

***INQUIRY HELD UNDER
FATAL ACCIDENTS AND
SUDDEN DEATHS
INQUIRY (SCOTLAND)
ACT 1976
SECTION 1(1)(a)
SECTION 1(1)(b)***

DETERMINATION BY

LINDSAY WOOD, Esquire, Sheriff of the Sheriffdom of Glasgow and Strathkelvin following an Inquiry held at Glasgow on 18 and 19 November 2013 and 24 and 27 January 2014 into the death of **STEPHEN THOMSON**, born 2 April 1966, who normally resided at 9 Sommerfield Road, Condorrat, Cumbernauld.

GLASGOW, 28 May 2014.

Part I: Introduction & Legal Framework

(1) This is an Inquiry under the Fatal Accidents and Sudden Deaths Inquiry (Scotland) Act 1976 into the circumstances of the death of Stephen Thomson who died at Unit 3A, 3 Lancaster Road, Bishopbriggs on 29 September 2012.

(2) Ms Carrie Macfarlane, senior procurator fiscal depute, appeared in the public interest. Mr Robert Fife, solicitor, appeared for the Health & Safety Executive (HSE). Mr McMillan, solicitor, appeared on behalf of the Glasgow Steel Nail Company Ltd (now known as Low Moss Properties Ltd). Ms Anderson, solicitor, appeared on behalf of Euroscot Contractors Ltd.

(3) The Inquiry heard evidence and submissions over the course of 18 and 19 November 2013 and 24 and 27 January 2014. The Crown led evidence from eight witnesses:

1. Alastair Richmond, Director, Glasgow Steel Nail Company Ltd.
2. James Carroll, employee of Euroscot Contractors Ltd.
3. Brian Whittingham, employee of Euroscot Contractors Ltd.
4. Andrew Buchanan, Crew Commander, Strathclyde Fire & Rescue.
5. Dr Julie McAdam, MBCHP FRCPath DIP FM, Forensic Pathologist, c/o Department of Forensic Medicine & Science, University of Glasgow.
6. Graham McKie, c/o Police Scotland.
7. Isabelle Martin, Inspector, c/o of HSE, Belford House, 59 Belford Road, Edinburgh.
8. Andy Gay, c/o HSE, Redgrave Court, Merton Road, Bootle, Merseyside.

(4) The HSE led evidence from Lesley Gordon, Complaints Officer, HSE Edinburgh and Iain Brodie, Head of Operations, HSE Construction Division, Scotland & North of England. A joint minute of evidence was tendered by parties.

Legal Framework

(5) Section 6 of the said 1976 Act requires the presiding sheriff to make determinations on the following matters:

- (a) Where and when the death and any accident resulting in the death took place.
- (b) The cause of such death and any accident resulting in the death.

- (c) The reasonable precautions, if any, whereby the death and any accident resulting in the death might have been prevented.
- (d) The defects, if any, in any system of working which contributed to the death or any accident resulting in the death.
- (e) Any other facts which are relevant to the circumstances of the death.
- (6) The court proceeds on the basis of the evidence placed before it and although described as an Inquiry, the sheriff's powers do not go beyond making a determination in relation to the circumstances established to his satisfaction by evidence following upon investigation by the procurator fiscal and any other party if so advised.

Part II: Determination as to the circumstances of the death

The Sheriff, having considered all the evidence adduced, FINDS and DETERMINES in terms of section 6(1) of the Fatal Accidents and Sudden Deaths Inquiry (Scotland) Act 1976:

- (1) In terms of section 6(1)(a), that Stephen Thomson, born 2 April 1966, who normally resided at 9 Sommerfield Road, Condorrat, Cumbernauld died at the industrial units at 3 Lancaster Road, Low Moss Industrial Estate, Bishopbriggs, Glasgow following an accident at approximately 0825 hours on 29 September 2012. Life was pronounced extinct at 0905 hours.
- (2) In terms of section 6(1)(b), that the cause of his death was (1a) postural asphyxia due to (1b) fall from a height. Further, the cause of the accident resulting in the death was that Mr Thomson lost his footing and fell through an opening in the roof whilst working at height,

his head then struck machinery and he then became entrapped in an enclosed space in a workshop below leading to him suffocating.

(3) In terms of section 6(1)(c), that there were reasonable precautions whereby the death and the accident resulting in the death might have been avoided. In particular, Euroscot Contractors Ltd should have followed safe working practices, namely:

- (i) A suitable and sufficient risk assessment under regulation 3 of the Management of Health & Safety at Work Regulations which would have identified the risk of falling through or from the roof at Unit 3A, 3 Lancaster Road, Low Moss Industrial Estate.
- (ii) The erection of scaffolding around the perimeter of the building.
- (iii) Installation of safety nets and bean bags to the underside of the roof.

(4) In terms of section 6(1)(d), the following were defects in the system of roof working by Euroscot Contractors Ltd which contributed to the death:

- (i) Lack of suitable and sufficient risk assessment in respect of work at height.
- (ii) Lack of fall mitigation in the form of nets and bean bags inside the workshop.

(5) In terms of section 6(1)(e), there were facts which were relevant to the circumstances of the death namely that more could have been done by the HSE in trying to identify the duty holder following the receipt of a serious complaint (with locus details and photographs) from a concerned member of the public on the Tuesday before the accident on the Saturday 29 September 2012. With better training and greater skills, the Complaints Handler could have used Google or another internet search engine and that may have led to the identification of the duty holder before 1010 hours on Friday, 28 September 2012 when the potential duty holder

was identified or after then and before the accident took place on the Saturday morning. The court cannot assume or speculate that proper identification would have been successful and the work stopped and the accident avoided but the particular circumstances regrettably leaves misgivings about whether sufficient positive action was undertaken by the Complaints Handler.

Part III: Findings in Fact

(1) In 2012, the Glasgow Steel Nail Company Ltd (now known as Low Moss Properties Ltd) owned a single storey industrial building with a number of industrial units at 3 Lancaster Road, Bishopbriggs. Some were occupied by the company (3 and 3A) and some were leased (1 and 2). Euroscot Contractors Ltd were tenants of Unit 2 and had been tenants for 5 years. Euroscot are a roofing and building maintenance company. Stephen Thomson was the owner and sole director of the company which employed up to six employees. The respective companies had good relations. Mr Alastair Richmond, the Managing Director of Glasgow Steel Nail Company Ltd, wished the whole of the roof of the said building to be replaced. It was a considerable piece of work. After some investigation, he discussed with Stephen Thomson about doing the work. Mr Richmond had made some enquiries about Euroscot and thought that the quality of the work would be good. After some negotiation, a price was agreed at approximately £76,000 to include some wall cladding. Mr Richmond was provided with a risk assessment document and method statement. He was happy with the assurances given by Mr Thomson that the job would be done to a good standard.

(2) The work began on 10 September 2012 and was supposed to complete by 21 September 2012. Work was ongoing to finish the job completely at Unit 3A on Saturday, 29 September 2012.

(3) Soon after the accident on 29 September, Mr Richmond was contacted by the police and attended on site. HSE issued a prohibition notice to prevent further work with a direction to leave the site undisturbed. The roofing work was completed some months later by Euroscot Contractors Ltd who employed a sub-contractor, Mark Whittingham, who put other safety measures in place including scaffolding, hand rails, crawler boards, safety harnesses, safety netting and bean bags. The work was completed satisfactorily.

(4) Mr Richmond had not brought in health and safety expertise in advance of the job as he was satisfied that Mr Thomson had the particular expertise, knowledge and experience to complete the job satisfactorily and in a safe manner. In accepting the quote, Mr Richmond required a risk assessment and adherence to safe working practices.

(5) The work involved lifting the old corrugated asbestos cement roof off and replacing it with individual roof sheeting which measured 2.5 metres x 1.5 metres and weighed approximately 2 stone. Four men were required to lift and put a new sheet on. The new composite roof sheets arrived on site on 10 September and were placed on the roof by the supplier using a mobile crane and stacked in various locations across the roof for easy access for fitting. The existing roofing was bolted in place and mainly cut free from the underside where it was practicable. A scissor lift was used. The roof sheet is one long piece that fits from the ridge to the gutter. It is slightly wider than the asbestos cement sheets so the men removed two

lines of asbestos cement sheets and then screwed the new roof sheet into place. To remove the asbestos cement sheets, the men walked along Youngman boards at the gutter and then up to the pitch of the roof towards the ridge. They walked on top of the asbestos cement sheets but walked along the line of the supporting roof purlins. Two men are required to lift an asbestos cement sheet and they then slide the sheet down the roof to another two men who walk along the Youngman boards to a small hoist that they had set up to assist lowering them to the ground. In effect, the men stood on the asbestos cement roof sheets adjacent to the one they were lifting. Once the sheet was lifted, they reached down into the hole where it had been to lift out the ceiling tile. The ceiling tiles are made from plasterboard and are fairly lightweight. They are located just below the asbestos cement roof sheet. Four men are required to lift the new composite roof sheet into place. They lifted a corner each. Two of them needed to step over the hole where the old sheets had been to position the new sheet. The new sheet is then placed down and screwed into place. There are 12 screws per sheet, 6 down each side. The men then lifted off the next line of asbestos cement sheets and ceiling tiles and then fixed the new sheet into place. This continued across the roof of the building. On Saturday, 29 September, work started just before 8 am. The men had reached the roof over Unit 3A where Glasgow Steel Nail Ltd have their factory. The men accessed the roof via a ladder onto a flat section of the roof to the rear of the building. They could then step up on to the asbestos cement roof of the factory. The bolts holding the sheets in place were cut from the top. They knelt on top of the asbestos cement sheets to do this. The first line of asbestos cement sheets and ceiling tiles were removed and the first three sheets of the second line had been removed.

Stephen Thomson then lifted the fourth asbestos cement sheet and as he was handing it to the others to take to the hoist, he lost his balance and his footing and fell through the hole where the sheet had been. His head struck a piece of machinery and he landed on the floor 3.5 metres below between a wall and a machine in an enclosed space and with his head in a downward position. It was not possible to move the machine to reach Stephen Thomson who was on his knees with his head into his chest. It was not possible to access him to give assistance. He was unconscious. The fire brigade were called and eventually managed to lift him out. However, it was unfortunately too late by then and life was pronounced extinct at 0905 hours.

(6) The post mortem on Stephen Thomson confirmed that he died on 29 September 2012 at 0905 hours after slipping and falling 3.5 metres when his head struck a piece of machinery. His position on landing was significant in that his head was stuck under his body and his jacket may have restricted his breathing. He had a cut to the back of his head which suggests that his hard hat may have fallen off when he fell. His employees tried in vain to access him but a heavy machine blocked their attempts. Mr Thomson was unconscious and suffocated before fire fighters could free him. Mr Thomson had been in good health otherwise.

(7) On the Sunday before the accident, 23 September 2012, Graeme McKie, an experienced supervisor with a roofing company had been walking his dog in the industrial estate at Lancaster Road and saw some work had been done on a roof. There was no-one working at the time and he noticed there was no edge protection or scaffolding. He was concerned about safety issues and took photographs. He told his employer, Alastair Price, the following day,

who reported the matter by email to HSE on Tuesday, 25 September 2012 at 12.41. Mr McKie and Mr Price had concerns that safety was being compromised in order to cut costs.

(8) Isabelle Martin, an experienced HSE Inspector, was advised on the morning of the accident of the fatality and visited the site late that morning. It was clear there was roof work at height and there were no means of fall prevention on site. She issued a prohibition notice that no further work was to be done. This was issued to Mr Richmond who was present and there was also a notice given to leave the scene undisturbed. Isabelle Martin carried out inquiries and investigations and discovered that Mr Thomson was the employer of five men and was responsible for planning the work on the roof. She reviewed the risk assessment for the job and found that it was very general and was not job specific. She found that there was no fall protection and risks were being taken in the execution of the job. She came to the view that Mr Thomson had been standing on the gutter and had either stumbled or overbalanced when holding an asbestos cement sheet. Ms Martin concluded that there were not sufficient measures in place to prevent falls. There should have been a combination of removing the sheets from below, installation of perimeter guard rails, safety netting to the underside of the roof and staging to spread the load on the old fragile roof sheets.

(9) Ms Martin was of the view that the Glasgow Steel Nail Company Ltd had fulfilled their statutory obligations in choosing a contractor with experience and competence. It was not for that company to assess how the job was done. They had been given satisfactory assurances by Euroscot Contractors Ltd.

(10) The HSE did not recommend proceedings against Euroscot Contractors Ltd. Although there were clear breaches of health and safety regulations (Work at Height Regulations 2005, regulations 4, 6(3) and 7 and the Health and Safety at Work etc Act 1974, section 2(1)), Stephen Thomson was responsible as principal of the company and in the circumstances, it was not appropriate to instigate proceedings.

(11) Andrew Gay, Head of Business Improvement & Delivery Unit at HSE based in Bootle managed the Complaints and Advice Team for the UK. When complaints are made to HSE about possible breaches of health and safety, staff are trained to determine what the complaint is, to identify the duty holder (ie the company causing concern - could be more than one) and to get the address of the duty holder. That could be the client and/or the contractor. There is a triage system to label the complaint either red, amber or green with red the most serious with the possibility of serious personal injury or fatality. The system is such that a complaint, as in this case from Mr Price, is not categorised as a complaint until the duty holder has been identified. Instead, and again as in this case, it was categorised as a red “matter of concern”. Until the duty holder is identified and the “matter of concern” becomes a complaint, there is no trigger that action has to be taken within any set period which, with a complaint, is 24 hours. The sequence of events following the receipt of the email complaint (with photographs) from Alastair Price at 1241 hours on Tuesday, 25 September is that HSE responded to the email at 0737 hours on Wednesday, 26 September. Prior to that, at 1913 hours on Tuesday, 25 September, Iain Brodie, Head of Contractors for HSE Scotland & Northern England had sent an email internally asking that the complaint be pursued as a matter of priority. He was then

advised by email at 0939 hours on Wednesday, 26 September that the matter had been passed to a Complaints Handler, Lesley Gordon, to try to identify the duty holder. At 1444 hours that day, Lesley Gordon replied to Iain Brodie saying that she had checked the F10 database, planning applications and asbestos applications but all to no avail. Details of the complaint had been entered on the MOC (Matter of Complaints) Register. At 1814 hours on Wednesday, 26 September, Lesley Gordon emailed Alastair Price saying that HSE had been unable to identify or establish who was responsible for the work. She said the information had been recorded and passed to the Principal Inspector who would decide whether to investigate or not. At 1413 hours on Thursday, 27 September, Iain Brodie emailed Lesley Gordon and asked her to try to get more information from the complainant such as a specific address or name of the company. At 1806 hours that day, Lesley Gordon emailed Mr Price to ask if he could obtain a specific address for the company. Mr Price replied at 2041 hours giving the address which was the identical address as had been advised in the original email of complaint. At 1010 hours on Friday, 28 September, Iain Brodie emailed Lesley Gordon and said he had done some internet research himself which appeared to show that the work was being done at the premises of the Glasgow Steel Nail Company as their logo was featured in the photographs. There was still no identification of the duty holder. He asked Lesley Gordon to pursue the complaint. There was no follow up that day. Mr Gay said that a Complaints Handler dealt with an average 18 complaints on any one day. Once the duty holder has been identified, the complaints officer will advise the duty holder of the complaint and ask that immediate action be taken to deal with any health and safety issues. When Lesley Gordon was advised by Mr Brodie at 1010 on Friday,

28 September of the potential duty holder, it was still only a matter of concern and there was no 24 hour trigger. If it is a red matter of concern, the principal inspector has to be advised within 24 hours and he then has to advance matters in a reasonable time. As soon as it becomes a red complaint, action has to be taken within 24 hours.

(12) Lesley Gordon, a Complaints Handler at HSE Edinburgh, became part of the Complaints Team in 2009 and received internal and external training. She was not able to recall the work that she did between Wednesday, 26 and Friday, 28 September 2012. She said she could not recall the complaint in relation to this Inquiry. She confirmed that one of her functions is to identify duty holders. She deals with red complaints first, then reminders and then red matters of concern. She did not think that Google was good for identifying addresses. She could not remember if she had used Google in this Inquiry. She thought she could remember being told there had been a fatality on the Monday, 1 October 2012.

(13) Iain Brodie remembered getting notification of the complaint. He asked the Complaints Handler to try to find out who the client is. He carried out research himself on Friday, 28 September by using Google and correlating the business and the photos that had been sent by the complainer. The photos showed the logo of Glasgow Steel Nail Company Ltd. He said it was not an easy search and was not definitive and it took him 25 minutes. He was unaware of what happened after his email on the Friday but remembered being told of the fatality on the Saturday morning.

Submissions

1. The Crown – the Procurator Fiscal Depute invited me to make certain determinations under section 6(1)(a) and 6(1)(b) which I have followed. The Depute also asked me to make determinations under section 6(1)(c) and 6(1)(d) which I have partly followed in respect of the actings and non-actings by Euroscot Contractors Ltd. The Crown also made a submission about possible precautions and defects in respect of the HSE. This is based on a complaint made to the HSE on the Tuesday before the accident by a concerned member of the public about the possibility of unsafe work at height at the locus. In the intervening period before the accident, HSE did not identify the duty holder for the works in question and accordingly, no contact was made to discuss the circumstances of the works and possibly halt it. The Crown submitted that the death may have been avoided had the HSE made prompter and more effective investigations to identify the duty holder for the works. It was not until the Friday morning that a potential duty holder was identified following work done by Iain Brodie. The Crown submitted that searches could have been carried out by the Complaints Handler prior to then as she had the same investigative tools as Mr Brodie. The Crown submitted that if such investigations were beyond the skills capacity of the Complaints Handler then there is a defect in the system whereby Complaints Handlers did not have adequate training or skills to carry out the work effectively and expediently to identify duty holders. The Crown submitted that the investigative work could have been carried out at an earlier stage leading to the opportunity of the duty holder to be contacted and consequently the work halted or safe systems of work put in place. This submission overlapped into section 6(1)(d) as a defect in the system of

working which contributed to the death or any accident resulting in the death. In light of the above submissions under sections 6(1)(c) and 6(1)(d), I am presuming the Crown chose not to make any submission in respect of 6(1)(e).

2. Glasgow Steel Nail Company Ltd – Mr McMillan submitted that his clients had discharged its various regulatory and statutory obligations in that they had instructed Euroscot Contractors Ltd to carry out the work and had been given sufficient assurances that it would be done in accordance with the law. I was invited to make no findings relevant to Glasgow Steel Nail Company Ltd in terms of section 6(1)(c), (d) or (e) of the 1976 Act.

3. Euroscot Contractors Ltd – Ms Anderson supported the submissions made by the Crown with regard to sections 6(1)(a) and 6(1)(b). She also very fairly accepted that criticism would be levelled at the company in respect of the actions of Stephen Thomson, the Managing Director of the company. Accordingly, she supported the submissions made by the Crown in respect of sections 6(1)(c) and 6(1)(d) in respect of Euroscot Contractors Ltd. She also sided with the Crown in respect of the failure on the part of the HSE to identify the duty holder in the days prior to the accident and which could have led to the duty holder being advised to stop the work whereby the accident and the death could have been avoided. She went further by suggesting that had Lesley Gordon contacted Glasgow Steel Nail Company Ltd on the Friday before the accident, having been given certain information at 1010 hours on the Friday by Iain Brodie, the work may have been stopped on site or additional safety measures put in place, and

that such a reasonable precaution might have prevented the accident and indeed, the death of Mr Thomson. Ms Anderson also cast aspersions on the evidence of Mr Gay as he had to retract evidence he gave on day 2 of the Inquiry and replace it with different evidence on day 3. She suggested that such confusion might well be indicative of a system which is neither clear nor robust. Ms Anderson was also critical about Lesley Gordon's assertion that internet searches such as Google were not necessarily a useful tool in the conduct of her work. Ms Anderson submitted that in trying to identify a duty holder, the lack of a Google search or any internet based investigations would appear to be surprisingly lacking. These remarks carried into section 6(1)(d) and a submission by Ms Anderson that there was a defect in the system of working by the HSE in terms of the time they took to identify the duty holder and which in this case, could have led to the work being stopped, the accident not taking place and Mr Thomson's death being avoided.

Finally, Ms Anderson submitted that Glasgow Steel Nail Company Ltd had not fulfilled their obligations in terms of section 6(1)(c) about the safety of the work being undertaken on their premises by Euroscot Contractors Ltd and that they should have sought external advice. Ms Anderson submitted that Mr Richmond of said company could and should have done more to satisfy himself as to the safety of the work being carried out on the company premises.

4. HSE – Mr Fife for the HSE adopted the submissions of the Crown with regard to sections 6(1)(a) and 6(1)(b). Similarly, he adopted the submissions made by the Crown in

respect of Euroscot Contractors Ltd with regard to sections 6(1)(c) and 6(1)(d). He opposed the submissions in respect of the HSE with regard to sections 6(1)(c) and 6(1)(d). Further, he submitted there should be no finding under section 6(1)(e) in respect of the HSE. Thereafter, he made submissions in support of the HSE complaints procedure and the evidence given by Mr Gay. He submitted that Mr Gay's evidence could be relied upon and that the procedures were robust and had been properly tested before and after the accident. He supported the actions of both Iain Brodie and Lesley Gordon in that they had carried out their functions in terms of the HSE complaints procedure.

Mr Fife's submissions with regard to the HSE involvement and any determinations under sections 6(1)(c) or 6(1)(d), stressed that any findings about reasonable precautions whereby the death and any accident resulting in the death might have been avoided, had to be based on findings in fact which are neither speculative or based on assumptions. Similarly, in respect of any findings under section 6(1)(d), he stressed that there is a difference in defects in any system of working which "contribute" to the death or accident as opposed to "prevent". Mr Fife's clear position was that there was no evidence which the court could rely upon to assert that the defects, if any, in the system of working of the HSE "contributed" to the death or the accident resulting in the death and consequently, section 6(1)(d) had no application.

Conclusions

There is no doubt that Stephen Thomson died in an accident which should not have happened. In many ways, Mr Thomson had control over that as he was the principal and Managing Director of Euroscot Contractors Ltd and in doing the roof replacement work for Glasgow Steel Nail Company Ltd at Lancaster Road, Bishopbriggs, corners were cut and risks taken for whatever reasons. In so doing, the health and safety of Mr Thomson and his employees was jeopardised. As detailed in this determination, there was not anything like sufficient measures in place to prevent falls and sadly on 29 September 2012, Mr Thomson lost his footing whilst working at height and fell through a gap in the roof to the floor below. There seems no doubt that Mr Thomson struck his head on machinery, was rendered unconscious and landed in a position where he could not be rescued in time to save him from being asphyxiated. I believe the court can safely say that if he had landed elsewhere, death might have been avoided.

Given the acceptance of the above facts, the court has no difficulty in determining where and when the death took place and any accident resulting in the death. Similarly, the court is able to determine the cause of death and any accident resulting in the death. Further, the court is able to determine the reasonable precautions which Euroscot Contractors Ltd should have carried through whereby the accident and the death might have been prevented and is also in a position to categorically state the defects in Euroscot's system of working which contributed to the accident resulting in the death.

The more difficult part of this Inquiry relates to the involvement of the HSE and as to whether the court should make findings under sections 6(1)(c) and 6(1)(d). The public, I am sure, would be concerned that where a serious complaint with locus details and photographs is made to the HSE at 1241 hours on a Tuesday about work being carried out on a roof and potentially having an effect on health and safety, that those holding a duty of care are not notified by the HSE prior to the accident and the consequent death on the following Saturday morning. That is what happened here and it is at least arguable, that if positive action had been taken and the duty holder identified, the accident may well have been avoided. Such assertions were pushed for both by the Crown and by Euroscot Contractors Ltd, and opposed by the HSE. On balance, however, I am not able to make the necessary findings in fact to make such a determination under section 6(1)(c) as to do so would be speculative and based on assumptions. Similarly, I am not able to make a determination under section 6(1)(d) as to do so would also be speculative. In addition, I am not satisfied on the evidence led and applying the test of the balance of probabilities that the defect “contributed” to the accident resulting in the death. It might be argued that if there were defects in the HSE system of working, the accident could have been prevented but the test here is whether it “contributed” and on balance, I am not able to make such a finding.

That said, I have made a finding under section 6(1)(e) and I trust the HSE will fully take on board the frustrations expressed about the slowness of response and the lack of expediency in identifying the duty holder.

Dealing with the other aspects of the submissions, I have no criticism of the corrective evidence given by Mr Gay nor was I persuaded that his change of position was indicative of a system which is neither clear nor robust. Indeed, I have no criticism of the robustness of the HSE complaints procedures as a whole and which, of course, has to operate within finite resources. However, any system can be flawed if those working within it do not apply the required skills. That said, I specifically wish to record that I have no criticism of Mr Iain Brodie's involvement in the investigation.

I exonerate fully Glasgow Steel Nail Company Ltd from not fulfilling their regulatory and statutory obligations and I also wish to commend Messrs Richmond, Carroll and Whittingham for the difficult circumstances in which they had to give evidence.

Finally, I wish to extend my condolences to Mr Thomson's widow and his family. It is indeed a tragedy that Mr Thomson is no longer with us. Mrs Thomson and her father were present throughout the Inquiry and that required courage on their part.

Lindsay Wood
Sheriff of Glasgow and Strathkelvin
GLASGOW, 28 May 2014