SHERIFFDOM OF GRAMPIAN, HIGHLAND AND ISLANDS AT STORNOWAY

[2023] FAI 25

STO-B36-21

DETERMINATION

BY

SHERIFF GORDON LAMONT

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

into the death of

JOHN NORMAN MURRAY

STORNOWAY, 8 June 2023

DETERMINATION

The Sheriff, having considered the information presented at the inquiry (the oral evidence, the productions, the terms of the joint minute and submissions presented at the Inquiry) under section 26 of the Inquiries into Fatal Accidents and Sudden Deaths etc. (Scotland) Act 2016 FINDS AND DETERMINES that:

1. In terms of subsection (2)(a) that John Norman Murray (hereinafter referred to as "Mr Murray"), born 19 October 1961 was pronounced dead at 12.28pm on 14 November 2019 at the Neurological Intensive Care Unit of the Queen Elizabeth University Hospital in Glasgow.

2. In terms of subsection 2(b) the accident which caused his death occurred at around 11 am on 13 November 2019. The locus of the accident was Bragar

Community Hub Buildings, Bragar. Mr Murray was a joiner and fell from height during the course of his employment.

3. In terms of subsection 2(c) the cause of death was head injury as a consequence of a fall from height.

4. In terms of subsection 2(d) the cause of the accident was the hooks of the roof ladder becoming detached from the ridge of the roof. The cause of the roof ladder becoming so detached is unknown.

5. No findings are made in terms of s 26(2) (e), (f) and (g).

6. In terms of section 26 (1) (b) I make the following recommendations:-

   a. The Health and Safety Executive (hereinafter called 'HSE') should consider investigating the photographic examples provided to the Inquiry by Mr Watkins showing mobile scaffolding towers were being used inappropriately.

   b. The HSE should consider whether current guidance regarding the inappropriate use of mobile scaffolding towers as i) a means of access; and ii) edge protection; can be improved or rehighlighted.

NOTE

Introduction

[1] An Inquiry was held under the Act at Stornoway Sheriff Court into the death of Mr John Norman Murray. The circumstances of the death had previously been

investigated by the procurator fiscal who presented evidence to the court in the public interest.

[2] The Notice for the Inquiry was dated 27 October 2021. A preliminary hearing was heard on 9 December 2021 which was continued to 6 January 2022. The Inquiry commenced on 3 February 2022. The court heard evidence on 3 and 4 February 2022, 4 August 2022, 7 November 2022 and 5 January 2023. Thereafter parties prepared written submissions which were expanded upon at a hearing on 2 March 2023.

[3] The Crown was represented by Miss Gillespie, procurator fiscal. The widow Mrs Murray was represented by Mr Bergin, advocate. The employers of Mr Murray, O'Mac Construction Limited, were represented by Mr Donaldson, solicitor.

[4] The court heard evidence from the following witnesses:

1. James Watson, bricklayer, O'Mac Construction Ltd
2. John Macleod, joiner, O'Mac Construction Ltd
3. Stewart Morrison, Site supervisor/joiner, O'Mac Construction Ltd
4. Stuart Taylor, joiner, O'Mac Construction Ltd
5. Callum McKenzie, labourer, O'Mac Construction Ltd
6. Stewart Macqueen, joiner, O'Mac Construction Ltd
7. James Caren, HSE Inspector
8. Mike Thompson Specialist HSE Inspector
9. Jon Watkins, consultant engineer (led on behalf of Mrs Murray)

[5] Two joint minutes were before the Inquiry agreeing evidence. The first joint minute agreed a number of non-controversial matters. The second joint minute agreed

that the statement of Finlay Morrison, Site Supervisor, O'Mac Construction Ltd, was to be held as the equivalent of his oral evidence.

The legal framework

[6] The Inquiry was held under section 1 of the 2016 Act. Mr Murray died during the course of his employment and therefore the inquiry was a mandatory inquiry held in terms of sections 2(1) and 2(3) of the 2016 Act. The inquiry was governed by the Act of Sederunt (Fatal Accident Inquiry Rules) 2017 ("the 2017 Rules"), and was an inquisitorial process. The Crown represented the public interest.

[7] The purpose of the inquiry was, in terms of section 1(3) of the 2016 Act, to establish the circumstances of the death of Mr Murray and to consider what steps (if any) might be taken to prevent other deaths in similar circumstances. It was not the purpose of the inquiry to establish civil or criminal liability (see section 1(4) of the 2016 Act). The manner in which evidence is presented to an inquiry is not restricted. Information may be presented to an inquiry in any manner and the court is entitled to reach conclusions based on that information (see Rule 4.1 of the 2017 Rules). The procedure adopted in this case was an appropriate way to present the available evidence in the circumstances.

[8] Section 26 of the 2016 Act sets out what must be determined by the inquiry, and for that reason it is convenient to set out the terms of section 26:

> "Section 26 - The sheriff's determination:
> (1) As soon as possible after the conclusion of the evidence and submissions in an inquiry, the sheriff must make a determination setting out –

(a) in relation to the death to which the inquiry relates, the sheriff's findings as to the circumstances mentioned in subsection (2), and
(b) such recommendations (if any) as to any of the matters mentioned in subsection (4) as the sheriff considers appropriate.

(2) The circumstances referred to in subsection (1)(a) 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.

(3) For the purposes of subsection (2)(e) and (f), it does not matter whether it was foreseeable before the death or accident that the death or accident might occur–
(a) if the precautions were not taken, or
(b) as the case may be, as a result of the defects.

(4) The matters referred to in subsection (1)(b) are –
(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.

(5) A recommendation under subsection (1)(b) may (but need not) be addressed to
(a) a participant in the inquiry,
(b) a body or office-holder appearing to the sheriff to have an interest in the prevention of deaths in similar circumstances.

(6) A determination is not admissible in evidence, and may not be founded on, in any judicial proceedings of any nature.”

The Facts

[9] At the time of his death John Murray was 58 years of age. He resided with his wife in Ness, Isle of Lewis.

[10] Mr Murray was a fit man who did not smoke or drink alcohol. He enjoyed general good health. In 2018 he suffered an episode of dizziness and a finding of cerebellar vascular changes.

[11] Mr Murray worked as a joiner throughout his adult life. He undertook a joinership in Lewis before moving to the mainland to carry out his trade there. In 2014 he returned to the Isle of Lewis. Mr Murray began his employment with O'Mac Construction Ltd on 7 May 2016. He was an experienced joiner. He was the holder of the construction skills certification scheme gold card.

[12] At the time of his death he was employed by O'Mac Construction Limited as a joiner. He was regarded by his employers as a good, hard worker who was quiet, mild-mannered and cautious.

[13] On Wednesday 13 November 2019, Mr Murray was employed at Bragar Community Hub Buildings, Grinneabhat, Bragar, Isle of Lewis. This site involved a former primary school (Bragar school) which was undergoing renovation.

[14] On the morning of Wednesday 13 November 2013 Mr Murray attended a briefing with the site supervisor Stewart Morrison. He was given the task of removing an existing vent pipe in the sloping part of a roof of a single-storey building. The vent pipe protruded through the pitch slate roof. The task also required removal and replacement of a small number of slates. It was a one-person job.

[15] The building was a single-storey detached regular stone property with a pitched asbestos slated roof. By 13 November 2013 the building had been partially renovated. The interior had been made almost completely open plan with the exception of a small storage area at the south facing gable end. This had been made into a small, floored room in the roof space. An opening had been made in the roof space. A Velux window was planned to be fitted. When facing the opening to the right was an old, internal vent pipe protruding from the roof. It was just under 1 metre (960mm) from the opening. The vent pipe was to be cut away and replaced by slates.

[16] In order to carry out this task Mr Murray required to access the roof. The edge of the roof commenced at approximately 3.8 metres above ground level. Mr Murray sourced ladders to use from within the site. He sourced an extendable 2-stage ladder and an extendable roof ladder. Both were appropriate ladders for the task at hand. The 2-stage ladder was 4.42 metres long when closed and 7.51 metres when opened. The roof ladder was 3.94 metres long when closed and 6.64 metres when opened.

[17] The 2-stage ladder allowed Mr Murray to gain access to the edge of the roof from ground level. The extendable roof ladder allowed Mr Murray access from the edge of the roof to the vent pipe area.

[18] Roof ladders have wheels on one side. They are placed in position by wheeling the ladder up the roof and then being flipped over. Hooks at the top of the ladder sit over the ridge at the top of the roof.

[19] Just after 11am Mr Murray fell from height. The roof ladder became detached from the ridge of the roof. The reason why this occurred is unknown. Mr Murray held

onto the ladder as it moved down the roof and then he fell heavily from the ladder. He struck his head.

[20] Adjacent to the property where work was being carried out were two large metal storage containers and a portacabin toilet. These were approximately 1-2 metres from the building. They were resting on tarmac. Mr Murray was located on the ground in the gap between the building and the large metal storage containers.

[21] The guttering on the edge of the building was approximately 4 metres high. Damage to the guttering was discovered in the region of where Mr Murray would have placed his ladders to access the vent pipe.

[22] The extendable 2-stage ladder and extendable roof ladder were found in close proximity to Mr Murray.

[23] At 11.13am Scottish Ambulance Service were notified of a male unconscious post-fall. They arrived at the locus at 11.31am. On arrival, the ambulance men found Mr Murray lying on the ground next to the Community Hub Building. He was being tended to by two other workmen. He was found to be breathing independently, his eyes were open and he appeared to be looking around. He did not appear to be distressed. However, he did not speak or respond to questions. He was assessed as between 7 and 10 on the Glasgow Coma scale.

[24] Mr Murray was conveyed by ambulance to the Accident and Emergency Department of the Western Isles Hospital, Stornoway. His condition deteriorated. A CT scan confirmed he had suffered a catastrophic head injury. He was transferred to the High Dependency Unit within the hospital. Later that evening, he was transferred by

air ambulance to the Neurological Intensive Care Unit of the Queen Elizabeth University Hospital, Glasgow. His condition continued to deteriorate. At 12.28pm. on 14 November 2019 his life was pronounced extinct by the consultant neuro-anaesthetist.

[25] A post-mortem was conducted on 19 November 2019. It revealed a fractured skull, brain injury and evidence of the effects of a rise in intra-cranial pressure. The cause of death was certified as 1(a) Head Injury due to or as a consequence of 1(b) fall from height. Toxicological analysis revealed no trace of alcohol. There was no pathology present which evidenced dizziness.

[26] Police attended at the locus on the afternoon of 13 November 2019. Weather conditions were cold and dry with no wind and no ice.

[27] The accident was subsequently investigated by the Health and Safety Executive. After their investigation they served a notice of contravention on O'Mac Construction Ltd. The notice was served on 18 May 2020. The notice identified amongst other matters failures in the risk assessment process. In particular it identified that risk assessments were not site specific. It identified that training was not adequate for those expected to risk assess work at height tasks at sites. The failures identified were not considered by the Health and Safety Executive to be causal factors in the death of Mr Murray.

[28] O'Mac Construction Ltd responded in detail on 25 June 2020 addressing the points raised by the Health and safety Executive in full. As a result the terms of the Notice of Contravention were considered to be met. As of 2 July 2020 the Health and Safety Executive was content that O'Mac Construction was meeting their legal duties in regards to work height, planning workers' height and risk assessments in general.

[29] The Health and Safety Executive ("HSE") issued a revised guidance note INDG284 entitled 'Working on Roofs' in 2008. The guidance sets out requirements for short-duration work on sloping roofs. Short-duration work is measured in minutes rather than hours. The guidance gives the example of tasks such as inspection, replacing a few tiles or minor adjustments to a television aerial. In terms of the guidance, the work Mr Murray was engaged on at the time of the accident was short-duration work. It was likely to take in the region of 10-15 minutes. The task was straightforward. The minimum requirement in the guidance for this type of work is a safe means of access to the roof level and a properly constructed and supported roof ladder.

[30] The extendable ladder and extendable roof ladder used by Mr Murray were inspected by the HSE after the accident. Both ladders were found to be in good condition and free from any defect. They were appropriate for use for short duration work in terms of the HSE guidance. The method used by Mr Murray to access the roof complied with HSE Guidance.

[31] Had HSE inspectors passed the site and viewed the way in which the access to the roof was being carried out by Mr Murray they would not have stopped the task.

[32] The use of free standing alloy towers as an alternative method to access the roof is directly contrary to industry guidance. It was not appropriate in the circumstances.

[33] The structure of the building was such that no suitable fall arrest system could safely be anchored through the Velux opening. In addition, it could not be operated in the specific circumstances of the task at hand within the manufacturers' specified loading requirements. In addition, using this harness would result in the safety line

running across the edge of the window opening and roof directly contrary to industry guidance.

Submissions

[34] There was no real dispute between parties over the potential findings in terms of paragraphs (a) to (c) of the s26 of the 2016 Act. In terms of paragraph (d) during submissions parties had no real difficulty in accepting a general form of wording consistent with the roof ladder becoming detached from the roof. It was agreed that there was insufficient evidence for the Inquiry to determine the reason why the roof ladder became so detached.

Crown

[35] In terms of paragraphs (e) and (f) the Crown submitted that the court should make no finding. It was submitted that Mr Murray was a careful and experienced joiner. No-one had witnessed the accident. The court should prefer evidence of the HSE Inspectors over the evidence of Mr Watkins. This was a short-duration job of a simple nature. The method used by Mr Murray in carrying out this work was entirely in line with the HSE guidance and reasonably practicable in the circumstances. Neither HSE inspector would have had any issue with the approach adopted by Mr Murray in carrying out this task. Had they been present on the day they would not have stopped him. The use of a fall arrest system or mobile scaffold towers had been specifically excluded by the Inspectors in the circumstances. For numerous reasons I should prefer

the evidence of Mr Caren and Mr Thompson over the evidence of Mr Watkinswhere appropriate.

Mrs Murray

[36] In contrast it was submitted by Counsel for Mrs Murray that the inquiry should make a determination in respect of precautions in terms of s26(e). The work was not of low risk. It involved Mr Murray climbing a ladder and then transitioning to a roof ladder at height. The work was completed after the accident using a system scaffold which was an appropriate control measure. The risk assessments carried out by the employers were neither suitable nor sufficient. They did not properly assess the level of risk that the task entailed and therefore did not fully consider appropriate control measures.

[37] In addition, it was submitted in terms of s26(f) that the system of work was defective by reason of:

a. Inadequacy of risk assessments and planning

b. Failure to disseminate risk assessments etc. to the workforce

c. A failure to implement their own plan in terms of Crown Production 5

d. A failure to provide appropriate training

It was submitted that the Health and Safety Management of O'Mac Construction Ltd was ineffective. Health and Safety plans were changed and not properly communicated to the workforce. Workers were permitted to deviate from these plans. In addition it was submitted that the inquiry was entitled to conclude that the work undertaken was

not low risk. The risk assessments were not site specific. Appropriate control measures were not identified or put in place to eliminate or reduce those risks. Mr Murray was given appropriate training by his employers in the use of roof ladders.

O'Mac Construction Limited

[38] The submissions on behalf of O'Mac Construction limited largely mirrored those of the Crown. It was submitted that no finding should be made in terms of 26 (e) or (f). In particular, it was submitted that I should prefer the evidence of the HSE Inspectors where there was any conflict with the evidence of Mr Watkins. The task was a simple one and of short duration. The approach taken by Mr Murray was consistent with both what his supervisor envisaged and HSE guidance. Mr Murray was a highly competent joiner. Neither a fall arrest system nor the use of a freestanding tower was appropriate in the circumstances.

Discussion

[39] In looking at the wording of the s26(e) any determination requires to consider precautions which had they been taken might realistically resulted in the death being avoided. Section 6(1) of the Work at Height Regulations 2005 provides:

> **"6.— Avoidance of risks from work at height**
> (1) In identifying the measures required by this regulation, every employer shall take account of a risk assessment under regulation 3 of the Management Regulations.
> (2) Every employer shall ensure that work is not carried out at height where it is reasonably practicable to carry out the work safely otherwise than at height.

> (3) Where work is carried out at height, every employer shall take suitable and sufficient measures to prevent, so far as is reasonably practicable, any person falling a distance liable to cause personal injury.
> (4) The measures required by paragraph (3) shall include–
> (a) his ensuring that the work is carried out–
> (i) from an existing place of work; or
> (ii) (in the case of obtaining access or egress) using an existing means, which complies with Schedule 1, where it is reasonably practicable to carry it out safely and under appropriate ergonomic conditions; and
> (b) where it is not reasonably practicable for the work to be carried out in accordance with sub-paragraph (a), his providing sufficient work equipment for preventing, so far as is reasonably practicable, a fall occurring.
> (5) Where the measures taken under paragraph (4) do not eliminate the risk of a fall occurring, every employer shall–
> (a) so far as is reasonably practicable, provide sufficient work equipment to minimise–
> (i) the distance and consequences; or
> (ii) where it is not reasonably practicable to minimise the distance, the consequences, of a fall; and
> (b) without prejudice to the generality of paragraph (3), provide such additional training and instruction or take other additional suitable and sufficient measures to prevent, so far as is reasonably practicable, any person falling a distance liable to cause personal injury."

Schedule 6(1) is in the following terms:-

> "Every employer shall ensure that a ladder is used for work at height only if a risk assessment under regulation 3 of the Management Regulations has demonstrated that the use of more suitable work equipment is not justified because of the low risk and–
> (a) the short duration of use; or
> (b) existing features on site which he cannot alter."

[40] Accordingly, in terms of Schedule 6(1) the use of a ladder is only appropriate for work at height if the use of more suitable work equipment is not justified because of low risk and the short duration of use.

[41] HSE publications were available concerning working on roofs. The HSE leaflet "Working on roofs" (revised 11/08) was in process. In addition, the HSE Guidance

"Health and safety in roof work" (published 09/12) was also in process. The relevant passages regarding the type of work being carried out by Mr Murray were as follows:

> "Short-duration work
> 110 'Short-duration work' means tasks that are measured in minutes rather than hours. It includes tasks such as inspection, replacing a few tiles or minor adjustment to a television aerial. It may not be reasonably practicable to install safeguards such as a full independent scaffold or even edge protection for such work, but you will need to provide something in its place. The decision on the precautions to take will depend on an overall assessment of the risks involved. You should consider:
> ■ duration of the work;
> ■ complexity of the work;
> ■ pitch of the roof;
> ■ condition of the roof;
> ■ type of roofing material (slate or tile);
> ■ weather conditions;
> ■ risk to those putting up edge protection; and
> ■ risk to other workers and the public
> 111 The minimum requirements for short-duration work on a roof are:
> ■ a safe means of access to the roof level; and
> ■ safe means of working on the roof, eg: – on a sloping roof, a properly constructed and supported roof ladder; or – on a flat roof without edge protection, a harness with a sufficiently short lanyard, attached to a secured anchorage, that it prevents the wearer from reaching a position from which they could fall.
> 154 For short-duration work on a pitched roof (e.g. replacing a few tiles or slates) the decision on whether or not to erect edge protection will depend on a number of factors (see paragraphs 110–115)
> 155 The minimum standard for short-duration work on a pitched roof is:
> ■ safe means of access to roof level; and
> ■ a properly constructed and supported roof ladder (see paragraphs 160–165) or equivalent
> "

[42] The task was considered by two HSE inspectors. Both agreed that the way in which Mr Murray had gone about accessing the roof was appropriate and in accordance with HSE guidance. Had they been present on site at the time Mr Murray was attempting to access the roof they would not have found any fault with the way he was

approaching the task. In particular, they would not have stopped him. The way in which Mr Murray was attempting to access the roof followed published HSE guidance. This was not contradicted by the evidence led on behalf of Mrs Murray. Mr Watkins (the Health and Safety expert for Mrs Murray) did not disagree with the HSE inspectors. In particular, he agreed with the following view of Mr Thompson:

> "The work activity being undertaken at the time of the accident can, in my view, be expressed as being of short duration (commonly defines as being less than 30 minutes) and would not have involved the use of any heavy equipment, tools or plant. I am therefore of the view that it would have been appropriate and suitable for the task to have been undertaken using a suitably secured roof ladder that was secured to prevent movement."

He did not suggest that the HSE guidance was wrong nor that it was not correct to follow this guidance in the particular circumstances faced by Mr Murray. In particular, he accepted the use of an extendable ladder and roof ladder in these circumstances as "reasonable".

[43] The joiners who gave evidence at the Inquiry were unanimous in their view that the way in which Mr Murray had approached the task was the same way in which they would have gone about it. They considered the use of ladders for this job as straightforward. Roof ladders are not difficult to use. They are flipped over to the wheeled side, run up the roof and then flipped over so the hooks fit over the roof ridge at the top of the roof. Mr Murray had regularly used ladders and roof ladders. No other joiner had any concerns over Mr Murray using these ladders to carry out the task before him. It was seen as a straightforward task for a joiner.

[44] Accordingly, there is no evidence to suggest that the task faced by Mr Murray was anything other than "low risk". The evidence of the HSE experts, the employees of O'Mac Construction Limited and Mr Watkins himself support this.

[45] Mr Watkins attempted to suggest alternative ways which the task could (note: not should) have been carried out. These involved use of a fall arrest system and the use of a mobile scaffolding tower to provide access. These were challenged in cross-examination. In particular, his final position appeared to accept the views of the HSE inspectors namely that the use of either a fall arrest system or mobile tower was unsuitable. I formed the impression that the initial suggestions made by Mr Watkins were not fully thought out, did not properly focus on the specific task and did not fully consider the design constraints of the various approaches considered by him. In contrast, I found Mr Thompson to be an extremely impressive witness.
He demonstrated obvious knowledge of work at heights and the guidance associated with them. For example, he was readily able to answer why the harness arrest system advanced by Mr Watkins was not appropriate to use on the specific site faced by Mr Murray. In addition, he gave compelling evidence regarding the use of mobile scaffold towers being inappropriate in relation to accessing the building (as favoured initially by Mr Watkins). Where it is necessary to do so I prefer the evidence of the HSE inspectors and, in particular, that of Mr Thompson. However, to be fair to Mr Watkins, he appeared to reconsider his views in the witness box where appropriate and, by the end of his evidence, he was not far from agreeing the position adopted by the HSE witnesses.

[46] The task was carried out with appropriate equipment in compliance with HSE guidance. A risk assessment would not have altered this. Accordingly, I reject the submissions made by Mr Bergen in respect of paragraphs 26 (e).

[47] In addition, I reject the submission made by Mr Bergen in respect of s26 (f) regarding the system of work. The submission was based in 4 parts namely:

a. Inadequacy of risk assessment and planning

b. Failure to disseminate risk assessments etc. to the workforce

c. A failure to implement their own plan in terms of C/P5

d. A failure to provide appropriate training

The section requires that the defect contributed to the death or any accident resulting in death. As previously stated, the work was carried out by an experienced joiner used to using roof ladders and working at height. The use of an extendable ladder and roof ladder was in accordance with HSE Guidance for this type of work. Had the HSE witnesses been present at the time the work was being carried out they would not have had any concerns. Accordingly, the risk assessments and training would have made no difference to the way in which Mr Murray carried out the task. The task was being carried out appropriately by him using appropriate equipment free from defects.

[48] It should also be noted that, the site supervisor at the time Finlay Morrison knew Mr Murray from schooldays and had worked with him in 2000. He had worked alongside Mr Murray for 8 to 9 years on a daily basis. They both had used roof ladders from an early age. Roof ladders are simple pieces of equipment in that you run them up the slope of the roof on wheels before flipping it over so the attachment fits over the

ridge and grips the roof on the opposite side. The roof ladder is then tested by the employee by ensuring it is secure. Mr Murray was a careful employee who was health and safety conscious. He always wore the correct protective equipment. His colleague would have had no concerns about Mr Murray using a roof ladder to remove a few slates. These views were held by other colleagues of Mr Murray.

[49] Accordingly, while the training of employees for work at height is always a matter which the court will take extremely seriously it cannot be said to have had a causative effect in the death of Mr Murray. Nor can the lack of a formal risk assessment in place. Mr Murray approached the task in a way which training should have recommended as an acceptable option. In addition, he approached the task in a manner which any risk assessment is likely to have assessed as suitable given the HSE guidance and opinion. Put simply, Mr Murray was an experienced joiner. He was carrying out a task that was straightforward. He was carrying out that task in a manner specifically approved by the Health and Safety Executive.

Recommendations in terms of s26(1)(b)

[50] The industry guidance (PASMA - the Prefabricated Access Supplier's & Manufacturers' Association) restricts the use of freestanding mobile towers (designed in accordance with BS EN1004) for gaining access to other places. Nor are they designed for use as edge protection. Either use is directly contrary to industry guidance (unless 11 additional steps are taken in relation to access). Mr Watkins provided photographs of mobile tower scaffolding being used in a manner which was not in accordance with the

guidance. At least one had been taken from a PASMA member website. Mr Watkins had seen free standing towers being used in this way.

[51] Accordingly, the evidence before the Inquiry suggests that these towers are used not infrequently in a manner contrary both to their design specifications and contrary to industry guidance. HSE should investigate the pictures provided by Mr Watkins and take any necessary remedial action required. HSE should also consider whether any additional steps are required to reinforce and highlight guidance concerning the use of mobile scaffolding towers as a means for gaining access to other areas and use as edge protection.

Closing remarks

[52] I would like to record my thanks to all parties for their assistance in the presentation of the evidence and efficient running of the Inquiry.

[53] Finally, I would like to formally offer my sincerest condolences and deepest sympathy to the family of Mr Murray for their unexpected, tragic loss. I note once again the high regard he was held in by both colleagues and his employers.