SHERIFFDOM OF NORTH STRATHCLYDE AT DUMBARTON

[2021] FAI 41

DBN-B27-21

DETERMINATION

BY

SHERIFF MAXWELL G HENDRY

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

into the death of

STEPHEN CONNOLLY

DUMBARTON 29 JUNE 2021

The Sheriff, having considered the information presented at an inquiry on 11 and 14 June 2021, in terms of sections 2(1) and 2(3) of the Inquiries into Fatal Accidents and Sudden Deaths etc (Scotland) Act 2016 ("the Act"), Finds and Determines:

1. That in respect of paragraph (a) of section 26(2) of the Act, Stephen Connolly, who was born on 5 August 1966, died on 12 December 2016 at 15.45 hours, within the Queen Elizabeth University Hospital, 1345, Govan Road, Glasgow

2. That in respect of paragraph (b) of section 26(2) of the Act , the accident occurred on 16 October 2015 at approximately 14.00 hours at Antonine Road, Bearsden.

3. That in respect of paragraph (c) of section 26(2) of the Act, the causes of death were aspiration pneumonia, significant traumatic brain injury and a fall from height.

4. That in respect of paragraph (d) of section 26(2) of the Act, the cause of the accident was Stephen Connolly falling from a scaffolding platform or walkway, at a height of 4.857 metres, to the ground.

5. I make the following findings under paragraph (e) of section 26(2) of the Act: the construction of a full perimeter scaffolding, with adequately wide platforms and walkways, together with edge protection in the form of toe boards at their edges, mid-height and top guard rails, together with a ladder giving safe access thereto, were precautions which could reasonably have been taken. If taken, they might realistically have resulted in the death of Stephen Connolly, or the accident resulting in his death, being avoided.

6. I make the following findings under paragraph (f) of section 26(2) of the Act: the construction of the scaffolding, platforms and too narrow a walkway, all without toe boards and adequate guard rails, together with too short a ladder with no safe step-off point were defects in the system of working which contributed to the accident and thereby to Stephen Connolly's death.

7. I make the following findings under paragraph (g) of section 26(2) of the Act (any other facts which are relevant to the circumstances of the death): none.

Recommendations

8. No recommendations are made under section 26(1)(b) and (4) of the Act.

NOTE

Introduction

[1] This is a mandatory public inquiry into the death of Stephen Connolly, in terms of the Act, given that the death happened at a place of self-employed work in Scotland. Stephen Connolly was assisting Paul McMillan, also then self-employed, with the re-roofing of a house in Antonine Road, Bearsden. On 16 October 2015, Stephen Connolly fell from a platform or walkway at roof height there, and sustained severe injuries to his brain. He remained in hospital until he died some fourteen months thereafter. The brain injury ultimately led to the development of aspiration pneumonia. The purpose of this inquiry is to establish the circumstance of the death and to consider what steps, if any, might be taken to prevent other deaths in similar circumstances.

The participants and their representatives at the Inquiry

[2] The Procurator Fiscal issued a notice of the inquiry in terms of section 15(1) of the Act on 29 January 2021. This was over four years after Stephen Connolly's death. That is a significant delay for Stephen Connolly's family, who chose not to participate in the inquiry, but did attend on the first day. The Crown has recognised that the delay was excessive, and apologised. I was advised that the Crown has changed the way its

death investigation work is managed, to ensure that such a delay does not happen in the future. There were only two participants to the inquiry: Miss Dow, Procurator Fiscal Depute, appeared for the Crown, and Mr Nimmo appeared on behalf of Paul McMillan.

[3] Agents were able to agree an extensive joint minute of admissions, and, in addition, the Crown prepared a bundle of numbered productions, as a result of which there was no need for Mr Nimmo to do likewise. I am grateful to agents for their assistance.

The evidence

[4] A joint minute of admissions was formally entered into the evidence on 11 June 2021. The only other evidence led was from two witnesses called by the Crown: Paul McMillan and Graeme McMinn (a Principal Inspector with the Health & Safety Executive ("H&SE"). After hearing submissions, I closed the inquiry, and reserved the making of my determination.

The legal framework

[5] The inquiry was held in terms of section 1 of the 2016 Act. The relevant procedural rules are found in the Act of Sederunt (Fatal Accidents Inquiries Rules 2017). The purpose of the inquiry is defined by section 13 of the Act, and is to:

(a) establish the circumstance of the death, and:

(b) consider what steps, if any, might be taken to prevent other deaths in similar circumstances.

[6] Section 26 of the Act requires the Sheriff to make a determination in relation to the circumstances of the death (section 26(1)(a)) and recommendations on certain matters (section 26(1)(b)). Section 26(2) sets out the factors that the Sheriff must consider as to what constitutes the circumstances of the death, including the causes of any accident and the precautions that might have been taken, defects in the system of working and any other factors relevant to the death. Section 26(4) sets out the issues for consideration as to whether any recommendations could be made which might realistically prevent other deaths in the future.

Summary

[7] The Joint Minute sets out the circumstances in which the accident occurred, and the consequences thereof. The property in Antonine Road, Bearsden is a two storey detached house, with a single storey garage attached to its north side and a single storey extension attached to the south side. Its gable walls form the front and rear of the property. Its owner had contracted with Paul McMillan to have the house re-roofed. Paul McMillan had asked two men to assist him with the work: Stephen Connolly and Charles McHugh (now deceased). Paul McMillan and Stephen Connolly were long-standing friends. They were both experienced roofers and were in the habit of working with each other when more than one man was required. Whichever of them took on the work was in charge and took responsibility for the work being done safely and in accordance with any contract.

[8] Paul McMillan decided that the re-roofing work at the property in Antonine Road could be carried out by the construction of four scaffolding towers, with platforms, one tower at each corner of the house. There was a single fixed ladder at the rear of the house, giving access to the southmost tower platform. The ladder was tied to scaffolding at one side only, near the top of the ladder, which terminated just above the platform, underneath a single, mid-height guard rail. The height of the ladder meant that it did not provide a hand hold for someone stepping off it. The platforms consisted of five boards laid edge to edge. The only walkway connecting the platforms was between the towers at the rear, and it consisted of only two boards, which were not secured in place. None of the platforms nor the walkway had toe guards at their edges. The fitting of guard rails was inconsistent: in some areas there were both mid-height and top guard rails; in others there was only a mid-height rail; and at the platform accessed by the ladder, there were no top rails, and only three mid-height rails. One edge (that facing the other rear platform) had no guard rail. The two-board walkway likewise had no guard rail. A person climbing the ladder would have had to climb over the mid-height guard rail, with no secure hand hold. He would then be standing on a platform with no guard rail to his right hand side, and only mid-height guard rails on the other sides.

[9] After the accident, Paul McMillan ordered additional scaffolding and full perimeter scaffolding was built round the entire house, with wider walkways and complete double level guard rails. The ladder was installed in such a way that it

terminated approximately one metre above the platform, thereby providing a hand hold and with a safe stepping area beside it.

Issues for the Inquiry and parties' submissions

[10] Crown Productions numbers 9 and 10 were agreed to be true and accurate copies of statements given by Charles McHugh (now deceased) to the police on 16 October 2015 (the day of the accident) and to the H&SE on 26 November 2015. He described working on the roof with Paul McMillan. He described the ladder as being "solid". He told the police that, shortly before the accident, Stephen Connolly had gone down the ladder (although he subsequently said to H&SE that Stephen Connolly had gone down the scaffolding at the front). Stephen Connolly had been lifting wooden battens from ground level up to the roof. Charles McHugh heard Stephen Connolly coming back up the ladder, and he remembered seeing the top of Stephen Connolly's head out of the corner of his eye. He told the police that he then heard a loud thud. He told H&SE that he heard a shout and a bang. He saw that Stephen Connolly had fallen to the ground "in the foetus position facing away from the house". He went to help him.

[11] The first witness to give evidence was Paul McMillan. He stated that he had been a roofer for some thirty eight years, though he had done little or no work since the fatal accident in 2015. He had not undergone any formal training in either roofing work or the construction of scaffolding, and had simply learned by watching colleagues do those types of work. He acknowledged that he knew little of the relevant legislation, regulations or guidance. He remembered that he and Stephen Connolly had looked at

the property in Antonine Road some time before the job started on 13 October 2015, but he accepted that it was his job, and Stephen Connolly was there to help him. He believed that Stephen Connolly had had some health issues with his back, which he thought had required an operation some six months prior to October 2015, but he seemed able to work. The third man, Charles McHugh, had little roofing or scaffolding experience, unlike both himself and Stephen Connolly.

[12] The witness said that the garage at the property had an asbestos roof, which made it impossible to construct scaffolding with a walkway above it. He considered that scaffolding was not necessary above the extension, as its roof could be used to access the roof of the remainder of the house. He and the others constructed most of the scaffolding on the first day, building scaffolding towers at each corner of the house, each with a platform consisting of five boards. He said that a tree at the front of the house prevented the laying of a walkway between the two towers there. There was no fixed ladder at the front, either. Mr McMillan described how he could climb up the scaffolding without using a ladder. There was a ladder at the rear, and there was a walkway between the towers at the rear.

[13] The witness was shown a number of photographs showing the house, the scaffolding, the ladder and the two-board walkway, all of which he recognised. He pointed out that the ladder was tied to the scaffolding near the top, and was further secured by being wedged against a block of wood which was screwed into decking.

[14] On the second day, 14 October, the witness remembered that he went to a nearby golf club, to use the toilet. In cross-examination (but not in examination in chief), he

stated that he had noticed before he left the site, that the walkway only consisted of two boards with no handrails and that he had told the other two men to fit five boards and two hand rails. When he returned, he saw that the other two men had started to strip the old tiles from the roof. He assumed they had completed any preparatory scaffolding work, including the walkway, left over from the previous day. He did not go to the rear of the property. Instead, he climbed up the scaffolding at the front, and joined them at work on the roof, towards the rear.

[15] On the following day, tiles were being stripped from the roof at the front of the house. In examination in chief, Paul McMillan said that it was at some point that day that he noticed that the walkway between the two rear towers consisted of only two boards (not five as he would have expected) and that there were missing guard rails. He spoke about that, firstly to Charles McHugh, who said that he had brought additional boards to the back of the house, but that Stephen Connolly had assured him that what was there already was sufficient. The witness then spoke to Stephen Connolly who said "Nobody is going to use it." The witness stated that, with the benefit of hindsight, he wished that he had himself fitted three more boards and two guard rails.

[16] On 16 October, the work being undertaken was the strapping of the roof with lengths of wood called tile battens. The area being worked upon was at the rear of the roof, above the single storey extension. Paul McMillan said that he was primarily responsible for strapping the battens to the roof, assisted by Charles McHugh, who was to his right and therefore nearer to the rear of the house. He had seen Stephen Connolly two or three minutes before the accident. He believed that Stephen Connolly was

passing up battens from ground level to Charles McHugh. The witness was, in the main, looking down at the roof, rather than sideways. He heard a bang, what he described as a "metal noise" and a thud, and he realised that there had been an accident at the rear of the house. Charles McHugh went to the ladder, and the witness climbed down the scaffolding at the front. When he reached the rear of the house, he saw that Stephen Connolly had fallen, and was lying on the ground between the two towers. The witness was unable to say from which point Stephen Connolly had fallen, or what had caused him to fall. The witness called an ambulance. He recollected little else, due to shock, but he did remember that H&SE staff attended and inspected the whole area. A Prohibition Notice was served. He completed the work some days later, once full perimeter scaffolding had been constructed.

[17] The only other witness to give evidence was Graeme McMinn, a Principal Inspector with the H&SE. He has considerable experience of inspecting similar accidents, as falls from height form a substantial proportion of cases which require the H&SE's attention. He and a colleague attended the locus on the day of the accident, and Mr McMinn spoke to all that he saw there, using the photographs in Crown productions numbers 1 and 2, which he and his colleague took that day. His conclusions in relation to the scaffolding, the platforms, the walkway and the ladder can be summarised as follows :

- The site was in a very tidy condition and best practice had been followed in some respects, such as the use of raking tubes to provide the towers with stability.

- There were several areas where there was an unguarded risk of falling from height.
- Double guard rails ought to have been fitted throughout, with the top rail at a height of 950 millimetres, and no gap wider than 470 millimetres.
- Toe boards ought to have been fitted at each edge
- The walkway ought to have been constructed to the same width (five boards) as the platforms, with guard rails and toe boards in place.
- The boards forming the walkway should have been secured.
- The ladder, while well secured at the bottom, ought to have been secured at both sides near the top. Good practice would have required the top of the ladder being secured at both sides to prevent the risk of the ladder pivoting, but the use of a tightly fitting wooden block at the foot of the ladder reduced the risk of that happening. The witness had tested the ladder, had concluded that it was safe to use and had used it. It was unlikely that the ladder would have twisted and projected Stephen Connolly sideways to the position in which he landed on the ground.
- The top of the ladder should have extended at least one metre above the platform with a safe access to the platform when stepping off the ladder. The single guard rail located above the top of the ladder created a hazard, as it would require to be stepped over, with no hand hold provided.
- The most likely scenario to explain how the accident occurred is that Stephen Connolly climbed off the ladder onto the platform and fell from the unguarded platform edge or the two insecure, unguarded boards forming the walkway.

Conclusions

[18] I accepted all of the evidence given by Mr McMinn as credible and reliable. Clearly, there was no eye witness to Stephen Connolly's fall, and nobody was able to speak to the cause of the fall or the point from which he fell. There was, however, consistent, indeed unchallenged, evidence that the ladder was "solid" and unlikely to have pivoted, throwing Stephen Connolly in such a way that he landed between the two towers; that there was no hand hold at the top of the ladder; that there were inadequate guard rails and no toe boards at the southmost rear platform; that there were no guard rails or toe boards at the walkway; that the paramedics required the removal of the two boards forming that walkway in order that they could attend to Stephen Connolly's injuries; and that those injuries were to his head and body, with no injuries to his legs or feet. Taken together, those adminicles of evidence point toward the most probable point of the fall as being the unguarded edge of the southmost rear platform or the immediately adjacent, insecure, unguarded walkway. I am not persuaded to come to a different conclusion by reason of the evidence from Paul McMillan about Stephen Connolly's health issues : there was no evidence of his being unfit to work or restricted in his activities on any of the three days preceding the accident.

[19] Following my consideration of the submissions and all the evidence before me, I consider the precautions set out at finding 5 above, could reasonably have been taken, and, had they been taken, I consider that in terms of section 26(2)(e) might realistically have resulted in Stephen Connolly's death being avoided. I also find that the defects of

working identified in finding 6 contributed to Stephen Connolly's death. I have found no other facts relevant to the circumstances of his death in finding 7.

[20] I wish to express my sincere condolences to Stephen Connolly's family and friends