on top of the container and whilst on the ground. It does not seem to me, based upon the evidence I heard that Darren Taylor's view of the overhead wires would have been improved had he been using an overhead device.
18. I do not accept that there was nowhere within the yard where there was adequate space and it was safe to unload for Mr Taylor but even had that been the situation I would have expected him to have gone back to the farmhouse and to have stated that there was insufficient room and ask for somewhere else to unload.
19. Finally I would wish to add my condolences to those already expressed to Mr Taylor's family and to thank them for the dignity and patience with which they conducted themselves throughout the hearing of this case.