SHERIFFDOM OF GLASGOW AND STRATHKELVIN AT GLASGOW

[2022] FAI 26

DETERMINATION

BY

SUMMARY SHERIFF JONATHAN GUY

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

into the death of

MR KENNETH McGREADY

Glasgow, 17 June 2022

Determination

The Sheriff, having considered the information presented at the inquiry, determines, in terms of section 26 of the Inquiries into Fatal Accidents and Sudden Deaths etc. (Scotland) Act 2016 ("the Act") the following:

1. In terms of section 26(2)(a) of the Act, Mr Kenneth McGready ("the deceased"), born 12 October 1950, died at 10 Lansdowne Crescent, Glasgow ("the property") at approximately 11.41am on 22 September 2020.

2. In terms of section 26(2)(b) of the Act, the accident resulting in the death occurred at the property shortly before 11.41am on 22 September 2020.

3. In terms of section 26(2)(c) of the Act, the cause of death was chest and pelvic injuries resulting from a fall from height.

4. In terms of section 26(2)(d) of the Act, the accident was caused by the deceased standing on the outside window ledge at the property, whilst holding on to a handle on the inside of a window, and that handle breaking, which caused him to fall onto the railings at street level and then to the ground at the basement area of the property.

5. In terms of section 26(2)(e) of the Act, it would have been a reasonable precaution for the deceased to have used a water fed pole to clean the windows at the property, and had he done so, this might realistically have resulted in the death being avoided.

6. In terms of section 26(2)(f) of the Act, there were no defects in the deceased's system of working that contributed to the death.

7. In terms of section 26(2)(g) of the Act, there are no other facts which are relevant to the circumstances of the death.

I have no recommendations to make under sections 26(1)(b) and (4) of the Act.

NOTE

Introduction

[1] This inquiry into the death of the deceased was held on 30 March and 24 May 2022, following preliminary hearings on 30 November 2021, 26 January 2022 and

1 March 2022. Mr Faure, procurator fiscal depute, represented the Crown and there were no other participants in the inquiry.

[2] The evidence at the inquiry was presented in the form of an unchallenged notice to admit that the Crown had intimated to the Health and Safety Executive ("HSE"), and family of the deceased, in terms of rule 4.12 Act of Sederunt (Fatal Accident Inquiry Rules) 2017. This had been prepared on the basis of the witness statements that Police Scotland obtained and productions that the Crown lodged, which were as follows:

1. Death Certificate.
2. Post-mortem and Toxicology Reports.
3. Photographs.
4. Precognition – Mr Christopher McGready – dated 21 February 2022.
5. Email from Helen Welsh dated the 21 February 2022.
6. Copy blank application form for window cleaner's license GCC – employee.
7. Copy blank application form for window cleaner's license GCC – employer.
8. HSE guidance document - "Safety in window cleaning using Waterfed Pole Systems".
9. HSE guidance document – "Window cleaning with Water-Fed Poles: How to do it and look after your body".

[3] In addition to this, I heard the oral testimony of Mr Cameron Adam, Principal Health and Safety Inspector of the HSE, who gave evidence to the inquiry on 24 May 2022.

Purpose of the inquiry

[4] Fatal accident inquiries and the procedure to be followed in the conduct of such inquiries are governed by the provisions of the Act and the Act of Sederunt (Fatal Accident Inquiry Rules) 2017. In terms of section 1(3) of the Act the purpose of an inquiry is to establish the circumstances of the death and to consider what steps (if any) may be taken to prevent other deaths occurring in similar circumstances.

[5] Section 26(1) of the Act requires the sheriff to make a determination setting out (a) in relation to the death to which the inquiry relates, their findings as to the circumstances mentioned in section 26(2), and (b) such recommendations (if any) as to any matters mentioned in section 26(4) as they consider appropriate. The circumstances in section 26(2) are:

(a) when and where the death occurred;

(b) when and where any accident resulting in the death occurred;

(c) the cause or causes of the death;

(d) the cause or causes of any accident resulting in the death;

(e) any precautions which — (i) could reasonably have been taken, and (ii) had they been taken, might realistically have resulted in the death, or any accident resulting in the death, being avoided;

(f) any defects in any system of working which contributed to the death or any accident resulting in the death;

(g) any other facts which are relevant to the circumstances of the death.

[6] In terms of section 26(4) of the Act the sheriff is to make such recommendations (if any) as they consider appropriate as to:

(a) the taking of reasonable precautions;

(b) the making of improvements to any system of working;

(c) the introduction of a system of working;

(d) the taking of any other steps, which might realistically prevent other deaths in similar circumstances.

[7] In order to identify precautions which, had they been taken, might realistically have avoided the death, or to defects in the system of working which contributed to the death, it is necessary that the sheriff is satisfied on the balance of probabilities that those precautions or the defects in the system of working contributed to the death. Likewise, in order to make recommendations the sheriff has to be satisfied that there is a reasonable possibility that the recommendations may prevent deaths in similar circumstances.

[8] The procurator fiscal represents the public interest. An inquiry is an inquisitorial process and the manner in which evidence is presented is not restricted. Section 26(6) of the Act provides that the determination shall not be admissible in evidence or be founded on in any judicial proceedings, of any nature. This prohibition is intended to encourage a full and open exploration of the circumstances of a death and in terms of

section 1(4) it is not the purpose of the inquiry to establish civil or criminal liability. The scope of the inquiry extends beyond mere fact finding. It looks to the future and seeks to prevent deaths occurring in similar circumstances.

Factual circumstances

The accident and surrounding circumstances

[9] The deceased was a sole trader operating a window cleaning business which covered Glasgow's West End. His business was known as "Westender Windows" and he had been a window cleaner for some thirty years. The Licensing Department of Glasgow City Council have no record of the deceased ever having held a window cleaner's license.

[10] At approximately 11.35am on 22 September 2020 the deceased was cleaning windows at the property with his son, Mr Christopher McGready. The property is a flat on the third floor of a traditional tenement style building. At the time of the accident the deceased and his son were in separate rooms within the property cleaning windows. The deceased did not indicate to his son that he had carried out a risk assessment and neither of them had previously cleaned the windows at the property. They also did not have a water fed pole or fall arrest harness with them on the day of the accident.

[11] As the deceased was standing on the outside ledge of the living room window holding on to a metal handle, which was on the inside of the window, the handle broke, causing him to fall backwards off the window ledge, onto metal railings at ground level, prior to falling to the ground at the basement area of the property.

[12] Mr Christopher McGready heard the deceased scream as he fell off the window ledge and then saw him fall to the ground. As quickly as he could, he went to assist the deceased and found him on the ground at the basement area of the property. He rendered first aid and was then joined by others who provided assistance, one of whom was a doctor, who took over until paramedics arrived.

[13] When paramedics arrived, they provided first aid, including CPR, but tragically the deceased succumbed to his injuries from the fall and his life was pronounced extinct at 11.41am. A post-mortem was conducted on 5 October 2020 by a consultant pathologist who established the cause of death as chest and pelvic injuries caused by a fall from a height.

Mr Adam's evidence regarding the accident

[14] Mr Adam has an MA (Hons), a Postgraduate Diploma in Occupational Safety and Health and a Diploma in Environmental Waste Management. He is presently employed by the HSE as a Principal Inspector and has worked for the HSE for over 30 years. From 1991 to 2006, he worked as a regulatory inspector inspecting workplaces and investigating accidents, ill-health and complaints across a range of industries including the chemicals and on-shore major hazards industries. From 2009 to 2018 he was the HSE's Head of Entertainment, Leisure, Commercial and Consumer Services Operational Policy Sector, as part of which he was responsible for the HSE's national strategy and operational policy in relation to various commercial activities including window cleaning.

[15] In advance of giving evidence, Mr Adam considered Police Scotland's death report and accompanying witness statements. He had also prepared and signed a witness statement.

[16] Mr Adam stated during his evidence that self-employed window cleaners, such as the deceased, have an overarching duty under section 3(2) of the Health and Safety at Work etc. 1974 to ensure that anyone affected by their work activities are not, so far as is reasonably practicable, exposed to risks to their health or safety. He said that self-employed workers have a duty under regulation 3(2) of the Management of Health and Safety at Work Regulations 1999 to assess the risks from working at height and under regulation 4(1) of the Work at Height Regulations 2005 to ensure that the work is properly planned, appropriately supervised and carried out in a manner which is, so far as is reasonably practicable, safe.

[17] Mr Adam referred to and endorsed the guidance on the HSE's website, "Working at height whilst window cleaning", and in particular, where it states:

> "When planning and organising window cleaning you must avoid work at height where it is reasonably practicable to do so, for example by using telescopic water fed poles or cleaning windows from the inside. Best practice guidance 'Window Cleaning with Water Fed Poles – How to do it and look after your body ' was produced jointly by HSE and industry is available from the Federation of Window Cleaners website. Where window cleaning at height cannot be avoided, you must first consider using an existing place of work that is already safe for example, cleaning from inside windows or from a balcony. If you cannot find an existing safe place, to work from, you must provide suitable access equipment. Where the risk of falling is not eliminated by either of these means, you must take additional measures to minimise the distance and consequences of any fall by using the right type of fall arrest equipment."

[18] Mr Adam referred to the Federation of Window Cleaners as an organisation that provides its members, for an annual cost of £105, with health and safety training opportunities as well as advice and support and referred to its guidance "Safety in window cleaning using Waterfed Pole Systems". This guidance includes the following information:

> "Traditionally window cleaners have relied upon portable ladders, platforms, scaffolds, bosun's chair and cradles for access for window cleaning. In recent years many window cleaners have adopted the use of waterfed pole systems that facilitate the cleaning of windows up to 60ft/20 metres high from ground level. Avoiding the need to work at height is an obvious immediate attraction;"

[19] Against this background, Mr Adam stated that the deceased should not have cleaned the windows in the manner that led to his death. This is because this was an inherently unsafe method of working as it involved unnecessarily working at height, which created a risk of him falling and injuring himself. Furthermore, this risk of the deceased falling was significant due to the potential for him to lose his grip of the handle, or for it to break, especially since he was unfamiliar with the property and the condition of the handle.

[20] In Mr Adam's opinion it was unnecessary for the deceased to have cleaned the windows in this manner as it was reasonably practicable for him to have used a water fed pole. He said that these poles extend up to 45ft in height (notwithstanding that the aforementioned guidance by the Federation of Window Cleaners suggests a height of 60ft), which is greater than the height of the windows that the deceased was cleaning. He was also not aware of any other reason that would have prevented the deceased from using such a pole.

[21] While Mr Adam discussed alternative methods of safely cleaning windows at height - such as using a fall arrest harness - he said that there was no need for the deceased to have considered these as the safest way to work was by using a water fed pole. In any event, he said that it would not have been possible to have used a fall arrest harness as there were no suitable tether points on the outside of the property to which it could have been attached.

[22] In conclusion therefore, Mr Adam was of the opinion that the accident demonstrated a failure by the deceased to plan and organise the work so as to avoid working at height and this placed him in breach of his duties under section 3(2) of the Health and Safety at Work etc. 1974, regulation 3(2) of the Management of Health and Safety at Work Regulations 1999 and regulation 4(1) of the Work at Height Regulations 2005.

Submissions

[23] The procurator fiscal depute invited me to make formal findings in terms of sections 26(2)(a), (b), (c) and (d) of the Act.

[24] In respect of section 26(2)(e) of the Act, the procurator fiscal depute invited me to accept the evidence of Mr Adam that the deceased's death could have realistically been avoided if he had used a water fed pole, which is consistent with the guidance provided to window cleaners by the HSE and Federation of Window Cleaners.

[25] The procurator fiscal depute did not invite me to make a finding in terms of section 26(2)(f) of the Act.

[26] With regard to section 26(4)(b) of the Act, the procurator fiscal depute invited me to make the following recommendation:

> "Before a window cleaner undertakes to clean windows at height the risk to his/her health or safety has to be assessed in advance and in order to complete the cleaning the window cleaner must use the most appropriate means whereby his/her health and safety are not unnecessarily compromised during the cleaning. This may involve the use of such equipment as a water fed telescopic pole, safety harness and protective clothing."

[27] In doing so, the procurator fiscal depute accepted there are no other parties participating in the inquiry and there would be no primary agency or other party under an obligation to respond to the recommendation. He also accepted that the facts and circumstances relating to the death are already subject to statutory provisions and promoted by at least one trade body. Therefore, he submitted the utilitarian value in making such a recommendation may not be immediately obvious, but nonetheless his position was that any determination which contained a recommendation would be in the public domain, and although not binding, could be persuasive in influencing tighter controls promoted by trade bodies, form the basis of a strand of legal argument in similar inquiries, change policy, highlight the risks and help to keep safety at work in the public gaze.

Discussion

[28] I consider that my findings in respect of sections 26(2)(a) to (d) of the Act are uncontroversial and flow from the accident described above, which caused the

deceased's death whilst working as a self-employed window cleaner. I do not therefore consider that these findings require further elaboration.

[29] With regard to my finding in respect of section 26(2)(e) of the Act, I accepted Mr Adam's evidence that the deceased could have cleaned the windows at the property using a water fed pole. As the use of such a pole would have avoided the deceased having to work at height, I accepted Mr Adam's evidence that this was the safest way to clean the windows; especially since it was not possible to use a fall arrest harness. This is consistent with the HSE's aforementioned guidance, which stresses the importance of planning and organising window cleaning to avoid having to work at height when it is reasonably practicable to do so. I was also satisfied that if this precaution had been taken, it might realistically have avoided the death as it would have eliminated the possibility of the deceased falling and injuring himself. On this basis, I consider that it is appropriate to make the aforementioned finding under this section.

[30] In relation to section 26(2)(f) of the Act, the fact that the deceased did not discuss risk assessment with Mr Christopher McGready, or have a water fed pole and harness with him on the day of the accident, may be because he did not utilise this equipment as part of his system of working. It may also be that as a consequence of not having this equipment, his process of assessing the risks from cleaning windows was defective. There was, however, no evidence regarding the deceased's system of working other than what occurred on the day of the accident. It is not as a consequence possible for me to determine, on the basis of the evidence, whether the failures on this day are reflective of his system of working, or alternatively, the product of an isolated error of judgement.

I do not therefore consider that it is appropriate for me to make a finding under this section and I was not invited to do so by the procurator fiscal depute.

[31] With regard section 26(4)(b) of the Act, I am not persuaded that the tragic circumstances of this death identify an improvement that should be made to a system of working which might realistically prevent other deaths in similar circumstances.

[32] It appears from the guidance issued by the HSE and Federation of Window Cleaners that they are broadly in agreement in relation to the system of working that window cleaners should employ, which (although more detailed) is consistent with the recommendation proposed by the Crown. This recommendation does not therefore identify a flaw in a current system of working, but instead invites me to endorse an accepted system of working. In my opinion, that is not the purpose of section 26(4)(b) of the Act and I have determined that it is not appropriate for me to make a recommendation under this section.

[33] I would nonetheless hope that the tragic circumstances of this death, which must have been deeply traumatic for the deceased's son as a result of witnessing the accident, are sufficient to highlight to window cleaners the importance of carrying out a suitable and sufficient risk assessment, and having the appropriate equipment with them when undertaking this work, so as to ensure that they avoid working at height when it is reasonably practicable to do so.

Final remarks

[34] I wish to conclude by extending my condolences to the deceased's family.