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PLEASE SEE THE FAI DATED 16 JUNE 2026 [2026] FAI 30
https://www.scotcourts.gov.uk/media/abwhjodc/2026fai030-fai-matthew-peter-burden.pdf

SHERIFFDOM OF GRAMPIAN HIGHLAND AND ISLANDS AT ABERDEEN

[2026] FAI 29

ABE-B723-24

DETERMINATION

BY

SHERIFF CHRISTINE P McCROSSAN

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

into the death of

MATTHEW PETER BURDEN

Aberdeen, 16 June 2026

The Sheriff, having resumed consideration of the evidence and the information presented at the Fatal Accident inquiry into the death of Mr Matthew Peter Burden (Mr Burden) determines in terms of Section 26 of the Inquiries into Fatal Accidents and Sudden Deaths etc (Scotland) Act 2016 ("the 2016 Act ") that:

1. In terms of section 26(2)(a) of the 2016 Act Mr Burden died, aged 36, at Aberdeen Royal Infirmary, Forresterhill Road, Aberdeen on 6 February 2022, life formally being pronounced extinct at 03.13 on that date;

2. In terms of section 26(2)(b) of the 2016 Act the accident resulting in the death of Mr Burden occurred shortly before 08.00 am on 29 January 2022 on the unclassified road from Tarland to Tillypronie, approximately 20 metres east of Pittentaggart Farm, Migvie, Aberdeenshire;

3. In terms of section 26(2)(c) of the 2016 Act the cause of Mr Burden's death as set out in a post mortem report dated 19 April 2022 was;

- 1 (a) : Head injury due to
- 1 (b) Road traffic collision (driver).

This head injury was sustained as a result of Mr Burden being thrown from the vehicle he was driving during the collision; this occurred due to his not wearing the restraining seat belt provided;

4. In terms of section 26 (2)(d) of the 2016 Act the cause of the accident resulting in the death of Mr Burden was his driving the Can-Am Traxter HD8 6 seater all-terrain vehicle (ATV), Registration number SV20 BNX provided to him by his employer Tillypronie Sporting Limited, Tillypronie House, Tillypronie Estate, Tarland (Tillypronie Estate) on this road that morning in extreme weather conditions, particularly in very high winds;

5. (i) In terms of section 26(2) (e) of the 2016 Act a precaution which could reasonably have been taken and had it been taken might realistically have avoided the accident which resulted in the death of Mr Burden would have been the cancellation of the shoot scheduled for the day of 29 May 2022 at a time prior to Mr Burden setting off on his vehicle that morning;

(ii) In terms of section 26(2)(e) of the 2016 Act a precaution which could reasonably have been taken and had it been taken might realistically have avoided the death of Mr Burden would have been for Mr Burden to have used the restraining seat belt which would have prevented him being thrown from the vehicle and sustaining the head injury which caused his death;

5. In terms of section 26(2)(f) of the 2016 Act the following defects in a system of working contributed to the accident resulting in the death of Mr Burden:

(i) the lack of any effective monitoring of those weather conditions in which it would be safe to conduct shooting including the conditions in which employees and others working on these shoots would be required/expected to travel to the location of the proposed shoots;

(ii) the over reliance on individual employees to report faults on vehicles on an *ad hoc* basis rather than a system which ensured so far as possible safe operation of vehicles on the estate.

6. In terms of section 26(2)(f) of the 2016 Act the following defect in a system of working contributed to the death of Mr Burden: the wearing of a seatbelt by him while driving in the course of his employment was not insisted upon by his employer, Tillypronie Estate.

7. In terms of section 26(2)(g) of the 2016 Act there are no other facts which are relevant to the circumstances of Mr Burden's death.

Recommendations

8. In terms of section 26(1)(b) of the 2016 Act and having regard to the matters set out in section 26(4) of the 2016 Act, having regard to the circumstances surrounding the death of Mr Burden, recommendations which might realistically prevent other deaths in similar circumstances are:

(i) Tillypronie Estate to introduce a system of working whereby the head gamekeeper or other senior member of staff is charged with the duty of checking the 7 day weather forecast as published on the Met office website in the 7 day period leading up to the date of shoots booked to take place on the estate, to include a record of all Police Scotland Weather Alerts issued in that same period; and to do so each day until the scheduled shoot in order that the estate has a working knowledge of the expected forecast for each shoot and can take timeous action to cancel or delay the start of a shoot in circumstances where it is not safe to proceed or for employees, staff or guests to travel due to adverse weather condition;

(ii) Tillypronie Estate to introduce a system of working whereby the head gamekeeper or other senior member of staff is to be responsible on a weekly basis for ensuring that any employee having use of a company vehicle complete a form confirming any concerns with the condition of the vehicle;

(iii) Tillypronie Estate to introduce a system of working to ensure that all employees while driving in the course of their employment use the seatbelts fitted to the vehicle.

Note

Purpose of Inquiry under the Act

[1] This Inquiry was held under section 1 of the 2016 Act. This was a mandatory inquiry in terms of section 2(3) of the 2016 Act as Mr Burden died as a result of an accident which occurred during the course of his employment. Mr Burden was employed as a gamekeeper by Tillypronie Estate.

[2] The Crown in the public interest is represented by the procurator fiscal depute. A fatal accident enquiry is an inquisitorial process and it is not the purpose of an enquiry to establish civil or criminal liability. The purpose of such an Inquiry is to establish the circumstances of the death and to consider what steps, if any, might be taken to prevent other deaths in similar circumstances. Section 26 of the Act sets out the matters which are to be considered by the court in light of the evidence led. The sheriff is entitled to apply hindsight in assessing any precautions which could reasonably have been taken; this matter is not to be limited to considering only those matters that were foreseeable at the time.

Procedural history of case

[3] The procurator fiscal issued notice of this inquiry on 21 August 2024. Preliminary hearings took place at Aberdeen sheriff court on 24 October and 20 December 2024. The evidential Hearing itself took place over 3 days in May and July 2025. A hearing on submissions took place on 30 September 2025. It is a matter of great regret that there has been such a delay in issuing this determination. This has been due to unforeseen circumstances which were unavoidable. Notwithstanding I apologise unreservedly to all parties, particularly to the family of Mr Burden for this delay.

[4] In the Notice of Inquiry the Crown noted the circumstances of Mr Burden's death as follows:

(i) Mr Burden was employed as a gamekeeper by Tillypronie Estate;

(ii) Tillypronie Estate provided Mr Burden with Can-AM Traxter HD8 6 seater all terrain vehicle, Reg SV20 BNX for use at work;

(iii) On 29 January 2022 an Amber adverse weather warning for high winds was in place for Eastern Scotland as a result of Storm Malik, said warning was in place from 7.00am to 3.00pm on said date;

(iv) Mr Burden was due to work at a shoot on said date and was driving the above vehicle in the course of his employment;

(v) About 08.00 on that date the vehicle was found stationary in the carriage-way of the unclassified road from Tarland to Tillypronie, approximately 20 metres east of Pittentaggart Farm, Migvie, Aberdeenshire, the offside

wheels of the vehicle were against a drystone wall and Mr Burden was found lying injured on the road;

(vi) The emergency services were summoned and Mr Burden was transferred to Aberdeen Royal Infirmary where he received treatment for a life-threatening head injury;

(vii) Mr Burden succumbed to his injuries and died at 03.13 on 6 February 2022;

(viii) a post-mortem examination was carried out on 11 February 2022 by Dr Leighanne Margaret Deboys and Dr Tamara Mary McNamee, they concluded that Mr Burden's death was caused by a head injury sustained in a road traffic collision in which he had been the driver.

[5] The Crown indicated in their Notice that they anticipated the Inquiry would consider: (1) the cause of the accident which resulted in Mr Burden's death, (2) any precautions which could reasonably have been taken and which might realistically have resulted in the death having been avoided, and (3) any defects in any system of working which contributed to the death or any accident resulting in the death. It was suggested that in light of those considerations the court may consider:

- The use of the seatbelt in the vehicle
- A fault with the driver's door on the vehicle and the level of knowledge of said fault by Mr Burden, his colleagues and employer
- Health and Safety Advice for such all-terrain vehicles

- Tillypronie Estate's processes and procedures for reporting faults in vehicles and plant, and processes and procedures for the maintenance of the vehicle
- The decision to continue with the shoot in the context of the adverse weather that day.

[6] Mr Burden is survived by his long-term partner and fiancé Ms Schooling together with their children. The procurator fiscal served the Notice of Inquiry on Ms Schooling and also Tillypronie Estate, the Health and Safety Executive (HSE) and Aberdeenshire Council (AC). The latter two bodies did not participate in this inquiry. Ms Schooling also chose not to become a participant, however she attended the inquiry each day with close members of family. She was also called to give evidence. She did so with courage and dignity. Other family members attended the hearing by Webex.

[7] Tillypronie Estate as Mr Burden's employer did serve a Notice of Intention to Participate. In that Notice they confirmed that they did not propose to put any additional issues before the court beyond those set out by the Crown; they did not intend to lead any witnesses or lodge any productions. In the event they did lead Mr Turner as a witness.

[8] As is the case in inquiries under the 2016 Act, during the period of the preliminary hearings the Crown discloses to the participants in the Inquiry the evidence they have ingathered and intend to lead at the hearing. As is frequently the case parties were able to agree a significant percentage of the evidence which reduced the number of witnesses that required to attend and physically give evidence. In this case the Crown

and Tillypronie Estate agreed the terms of an extensive Joint Minute dealing with a lot of evidence. Therefore in addition to the oral evidence led over the days in May and July the court had the benefit of the evidence set down in this Joint Minute. This included the evidence of the following witnesses:

- Mr Alec McVean
- Ewen Littlejohn, attending paramedic
- Shaun McLeod, attending trauma consultant
- Dr Leighanne Margaret Deboys, in respect of her involvement in the post-mortem examination of Mr Burden and her views on the likely mechanics of the accident
- Dr Tamara Mary McNamee, in relation to her involvement in the post-mortem examination
- PC Andrew Ramsay, collision investigator
- Henry Mackie of DVSA, vehicle examiner
- Statements of Fraser Mitchell
- Statement of Ryan Paterson (he also attended at the Inquiry).

[9] The contents of the following documentary productions were agreed by the parties: (I note below the Numbers on my copy Productions as on occasion these appeared to differ from numbers within the Joint Minute)

(i) Crown production 14 which is an alert issued by Police Scotland to the effect that the Met office had issued an Amber adverse weather warning

applying to the locus of the accident for 29 January 2022 between the hours of 0700 and 1500;

(ii) Crown Production 4: post-mortem report date 19 April 2022;

(iii) Crown Production 9: maintenance carried out on Tillypronie Estate vehicles;

(iv) Crown Production 10: vehicle examination report on Mr Burden's vehicle. This is not the joint examination carried out by a DVLA examiner with Police Scotland. The joint examination was carried out on 16 May 2022 and is spoken to in the lodged statement (WS8) of the DVLA examiner Mr Henry Mackie;

(v) Crown Production 13: email written by Craig Logan formerly HM Inspector of Health and Safety regarding purpose and functionality of doors on vehicles such as Mr Burden's vehicle;

(vi) Crown Production 14: Health and Safety Guidance document " Safe use of all-terrain vehicles (ATVs) in agriculture and forestry

(vii) Crown Production 12: Code of Good Shooting Practice.

[10] The parties agreed the following matters in the terms of the Joint Minute:

(i) the seatbelts in the vehicle used by Mr Burden, including the driver's seatbelt were in proper working order;

(ii) there were no mechanical defects with the vehicle which could have caused or contributed to the accident;

(iii) the door latch mechanism of the driver's door was operational but the door was found to be misaligned. The pin in the door latch mechanism was scored, indicating where the mechanism had become misaligned, and the door latch had caused wear in lines or grooves. The presence of wear in lines indicates progressive wear of the door hinges over time;

(iv) Other employees who used the Can-Am were unaware of any issue with the door latch mechanism. Examination of Mr Burden's mobile telephone by Police Scotland after the accident revealed no messages, reports or information relating to the door latch mechanism on the said Can-Am vehicle;

(v) The passenger compartment of side-by-side ATVs such as the incident vehicle is usually open, although some vehicles – such as the Can-Am vehicle in this instance – are fitted with a windscreen and/or side doors. The Can-Am vehicle in this instance was fitted with a roll-over protective structure (ROPS). It had functioning seat-belts. The ROPS and seatbelts are intended to reduce the risk of injury in the event of a roll-over or other incident; any optional doors (such as those fitted on Mr Burden's vehicle) are not designed to restrain the occupants.

[11] On the days of the evidential hearing the following witnesses were called:

- Ms Schooling
- Mr Matthew Allardyce
- Darren Morrison

- Ryan Paterson
- Mr Turner (Mr Turner was recalled to provide clarity on that element of his evidence relating to what employees and day labourers would do in the event of a shoot being cancelled and what payments would be made to them).

Mr Burden's employment

[12] Mr Burden was one of three employees of Tillypronie Estate, the others being Mr Ryan Paterson and a Mr William Humphreys. Mr Paterson was the head gamekeeper with both Mr Burden and Mr Humphreys being under-keepers who in effect reported to Mr Paterson. Mr Burden looked after and managed shoots. In between shoots he would carry out general ground keeper duties, look after pheasant poults, maintain bird pens, feed and medicate the birds and control predators. I understand that in addition to this he would have a variety of miscellaneous duties around the Estate. I note from the statement of Mr Turner that Mr Burden was very popular. He was very impressive in his work, very driven with great attention to detail. He considered him to be a very good representative for the estate.

Day of accident

[13] On 29 January 2022 there was in force an Amber adverse weather warning covering Tillypronie Estate and in particular the locus of the accident. Police Scotland had issued travel advice : (Crown Production 15) : ***" HIGH WINDS – TRAVEL WITH***

CAUTION. The conditions for travel in the above areas may be HAZARDOUS and EXTRA CAUTION should be exercised".

[14] On the second page of the Police Scotland Travel Advice there was a series of bullet points under two sections respectively headed – **"What to expect"** and **"What to do"**. The advice indicates that

> "the strongest winds are expected in the east of Scotland later in the morning. Gusts of widely 50-60 mph are likely with a short period of gusts in excess of 75mph, particularly for Moray and north Aberdeenshire as well as the Lothians."

Under **"What to do"** Police Scotland advise, *inter alia:*

> "If you are driving a vehicle which may be vulnerable to being blown over in such conditions along exposed routes including bridges, please exercise additional caution and plan your oute to avoid exposed areas or consider cancelling your journey until conditions improve."

[15] It is not in dispute that morning broke on 29 January 2022 to extreme winds. The witnesses spoke to being aware of the wind even before it was light. Ms Schooling spoke to it howling around her home. It was so severe that the windows were rattling and the dog kennels beside the house were blown down with the dogs having to be taken indoors for safety. The force of the wind had moved the family car from its parking spot notwithstanding the handbrake was engaged. Mr Burden's parents were staying with the family at the time. They spoke amongst themselves about the shoot proceeding in these conditions. All were aware that there was a weather warning in place. Mr Burden was sufficiently concerned to make the decision that their oldest son, who was to be a beater at the shoot, stay at home and not attend the shoot that day.

[16] There had been a shoot the previous day, with guests attending from London. Some had departed with two remaining at the estate house to have a further day of shooting on Saturday 29th. Shooting tended to take place on the estate on a Friday and Saturday.

[17] Mr Burden had been in charge of the shoot on the previous day as Mr Paterson had been absent for the purposes of getting a COVID test. On that day Mr Turner had been escorting the guests around the shoot in Mr Burden's vehicle. As only two guests remained for the shoot on the Saturday Mr Burden uplifted the vehicle from Mr Turner on the evening of 28 January.

[18] On the morning of the 29th Mr Paterson was also aware of the extreme weather in the early hours. He too was aware of the adverse weather warning. He tried to contact Mr Turner before 7.00 but did not reach him. Mr Turner returned his call at about 07.00. There was a dispute in evidence about whether the viability of the shoot was discussed during this call. Mr Paterson said that a discussion did take place during the telephone call. His evidence was that he had said to Mr Turner: "we should think about cancelling" due to how windy it was. Mr Turner did not respond to the concerns raised about the weather but instead instructed him to make preparations for the shoot. Mr Paterson said Mr Turner intended to make a decision about whether the shoot should go ahead or not once they got to the meeting point.

[19] Mr Turner's evidence was that he was aware from the point of waking how strong the wind was. His priority when calling Mr Paterson was to make arrangements for him to get breakfast for the guests at another property on the estate ("the Mill") as

the power was out at the estate house. He says that he had decided that the shoot would not be going ahead at that time; however he agreed that he did not tell Mr Paterson of this decision during the call. He had no recollection of whether the shoot was discussed or not during this call.

[20] I prefer Mr Paterson's evidence on this point. The reason Mr Paterson called Mr Turner that morning was to discuss whether the shoot was going ahead or not. Mr Paterson was the head-keeper, it stands to reason that his primary inquiry to Mr Turner would be what was happening regarding the shoot. I do not find it plausible that he would have a conversation with Mr Turner when his call was returned with the weather so obviously not favourable to a shoot, and not discuss what was happening. In addition I have difficulty in understanding why, if Mr Turner had made a decision that the shoot was not progressing, that was not the foremost matter to convey to Mr Paterson. Surely this decision determined whether there was any immediate urgency in getting breakfast organised at the "Mill". If the shoot was progressing then there was a timetable of sorts to adhere to. If it was to be cancelled then breakfast could be a more leisurely affair, with the priority being standing down employees and workers in such weather. I come to the conclusion that Mr Turner had not made his mind up by that time in the morning, thus his focus was getting the guest's fed and ready for the shoot; with a decision to be made nearer the time the shoot was actually due to start. I am confirmed further in this view by the fact that Mr Turner was not aware of the weather warning, thus would have no information about the likely duration of the extreme weather.

[21] In actuality the important factor so far as my determination is concerned is not whether cancelling the shoot was or was not discussed during this call but whether doing so would have been a reasonable precaution which might realistically have avoided the accident and Mr Burden's death. However I do consider where there is a divergence in evidence between important witnesses as to what took place during this very significant phone call I am bound to make a finding on the version I accept. Relevant in any fact finding exercise is assessing the credibility and reliability of the witnesses to important facts.

[22] I am satisfied that the weather was most extreme. It was a storm. As is noted above the dog kennels beside Mr Burden's and Ms Schooling's house had blown down. A Mr Allardyce and Mr Mitchell came to help Mr Burden fix them, but this was not possible due to the ferocity of the wind. These witnesses said that it was not possible even to stand up. Mr Paterson described the conditions as dangerous and being concerned about people moving about the estate in high sided vehicles in the wind. The ambulance crew and police who attended the scene of the accident describe in their statements the extreme conditions with the roads being strewn with fallen trees and debris. Mobile phone signals had been lost.

[23] When Mr Mitchell and Mr Allardyce were with Mr Burden at his home he was still waiting to hear whether the shoot was going ahead. None of these individuals considered it was safe to proceed. The principal concerns were around the shoot itself: the dangers of shotguns being used and likely stray pellets, together with the danger of being in among trees. Mr Burden was then contacted by Mr Paterson who told him no

decision had yet been made; they would thus proceed to prepare. In the first instance as the dogs remained without their kennel, Mr Burden was to transport them to Mr Paterson's pending the start of the shoot. The dogs were placed in the trailer attached to the Can-Am vehicle and Mr Burden set out to Mr Paterson's. This required him to drive along the unclassified road towards the "big gates" of the estate. He did not require to travel a long distance.

[24] Mr Burden drove towards the unclassified road with Mr Mitchell and Mr Allardyce following in a vehicle behind. They witnessed Mr Burden stopping the vehicle and getting out. Both speak to seeing him appear to struggle to an extent with the door at the driver's side – as if trying to close it and then seeming to slam it. One spoke to them intending to get out of their vehicle to go and help him, but before they could do so, Mr Burden got back into the vehicle and drove off. They simply continued on their way. Very sadly Mr Burden did not get very far along the unclassified road before the fatal accident which took his life.

[25] Witness Mr McVean had what must have been the very distressing experience of coming across the accident shortly after it had occurred, at about 0800. He himself was on the way to a shoot. He described the conditions as very windy. As he passed what he called Migvie Kirk, drove up the hill and passed a farm on his left hand side, he came across Mr Burden's vehicle now stationary. Mr Burden was lying on the road, with his feet towards the middle of the road and his head on the left hand side of the road. Mr McVean found Mr Burden to be unconscious. He called for emergency services and was able to give them his location before losing the signal on his mobile phone. Other

witnesses spoke to their mobile phone signals being lost that morning in the extreme weather conditions. Very admirably Mr McVean attended to Mr Burden as best he could by giving him first aid and talking to him until others arrived.

[26] Ms Schooling herself came upon the accident when she was on her way to work. This must have been a terrible shock for her. Mr Allardyce also saw the aftermath from a nearby field and made himself available to help the paramedics transfer Mr Burden from the road to the ambulance. The paramedic and trauma consultant who attended the scene identified that Mr Burden had sustained a life-threatening head injury. He was put into an induced coma at the scene and transferred to Aberdeen Royal Infirmary Accident and Emergency Department. Unfortunately despite the treatment he received in the intensive care unit there Mr Burden died of his injuries on 6 February 2022 at 0313 hours.

Cause of accident resulting in Mr Burden's death / contributory factors

[27] The post-mortem found the cause of Mr Burden's death to be 1a Head Injury due to 1b Road traffic collision (driver). There were no eye-witnesses to the accident. In these circumstances Dr Leighanne Deboys was asked by the Crown if she could form any view as to the possible mechanism causing Mr Burden's fatal injuries. She based her view on the injuries Mr Burden had sustained and her conclusion, from information provided to her, that this was not a particularly high speed collision; albeit she caveated this latter point by acknowledging that she is not a road traffic collision investigator. I will point out at this stage that the road traffic collision investigation was not

particularly thorough in this case. This is attributed to the extreme weather conditions on the day making it difficult to carry out an investigation. There is no suggestion that Mr Burden contributed to the accident by being under the influence of any substances or anything of that nature as full toxicology reports are available.

[28] The vehicle had come to rest on the left-hand verge as one approaches up the hill there. The front offside wheel was up on the grass verge with the lower front attachment bar sheared. There was grass trapped between the tyre and tyre wall on the inner front rim, the mounting of the wheel was rotated rearwards and clockwise. The nearside door mirror was missing, the casing was broken at the mounting with a fragment of the casing remaining intact; the vehicle had cosmetic light bodywork damage consistent with off road use; the driver's door telescopic gas strut was detached at the roof mount with the remains attached to the door frame.

[29] Mr Henry Mackie vehicle examiner carried out a partial examination of the vehicle on 16 May 2022 at a garage in Kintore with Constable Andrew Ramsay. His instruction was to look particularly at the nearside door latch. He noted that the nearside front door could not be latched securely in the closed position and was likely to open inadvertently. The latch was at the front of the door with the hinges to the rear. Both top and bottom hinges were deformed and the door was mis-aligned to the body. He confirmed that if the door inadvertently opened while the vehicle was being driven in a forward direction it would be forced open against the stay. The stay being a metal post which connected the door to the topside of the vehicle. If the stay was to detach due to the force imposed upon it the door would be forced back against its hinges. At

the time of his examination the stay was detached allowing the door to open fully to the rear against the hinges. This appears consistent with the view of the vehicle shown in photographs 0017.jpg and 00.19.jpg (Crown production 1).

[30] There is no dispute between the parties that the door latch was not working properly nor that the driver's door was fully open when the vehicle was found after the accident. Photograph 00.60jpg (Crown Production 3) shows the stay sheared from the roof but remaining attached to the driver's door. Ms Schooling had been in the Can-Am vehicle on occasion with Mr Burden. Her evidence was that due to the faulty latch the door opened in windy conditions or when the vehicle went over rough ground. It was her belief that Mr Burden had reported the latch, but as stated above it has been agreed that other employees were unaware of any problems. I have no doubt that Ms Schooling genuinely believed the fault to have been reported.

[31] Photographs 00.32. jpg to 00.38. jpg (Crown production 2) show the front seats in the vehicle. There are three bench like seats at both front and rear. In the vehicle examination report (Crown Production 10) the following is noted regarding the seat belts : *"6 x 3 point inertia reel. All AIO.* ***Driver's belt and front centre seat belt tucked behind respective seat backs.*** *All others stowed AIO."* (All In Order).

[32] Dr Deboys carries out the following analysis: there are broadly three possibilities regarding the mechanism of injury-

- Mr Burden got out of the vehicle and collapsed striking his head
- Mr Burden struck his head on the interior of the vehicle before getting out and collapsing

- Mr Burden was ejected or fell from the vehicle and struck his head on the ground

[33] Dr Deboys is of the opinion that it is more likely that Mr Burden was thrown from the vehicle which then came to a stop in its final resting place against the wall. She comes to this view relying on the following:

(i) Mr Burden's head injuries were similar to those she has previously seen in accelerated falls where someone is pushed or punched resulting in a fall backwards with speed;

(ii) significant force would be required to inflict the injuries sustained by Mr Burden, and would be sustained had Mr Burden had a simple fall from his own height on exiting the vehicle;

(iii) it is more difficult to envisage Mr Burden causing these injuries by striking the back of his head in the vehicle unless the vehicle had been overturned and rolling. There is no evidence of that having occurred;

(iv) the head injuries are in keeping with a blow of a significant force and this is consistent with Mr Burden having been ejected from the vehicle, fallen onto his back and struck his head forcibly on the ground. The collision itself did not seem to be of a type that by itself would have caused Mr Burden's injuries; it is more likely that he was thrown from the vehicle.

Dr Deboys does not mention this specifically, but of course Mr Burden would not have been thrown from the vehicle had he been wearing his seatbelt. It is not in dispute that Mr Burden was not wearing a seatbelt that day.

[34] In my view it is reasonable to rely on the opinion of Dr Deboys as to the most likely cause of Mr Burden's injuries : that he was thrown from the vehicle and hit his head on the road surface. He sustained life-threatening injuries as a result which alas he did not survive. Clearly the door to the vehicle must have been open to allow Mr Burden to be thrown from it.

Crown's submissions

[35] It is the Crown's submission that in the absence of witness testimony as to exactly what happened the most likely cause of the accident itself is the faulty latch on the door causing it to blow open in the windy weather conditions which caused Mr Burden to attempt to close it. He was then thrown from the vehicle as per Dr Deboys analysis. Ms Adair acknowledges that a reasonable precaution which might realistically have prevented Mr Burden's death was the wearing by him of a seatbelt. That is supported by the evidence that Mr Burden's injuries were caused by his being thrown from the vehicle. However Ms Adair is adamant in her submission that the primary precaution which might realistically have prevented the accident at all was the cancelling of the shoot at an early stage when severe weather conditions were apparent and Mr Turner to have advised Ryan Paterson of that during the telephone call at around 0700. Had that precaution been taken Mr Burden would not have been on the road at the material time and the wearing of the seatbelt would no longer be relevant.

[36] The Crown submit that the failure to have an adequate process involving a proper and timeous appraisal of the forecast weather ahead of planned shoots left

decisions to be made on an *ad hoc* basis with no clear prioritisation. This amounts to a defect in a system of working. This defect contributed to the failure to cancel the shoot timeously and therefore to Mr Burden being on the road at the material time and thus to the accident and his death as a result thereof. Ms Adair identifies the system of working as the organisation of and preparation for a shoot.

[37] Ms Adair submits that had the shoot been cancelled whilst it would have been possible that Mr Burden would have been on the road in his vehicle to carry-out other duties it would have been reasonable for Mr Burden to have remained at his home in order to repair the dog kennels; in such circumstances he would not have been on the road at the time. On a balance of probabilities this would have been his chosen course of action. There is therefore at least a lively possibility that his death would have been prevented.

Submissions for Tillypronie Estate

[38] Mr Smith acting for Tillypronie Estate submits that the Crown's submission insofar are relating to the likely cause of the accident

> "…is misguided; that it proceeds on a wholly speculative basis, in a complete absence of evidence (both direct and even from which a reasonable inference might be drawn); and an erroneous application of the law and principles of causation."

Mr Smith claims that the faulty latch is nothing more than a pre-existing condition; there is no evidence on which to base a finding that this was the operative cause of the accident. The only evidence available to the court from which any conclusion might be

drawn about the circumstances of the accident are those found post-accident. He says the Crown has strayed into the realm of speculation by asserting that the faulty latch caused the door to blow open which in turn caused Mr Burden to attempt to close it. Mr Smith goes on to state that it would be equally illegitimate to speculate about other possible causes of the accident, such as excessive speed or other distractions such as Mr Burden using his mobile phone. Indeed even if it were legitimate for the court to speculate that the door was blown open due to the faulty latch the obvious precaution in such circumstances would have been for Mr Burden to stop the vehicle and close the door. In addition if the faulty latch is to be implicated then it could be said that a reasonable precaution would have been for Mr Burden to have reported the fault.

[39] Mr Smith rejects the Crown's position that a reasonable precaution would have been the cancelling of the shoot. Again a causal connection requires to be established, which is not supported by the evidence; also that the obvious and direct reasonable precaution whereby the death of Mr Burden might have been avoided was his wearing a seat belt. Mr Smith argues that the only appropriate course is for this court to determine that the cause of the accident was unknown. The direct cause of Mr Burden's death was the failure to wear the seat belt; for the Crown to submit this was secondary to a purported precaution of cancelling the shoot is incorrect. Mr Smith claims that this section of the 2016 Act is primarily concerned with whether the death might have been avoided. I am not sure I fully understand this latter proposition. The section appears equally concerned with preventing accidents which result in deaths. I am satisfied that the accident itself was not a result of Mr Burden not wearing a seat belt albeit, very sadly

this led to his suffering fatal injuries as a result. Mr Smith goes on to state that even had the shoot been cancelled at 07.00 as the Crown say it would have been reasonable to do, Mr Burden may still have been out on the road. Once again the court is being asked to speculate.

[40] Dealing with the Crown's submission that a defect in a system of working contributed to the accident Mr Smith says there was no defect. It is his view that the Code of Good Shooting Practice – and common sense - is apt to deal with this point, it is unnecessary to have some sort of formalised procedure for appraisal or assessment of weather conditions in advance of a shoot. It cannot be said that the absence of such a process was a defect in a system of work at the estate. He says the evidence demonstrates the outworking of part of such a process on the day: a final decision was to be made at a given time, at the bothy at Haughton, formalising that process might well be unworkable, given the variables involved and is unnecessary. This process is in essence and of necessity dynamic in nature.

[41] Mr Smith considers that the Crown's submission regarding cancellation of the shoot is made under reference to unfair and unwarranted criticism of Mr Turner; he suggests that the unpleasant inference that the Court is being invited to draw is that Mr Turner was somehow unconcerned with the safety of the estate staff. This is not supported but is actually at odds with Mr Turner's unchallenged evidence that the safety of everyone was his priority.

[42] I consider I should deal with this latter point first. I wish to reiterate that it is not this court's function to determine fault on the part of any party or indeed to consider

matters of foreseeability. What is relevant is whether there were precautions which were reasonable to take and which had they been taken might realistically have avoided the accident or death of Mr Burden and/or whether there was any defect in any system of working. The terminology of "failure" is not useful in an inquiry of this nature. That being said it appears that Ms Adair has based her comments about Mr Turner directly from the evidence he gave to this court and that being the case it is questionable whether it is accurate to characterise them as unwarranted and unfair. That being said my determination is based solely on an assessment of the facts and not on what may or may not have been the priority or preoccupation of any witness.

Analysis and conclusions

[43] I do not accept that the only evidence available to the court is that found post-accident. There is clear and persuasive circumstantial evidence available to the court from a time prior to the accident. Firstly there is the evidence of the DVLA vehicle examiner as to the door being likely to open inadvertently if the vehicle was driven in a forward direction; with it being forced back against its hinges if the stay was detached (which it was). There is also Ms Schooling's unchallenged evidence that she had experience of the door opening in windy conditions and when the vehicle was being driven over rough ground. On the day of the accident itself Mr Burden's colleagues speak to his stopping on that very journey ahead of them on the road, getting out of the vehicle and trying to close the door, even slamming it. We heard evidence that the wind was so extreme that the kennels were blown down, Ms Schooling's vehicle moved

notwithstanding being secured by the handbrake and Mr Allardyce could not even stand up properly. It is clear from photographs, including 0001.jpg, 0005jpg, 0017jpg, 0019jpg (Crown Production 1) that the road was exposed at the point at which Mr Burden's vehicle came to rest and for some distance prior to that, there being a gap in any tree cover. In my view it is not speculation but instead a reasonable inference to draw from this evidence that on that road in these extreme wind conditions the door blew open again. As there were no eye witnesses to this tragic accident we cannot know for certain the exact dynamic that led to Mr Burden being thrown from the vehicle; but in the court's view it is more likely than not that the door flew open suddenly and violently in gusts which according to Police Scotland's alert could have been as strong as 75mph. Mr Burden had been witnessed taking the precaution of exiting his vehicle earlier on this journey to try to shut the door when it had opened previously. On this basis I have no reason to believe that shortly afterwards he was engaged in an attempt to close it against the high winds while continuing to drive. It is in my view far more likely than not that a sudden and violent gust of wind causing the door to fly open forcibly against its hinges led to the fatal loss of control of the vehicle and Mr Burden being thrown out. He may have made an instinctive grab as the door blew open but I am not at all persuaded that he chose to continue driving while struggling against the elements. His previous sensible behaviour in my view rules that out.

[44] I can make no findings as to what the situation would have been on 29 May had Mr Burden reported the faulty latch. Evidence from the various witnesses confirmed there was an *ad hoc* system in place whereby the employee allocated the vehicle would

report faults and arrangements would be made with the local mechanic Mr Darren Davidson to repair them. There is no suggestion that when faults were reported there was any delay in having them attended to. However it is not clear from the evidence available to the court when it would have been reasonable for Mr Burden to haver reported this faulty latch; nor can I possibly tell what would have happened and within what time scale had he done so. By this I refer to matters such as – what priority would this repair have been given, when would it have been fixed? Would the vehicle have been taken out of use until such time as the latch was repaired or would Mr Burden have been expected to continue to use it pending the repair? For all I know if the latter he may still have been driving it with a faulty latch on 29 May even had he reported it. On this basis I find that while his reporting it would have been a precaution which it was reasonable to make, there is insufficient evidence to support a finding that his doing so might realistically, in the sense of being a real or lively possibility, have avoided the accident happening.

[45] Regarding the issue of the seatbelt. In the statement provided by Mr Paterson he states that it was common practice to wear seatbelts. Having had sight of the photographs showing the position of the seat belts on Mr Burden's vehicle following the accident, together with the content of the vehicle examination report I have some doubt about this certainly insofar as Mr Burden's vehicle was concerned. The evidence of the investigators was that the seatbelts, not only for the driver's seat, but also for the front middle seat were tucked behind the seat backs: ***Driver's belt and front centre seat belt tucked behind respective seat backs.*** One can see especially from photographs 00.33,

00.36 and 00.38 (Crown Production 2) exactly what that entailed. It was not a case of Mr Burden simply not pulling his seatbelt across and securing it while he was driving; the position of the seatbelts indicates that they had been tucked deliberately into a fixed position behind the seats, completely out of the way. Not only the drivers' seatbelt but also that of the middle passenger together with the connecting restraint. The impression that is given from the photographs is that this is a permanent position for these belts.

[46] The court heard evidence that on Friday 28 May Mr Turner had been driving Mr Burden's vehicle for guests. He stated in evidence that he did not notice any problems with the door latch. He said nothing about the positioning of the seatbelts, in fairness he was not asked. He does say that Mr Burden came to collect the vehicle from him on the evening of Friday 28 May. It was not needed for the shoot the following day given there were only to be two guests. It is, in the court's view, more likely than not that the belts were in this position when Mr Turner drove the vehicle. To conclude otherwise would mean that Mr Burden had, after uplifting the vehicle from Mr Turner on the evening of 28 May gone to the not inconsiderable trouble of tucking the driver's seat belt and also that of the middle passenger's into these positions prior to driving to the shoot on 29th. In fact more than that – it would mean that Mr Burden had in fact untucked the belts from these fixed positions before giving the vehicle to Mr Turner for the shoot on 28th and then **re-tucked** them into position after uplifting it from Mr Turner. Otherwise one would have to conclude that for some reason Mr Burden took it upon himself to put the belts into these fixed positions on the evening of 28 May or in the extreme windy conditions of 29 May notwithstanding they had not been in that position

before. This appears to the court to be highly unlikely. The most likely scenario in my view is that the belts had been in those positions for some time, including when being driven by Mr Turner on 28 May 2022. If that is indeed the case then a precaution which it would have been reasonable to take and which had it been taken might realistically have avoided Mr Burden's death would have been for his employer, Mr Turner to instruct Mr Burden to untuck the seat belts on these seats and ensure they were used properly by him in the course of his employment. To not do so demonstrates a defect in a system of safe operation of vehicles on the estate, which defect contributed to the death of Mr Burden.

[47] The court was advised that Tillypronie Estate had engaged a firm of Consultants to carryout an audit following the death of Mr Burden. The court was not provided with the instructions that had been provided to these consultants nor with a copy of the Report they produced. The only information that was provided to the court was that the Report did not provide any guidance, or indeed deal in any way, with the possible impact of adverse weather conditions on the business of the estate. It is not clear whether the Report covered the issue of seatbelt use on this ATVs.

[48] The court was advised that the system for reporting and carrying out repairs on vehicles had been improved since the accident. Where previously it relied on the particular employee, or his supervisor, reporting any concerns to the witness Darren Davidson, who would then carryout the repair; following the accident Mr Turner was now kept appraised of the repairs that were carried out and a record was maintained. I consider there remains room for improvement in this system yet, particularly as I heard

evidence that the vehicles can be passed around between different individuals who may for example assume a fault has already been reported or alternatively not consider a repair is urgent or required. I have set out in the introductory paragraph the recommendation I make in this regard.

[49] I find that cancelling the shoot at 07.00am would have been a precaution which was reasonable to take on the morning of 29 May 2022 and had it been taken there is a lively possibility that the accident would have been avoided. Mr Turner himself in his own evidence says he had decided at the time of his phone call with Mr Paterson that the shoot would not go ahead. Whilst I do not accept that he had made that decision at that time, it is my view that there was an abundance of evidence to confirm that it was a reasonable precaution to have taken. All of the witnesses who spoke to the weather that morning - Mr Paterson, Mr Allardyce, Mr Fraser, Ms Schooling agreed it was unsafe to proceed to have a shoot. Ms Schooling spoke to Mr Burden himself having concerns. Whilst these focused mainly on the safety of the shoot itself Mr Paterson was concerned about workers moving about in high vehicles. The Amber weather warning urged against unnecessary travel due to very high winds. Had Mr Burden not been on the road driving that vehicle in those high winds the accident would not have happened. I do not make that statement in the limited sense of "but for" but based on the evidence I have set out in para [42] above.

[50] I was surprised that the Health and Safety Audit instructed by Tillypronie Estate following this tragic accident had not provided any guidance on how to deal with extreme weather forecasts when managing a shooting business. Even had the report

provided an opinion such as that presented by Mr Smith it would have evidenced that consideration had been given to a matter that must arise on a fairly regular basis in this area. Not to consider that issue at all, given the circumstances of Mr Burden's accident, in my view leaves an important health and safety factor out of account.

[51] I do not consider the Code of Good Shooting Practice to be apt to deal with the situation. This inquiry has not taken place due to Mr Burden losing his life on a shooting outing; it is a mandatory inquiry as a result of his losing his life in the course of his employment. The Code deals only minimally with issues of health and safety of employees, in fact only by this reference : Shoots must make sure that they comply with the Health & Safety at Work Act 1974… (reference to NI regulations) For more details and assistance visit www.hse.gov.uk; which reference appears as the tenth bullet point in Section 9 of the Code under the heading Legal Requirements.

[52] The Code's focus is on good husbandry, good shooting practice etc – the Chapters are as follows:

- Shooting Behaviour
- Responsible Shooting
- Consideration for others
- Game is food
- Shoot management
- Rearing Game
- Releasing Game
- Predator and Pest Control

- Legal Requirements.

The only mention of adverse weather conditions is on page 7 of the Code: Shooting should be cancelled or stopped if adverse weather conditions mean that birds cannot be presented in a safe and appropriate sporting manner; or shot and retrieved safely.

[53] The Code is no answer to the issues before this inquiry. Nor can we rely on parties invoking common sense. The court heard evidence that a shoot involves participants using shotguns outside in wooded areas with the beaters walking into the woods. This Inquiry is concerned with the death of an employee on the estate. For Mr Turner not to have been aware that there was a weather alert for that day of shooting in my view indicates there was no system in place at all to monitor whether it was safe for his staff to drive ATV's particularly on roads and rendezvous for a shoot to commence. His evidence that he simply obtained weather information from the TV the night before does not disclose any effective system. Mr Smith argued that it was a dynamic situation and it may not be practicable to formalise this matter. I appreciate that weather is a matter that cannot be governed by a strict rigid system and different employers across a variety of employments by necessity will have differing considerations. Notwithstanding it is my finding that the lack of any system whatsoever was a contributor to this accident and the death of Mr Burden.

[54] Accordingly I have set out the recommendations I make in this regard in the determination at the outset of this decision.

[55] The evidence of the vehicle examiners was that while the ATV was exempt from an MOT it was not roadworthy due to the rear nearside tyre not being fit for highway

use; the horn not working and the door latch not being capable of securing the door in a secure position. I set out above the contribution the faulty door latch made to the accident and my recommendations in that regard.

[56] In conclusion I wish once again to apologise for the very long time it has taken for this determination to be issued. I extend to Ms Schooling and all of Mr Burden's family my sincerest condolences for their tragic and very great loss.