SHERIFFDOM OF GRAMPIAN HIGHLAND AND ISLANDS AT ABERDEEN

[2025] FAI 4

ABE-B552-25

DETERMINATION

BY

SHERIFF ANDREW MILLER

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

into the death of

ANDREW MCCALLUM PIRIE

ABERDEEN, 9 January 2026

DETERMINATION

The sheriff, having resumed consideration of the evidence and information presented at the Fatal Accident Inquiry into the death of Andrew McCallum Pirie, determines in terms of section 26 of the Inquiries into Fatal Accidents and Sudden Deaths Etc. (Scotland) Act 2016 ("the 2016 Act") that:

1. Andrew McCallum Pirie was born on 17 July 1966 and was aged 53 at the time of his death.

2. In terms of section 26(2)(a) of the 2016 Act, Mr Pirie was pronounced dead at 10.10am on 25 June 2020 at an access road to Middle Touks Farm on Touks Road between Kirkton of Fetteresso and Dunnottar Woods, Dunnottar, near Stonehaven, Aberdeenshire.

3. In terms of section 26(2)(b) of the 2016 Act, the accident resulting in the death of Mr Pirie occurred at approximately 9.15am on 25 June 2020 at an access road to Middle Touks Farm on Touks Road between Kirkton of Fetteresso and Dunnottar Woods, Dunnottar, near Stonehaven, Aberdeenshire.

4. In terms of section 26(2)(c) of the 2016 Act, the cause of Mr Pirie's death was:

1(a) craniocervical injuries

1(b) incident whilst at work felling trees

5. In terms of section 26(2)(d) of the 2016 Act, the accident resulting in the death of Mr Pirie was caused when a section of the trunk of a tree situated at the access road to Middle Touks Farm on Touks Road between Kirkton of Fetteresso and Dunnottar Woods, Dunnottar, near Stonehaven, Aberdeenshire fell from the tree during tree-felling work undertaken by Scott Lee Menhinick whilst Mr Pirie was working on the ground at the base of the tree, whereby the section of trunk struck Mr Pirie resulting in injuries from which he died at the scene.

6. In terms of section 26(2)(e) of the 2016 Act, the following precautions could reasonably have been taken and, had they been taken, might realistically have avoided the accident which resulted in the death of Mr Pirie:

i. The drop zone beneath the tree (the area into which sections of timber cut from the tree would be expected to fall) should have been clearly identified to everyone involved in the work;

ii. The drop zone should have been clearly marked by means of a physical barrier such as coloured plastic tape or rope attached to appropriately

positioned cones or other markers, so that the extent and limits of the drop zone were clear to everyone involved in or affected by the work;

iii. Measures should have been put in place to supervise access to the drop zone in order to exclude or minimise the risk of anyone entering the drop zone whilst the cutting of sections of timber from the tree was taking place in circumstances which carried any risk of a person on the ground being struck by falling timber;

iv. A clear and reliable means of communication between Mr Menhinick and everyone on the ground who was involved in the work including Mr Pirie should have been put in place in order to exclude or minimise the risk of a person on the ground being struck by falling timber;

v. Consideration should have been given to cutting timber in smaller sections or using other means of controlling or directing falling timber, such as the use of ropes to lower large sections of timber; and

vi. In the absence of any of the foregoing precautions, the work should not have proceeded.

7. In terms of section 26(2)(f) of the 2016 Act, the following defects in a system of working contributed to the death of Mr Pirie or to the accident which resulted in his death:

i. The drop zone beneath the tree was not clearly identified to everyone involved in the work;

ii. The drop zone was not clearly marked by means of a physical barrier such as coloured plastic tape or rope attached to cones or other markers;

iii. No reliable measures were put in place to supervise access to the drop zone in order to exclude or minimise the risk of anyone entering the drop zone whilst cutting was taking place;

iv. No clear and reliable means of communication between Mr Menhinick and everyone on the ground who was involved in the work including Mr Pirie were put in place in order to exclude or minimise the risk of a person on the ground being struck by falling timber; and

v. No steps were taken to cut timber in smaller sections or use other means of controlling or directing falling timber, such as the use of ropes to lower large sections of timber.

8. In terms of section 26(2)(g) of the 2016 Act, no other facts are relevant to the circumstances of Mr Pirie's death.

Recommendations

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

i. That the Arboricultural Association, The Malthouse, Stroud Green, Standish, Stonehouse, Gloucestershire GL10 3DL considers whether there

are further steps it can take to maximise awareness within the arboriculture industry throughout the UK of the contents of the Industry Code of Practice for Arboriculture: Tree Work at Height, published by The Arboricultural Association with input from the Health and Safety Executive (currently in its Second Edition, published in 2020), and in particular section 3.4.6 "Site conditions;" and

ii. That the Arboricultural Association considers whether the Industry Code of Practice for Arboriculture: Tree Work at Height requires to be amended or revised in light of the circumstances of the death of Andrew Pirie, as set out in this determination.

NOTE

Andrew McCallum Pirie

[1] It was clear to me during the inquiry hearing that Andrew Pirie, known as Andy, was a much loved husband, father, brother and friend who was devoted to his family. His family continue to be profoundly affected by his tragic and untimely death.

The legal framework

[2] Sections 1 and 2 of the 2016 Act are in the following terms:

> **"1 Inquiries under this Act**
> (1) Where an inquiry is to be held into the death of a person in accordance with sections 2 to 7, the procurator fiscal must—
> (a) investigate the circumstances of the death, and
> (b) arrange for the inquiry to be held.

(2) An inquiry is to be conducted by a sheriff.
(3) The purpose of an inquiry is to—
  (a) establish the circumstances of the death, and
  (b) consider what steps (if any) might be taken to prevent other deaths in similar circumstances.
(4) But it is not the purpose of an inquiry to establish civil or criminal liability.
(5) In this Act, unless the context requires otherwise—
  (a) *'inquiry'* means an inquiry held, or to be held, under this Act,
  (b) references to a *'sheriff'* in relation to an inquiry are to a sheriff of the sheriffdom in which the inquiry is, or is to be, held.

2 Mandatory inquiries
(1) An inquiry is to be held into the death of a person which—
  (a) occurred in Scotland, and
  (b) is within subsection (3) or (4).
(2) Subsection (1) is subject to section 3.
(3) The death of a person is within this subsection if the death was the result of an accident which occurred—
  (a) in Scotland, and
  (b) while the person was acting in the course of the person's employment or occupation.
(4) The death of a person is within this subsection if, at the time of death, the person was—
  (a) in legal custody, or
  (b) a child required to be kept or detained in secure accommodation.
…"

[3] The specific matters to be determined by the court are set out in section 26 of the 2016 Act, which is in the following terms:

"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."

[4] Thus, in terms of section 1(3) and (4) of the 2016 Act, the purpose of a Fatal Accident Inquiry is to establish the circumstances of the death and to consider what steps (if any) might be taken to prevent other deaths in similar circumstance, but not to establish civil or criminal liability or blame. It is an inquisitorial, as opposed to an adversarial, process, in which the procurator fiscal represents the public interest.

[5] Consistent with the terms of section 26(3) of the 2016 Act, the sheriff is entitled to use hindsight in identifying any precautions which could reasonably have been taken and, had they been taken, might realistically have resulted in the death being avoided, whether or not the need for the precautions was foreseeable at the time of the events

which resulted in the death (Determination in relation to the death of Sharman Weir, Glasgow Sheriff Court 23 January 2003, per Sheriff Reith QC at page 32).[1]

Overview

[6] An inquiry was held at Aberdeen Sheriff Court on 27 and 28 November 2025 into the death of Mr Pirie, which occurred on 25 June 2020.

[7] That day Mr Pirie, then aged 53, was in the course of his employment as the principal of a business, Dunnottar Maintenance Services, which he operated from his home near to Stonehaven, Aberdeenshire and which undertook garden maintenance and groundworks. Mr Pirie had one employee, Kevin O'Donnell, who was his labourer. Around 2 weeks before his death Mr Pirie was approached by Leonard Smith, who owned land near to Dunnottar Wood, Stonehaven, close to Mr Pirie's home. Mr Smith explained that he wanted to have two mature ash trees on his land, which he believed had died, taken down in order to remove any risk which they might pose to users of an adjacent road. The dismantling of the trees would require to be undertaken by an arborist or "tree surgeon" (although I understand that there is a technical difference between an arborist and a tree surgeon, those terms appeared to be used interchangeably during the evidence and nothing in this determination turns on any technical distinction between the two terms). Mr Pirie recommended Scott Menhinick, a tree surgeon with whom he had worked in the past, for the job and Mr Smith was happy

[1] https://www.scotcourts.gov.uk/media/c34hl0x4/fai-sharman-weir.pdf

to accept Mr Pirie's recommendation. Scott Menhinick was to be paid £500 for his work by Mr Smith, separately from Mr Pirie's own payment for his part in the work.

[8] The work commenced at about 7.45am on Thursday 25 June 2020, when Mr Menhinick ascended one of the trees using ropes and spikes to secure himself, and began the sectional removal of timber using a chainsaw. The tree could not be cut down from its base due to its proximity to a road and to overhead power lines. The cut timber was allowed to fall to the ground, as opposed to being lowered by other means, for example by the use of ropes or a pulley system. Mr Pirie, Mr O'Donnell and Mr Smith were present on the ground during this work. They were variously engaged in removing cut timber from the "drop zone" beneath the tree (the area into which sections of cut timber would be expected to fall), passing smaller sections through a "wood chipper" machine nearby, cutting larger sections of the cut timber into smaller pieces using a chainsaw (for retention by Mr Smith) and looking out for traffic on Touks Road, a rural road which ran past the tree. By about 9.15am, Mr Menhinick had removed all of the limbs of the tree and had begun to remove sections of the trunk. He cut a section from the top of the trunk, of between 1m and 2m in length. That section then fell to the ground when Mr Pirie was within the drop zone near to the base of the tree. The cut section of trunk struck Mr Pirie to the left side of his head and torso, rendering him immediately unconscious and causing injuries from which he died at the scene without regaining consciousness.

[9] The others present rendered assistance to Mr Pirie as best they could and summoned emergency services. Despite the efforts of medical staff who attended the

scene, Mr Pirie was pronounced dead by Dr Shaun McLeod at 10.10am. A subsequent post mortem examination established the cause of death as:

1(a) craniocervical injuries

1(b) incident whilst at work felling trees

[10] The circumstances of Mr Pirie's death were investigated by the Health and Safety Executive ("HSE"), who submitted their report to the Crown Office and Procurator Fiscal Service ("COPFS") on 22 September 2021. COPFS subsequently instructed summary criminal proceedings against Mr Menhinick in relation to a charge alleging contravention of section 3(2) of the Health and Safety at Work etc Act 1974 and a charge of attempting to pervert the course of justice.

[11] Section 3(2) of the Health and Safety at Work etc Act 1974 provides as follows:

> "(2) It shall be the duty of every self-employed person who conducts an undertaking of a prescribed description to conduct the undertaking in such a way as to ensure, so far as is reasonably practicable, that he and other persons (not being his employees) who may be affected thereby are not thereby exposed to risks to their health or safety."

[12] Mr Menhinick pled not guilty to both charges. The case proceeded to trial at Aberdeen Sheriff Court, which concluded on 30 October 2024. Mr Menhinick was found not guilty of both charges.

[13] The Fatal Accident Inquiry in relation to the death of Mr Pirie was mandatory in terms of section 2(3) of the 2016 Act, since Mr Pirie's death was the result of an accident which occurred while he was acting in the course of his employment or occupation.

[14] The first notice in relation to the inquiry, in terms of rule 3.1 of the Act of Sederunt (Fatal Accident Inquiry Rules) 2017 ("the 2017 rules") was issued by the

procurator fiscal on 30 June 2025. A preliminary hearing in terms of rule 3.6 of the 2017 rules was held within Aberdeen Sheriff Court on 3 September 2025. The only participant was the procurator fiscal. Due intimation of the inquiry was given to the family of Mr Pirie, to Mr Menhinick and to the HSE, none of whom chose to enter the proceedings as participants.

[15] The inquiry proceeded before me at Aberdeen Sheriff Court on 27 and 28 November 2025. The procurator fiscal was represented by Ms Ross-Davie, Procurator Fiscal Depute. Mr Pirie's wife, son, brother and sister in law attended the inquiry hearing on 27 November and heard all of the evidence, which was all presented that day. The Crown called as witnesses Leonard Smith, Kevin O'Donnell, Scott Menhinick and Niall Miller, HM Principal Inspector of Health and Safety. In accordance with orders made by me in terms of rules 4.1(4) and 4.2 of the 2017 rules, the evidence was otherwise allowed to be taken in the form of witness statements and reports. I heard Ms Ross-Davie's submissions on the evidence, with reference to the relevant provisions of the 2016 Act, on 28 November. I am grateful to Ms Ross-Davie for her assistance in relation to the presentation and analysis of the evidence.

Summary of evidence presented

Leonard Smith

[16] Leonard Smith, aged 80, gave evidence. He volunteered a number of times during his evidence that his recollection of the morning of this incident was clear, that

he thinks about the events of that morning every day and that he will never forget what happened.

[17] Early on the morning of 25 June 2020 Mr Smith, Andrew Pirie, Mr Pirie's "gardener" Kevin O'Donnell and "the tree surgeon" (Scott Menhinick) assembled on Mr Smith's land in order that Scott Menhinick could take down the two ash trees which Mr Smith wanted to have removed. The morning was very still and not windy. The trees were adjacent to Touks Road, Dunnottar. The particular tree which was involved in the fatal accident was at the junction of Touks Road and an access road or track leading to Middle Touks Farm. Mr Smith was interested in the operation and took a number of photographs of Scott Menhinick as he sectionally felled the tree. The photographs were produced as production 2 and were referred to in evidence. So far as obvious hazards were concerned, not only was this tree in close proximity to both Touks Road and the farm track, the photographs showed that its upper branches were also close to overhead power lines. Scott Menhinick was using ropes to position himself at various points in the canopy of the tree and was using a chainsaw to cut section of timber. In between cuts, the chainsaw could be seen on the photographs dangling from a harness which he wore. Scott Menhinick started by cutting branches, which simply fell to the ground below the tree, as opposed to being lowered on ropes or by any other means. When he had finished removing all of the branches, he began to cut the trunk, again in sections. This was when the fatal accident occurred.

[18] According to Mr Smith, the work was being carried out by Scott Menhinick, who was up in the tree cutting sections of timber with his chainsaw, and by Andrew Pirie

and Kevin O'Donnell, who were on the ground clearing away the cut sections of timber which fell to the ground below the tree. They threw some cut branches over a nearby fence into a field owned by Mr Smith and put other branches through a woodchipper machine which was positioned nearby.

[19] Mr Smith described himself as the "traffic warden," a role he said he took upon himself, rather than having been asked to it by anyone. He stopped cars on a couple of occasions as they approached the point on Touks Road where this tree was situated and asked the drivers to wait until it was safe to pass.

[20] Under reference to Crown production 1 (photographs taken later that day by an HSE inspector in the aftermath of the fatal accident), Mr Smith identified photograph 4 as showing the tree after the branches had been removed. Scott Menhinick then cut a section from the top of the trunk. Mr Smith saw him make a cut at one side of the trunk and then another cut at the opposite side. Scott Menhinick had his hand on the top of the cut section, which was still in place. Andrew Pirie was on the ground at the foot of the tree clearing cut branches. Mr Smith looked along Touks Road for traffic. When he looked back towards the tree, Scott Menhinick still had his hand on top of the cut section of trunk, which was still in place. However, the weight of that section caused it to fall towards Andrew Pirie, who had no chance to avoid it. The cut section of trunk, which was of a significant size, struck Andrew Pirie, who was immediately rendered unconscious. Emergency services were summoned and rendered assistance to him.

[21] Mr Smith's evidence was that he heard no warning or other shout from Scott Menhinick at or prior to the cut section of trunk falling towards Andrew Pirie. All he could hear was the sound of the chainsaw.

[22] Mr Smith was adamant that, although the three men on the ground were able to speak to each other, there was no communication between Scott Menhinick and anyone on the ground when Mr Menhinick was up in the tree cutting sections of timber. He was also adamant that he was not aware of or involved in any discussion that morning with any of the others who were involved in this work about methods of communication between Scott Menhinick and anyone on the ground during the cutting operation.

Kevin O'Donnell

[23] Kevin O'Donnell, aged 63, gave evidence. In June 2020 he worked for Andrew Pirie as a general labourer. On 25 June 2020 he was present during work to take down a mature tree on Leonard Smith's land next to Touks Road, Dunnottar. Andrew Pirie asked Mr O'Donnell to operate the woodchipper machine, which was situated a safe distance from the tree. In addition to Mr O'Donnell and Mr Pirie, the others present were Scott Menhinick, who was to cut down the tree, and Leonard Smith.

[24] Mr O'Donnell was not involved in any discussions with Scott Menhinick about the work. As far as he was aware, any discussions would have taken place between Scott Menhinick and Andrew Pirie. Mr Pirie simply asked Mr O'Donnell to clear the smaller branches cut by Scott Menhinick away from the ground under the tree and put

them through the woodchipper and to keep an eye out for traffic on Touks Road and stop it if necessary. Mr Pirie used a chainsaw to cut up larger sections of cut timber, which the three men on the ground then loaded into Leonard Smith's trailer, because Mr Smith wanted to keep them.

[25] Mr O'Donnell was familiar with the term "drop zone" in relation to tree-felling work. However, Scott Menhinick did not speak with him that morning about where the drop zone in relation to this particular tree would be or about when cut timber would fall and how those on the ground would know when that was about to happen. The drop zone under this tree was not marked by any physical barrier, or in any other way apart from a single traffic cone positioned on the roadway of Touks Road adjacent to the tree (production 4, photograph 1). In addition, a sign was positioned around 300 yards along Touks Road from the tree warning drivers and pedestrians that tree-cutting work was underway ahead. Andrew Pirie did not discuss the location or extent of the drop zone or his expectations as to when and where cut timber would fall with Mr O'Donnell. He simply asked Mr O'Donnell to operate the woodchipper, keep the road clear, maintain observations and otherwise "keep out of the way." Mr O'Donnell did not know who was in overall charge of the work. He personally had no discussion with Scott Menhinick and he took his instructions from Andrew Pirie.

[26] During the cutting operation, there was no communication between Scott Menhinick and anyone on the ground. No radios were used and there was no verbal communication between Mr Menhinick and anyone on the ground in relation to when timber was about to fall and when it was safe for anyone on the ground to enter

the drop zone. The men on the ground simply watched Scott Menhinick to see what he was doing. The sections of timber cut by Scott Menhinick simply fell to the ground, rather than being lowered on ropes or pulleys.

[27] After Scott Menhinick had removed all the limbs from the tree, he started work on the trunk. The first piece of the trunk which he removed was around 6 feet in length with a circumference of around 3 feet. This was when the fatal accident occurred. Mr O'Donnell was standing away from the tree adjacent to the fence running along the opposite side of Touks Road (Crown production 1, photograph 4). Andrew Pirie was standing nearby, further along the line of the same fence. Scott Menhinick was up in the tree, cutting a section of timber from the top of the trunk. Mr O'Donnell turned away to light a cigarette. When he had done that and turned back around towards the tree he saw that Andrew Pirie had made his way to the base of the tree and was cutting up a section of timber on the ground with his chainsaw. Mr O'Donnell initially assumed that Scott Menhinick had stopped cutting. However, he had not. As soon as he realised that Mr Menhinick was still cutting timber from the top of the trunk, Mr O'Donnell shouted to warn Andrew Pirie, but he was not able to make himself heard above the noise of the two chainsaws. In addition, everyone was wearing ear protectors. Andrew Pirie did not hear Mr O'Donnell. The large section of trunk cut by Scott Menhinick then fell and struck Mr Pirie, who fell to the ground unconscious. Mr O'Donnell and Leonard Smith ran to Mr Pirie. Leonard Smith phoned for emergency services and then handed the phone to Mr O'Donnell, who followed the operator's instructions and rendered such

assistance as he could until a fast response paramedic vehicle arrived and the crew took over.

[28] Mr O'Donnell's evidence was that there was no communication from Scott Menhinick at or around the point in time at which the final section of timber fell and struck Andrew Pirie.

Scott Lee Menhinick

[29] Scott Lee Menhinick, aged 46, gave evidence. Mr Menhinick is an arboricultural area supervisor employed by Aberdeen City Council. In that role, which he has held for 7 years, he supervises all of Aberdeen City Council's arborists (employees concerned with the care of trees). He has worked as an arborist for approximately 16 years. Although Mr Menhinick now only undertakes work in his official role with Aberdeen City Council, he did previously also undertake other work of the same kind privately, in addition to his duties with Aberdeen City Council, including work to take down a tree on Leonard Smith's land on 25 June 2020.

[30] According to Mr Menhinick's evidence, he was "contracted in" by Andrew Pirie to dismantle an ash tree belonging to Leonard Smith. Mr Menhinick's role was to climb and dismantle the tree. Andrew Pirie was in charge of "ground operations." Mr Pirie used a chainsaw to cut up branches into smaller pieces which would either be put through a woodchipper or into a trailer so that they could be retained by Leonard Smith. The woodchipper was mostly operated by Andrew Pirie's labourer Kevin O'Donnell, but sometimes by Leonard Smith.

[31] When asked whether he had carried out any risk assessment prior to commencing this work, Mr Menhinick said that he asked Andrew Pirie to put cones and signs up to warn traffic approaching from either direction on Touks Road that there was a potential hazard on the road and to keep traffic away from the side of the road closest to the tree. One of the cones is shown in Crown production 1, photograph 4, situated on Touks Road adjacent to the tree which was involved in this incident. A sign was positioned around a hundred yards along Touks Road on one side of the tree (to the right in photograph 4) stating that a tree-cutting operation was in progress ahead. Adjacent to that sign, a number of plastic cones were placed on the roadway to encourage vehicles approaching the tree to move towards the right-hand edge of the road so as to keep them away from the left-hand verge, where the tree was situated. In addition, a "men at work" sign was placed 50 yards or so to the other side of Touks Road from the tree (to the left in photograph 4), which was intended to serve a similar purpose for traffic approaching the tree from that direction. Andrew Pirie was to look out for approaching traffic from the right and Leonard Smith was to look out for approaching traffic from the left, all as part of the ground operations for which Andrew Pirie was to be responsible.

[32] It was clear from his evidence that Mr Menhinick did not regard himself as having any responsibility for anything that happened on the ground or for any risks to anyone on the ground during the cutting operation carried out by him, even though he confirmed that no one on the ground had any control over his activities, which were all carried out at his discretion. He was using a "freefall" technique to remove sections of

timber. In other words, the cut timber was simply allowed to fall into the drop zone (which Mr Menhinick described as the ground below the tree, extending over the circumference of the tree canopy), rather than being lowered on ropes or pulleys. The sections of branch cut by him would have been up to 6 feet in length. The largest section of trunk cut by him was approximately 1 metre long and between 12 and 20 inches in circumference.

[33] When asked whether there had been any discussion about methods of communication between him and the men on the ground prior to the commencement of the work Mr Menhinick's evidence was that, as part of the "verbal risk assessment" which he said he had carried out on the day, he gathered the three other men at the base of this tree, pointed out the drop zone to them and told them that they were not to enter the drop zone whilst his chainsaw was running. He also told them that, after he had cut a section of timber, he would switch off his chainsaw and give a "double thumbs up" signal to indicate that it was safe for them to enter the drop zone and work on the cut timber. He told them that they were only to enter the drop zone when his chainsaw was switched off and he gave the "double thumbs up" signal. Mr Menhinick's evidence was that he had decided to use hand signals because verbal communication would not be reliable above the noise of the two chainsaws (used by him and Andrew Pirie) and the woodchipper. In addition, everyone apart from Leonard Smith was wearing ear protectors. Mr Menhinick stated that he did not consider the use of radios as a means of communication. He has never used them during a tree-felling operation. He did not

consider them to be cost effective or reliable. He has only ever used hand signals as a means of communication during tree-felling work.

[34] Mr Menhinick accepted that the drop zone was not marked out by any physical barrier, but his evidence was that there is no requirement to physically mark the drop zone if fewer than five people are on site.

[35] Mr Menhinick gave evidence that, before making any cuts, he visually checked that no one was on the ground below him and that, having made a cut and sent timber into the drop zone, he would visually confirm that the men on the ground had completed their work on the cut timber and had safely moved out of the drop zone before moving on to his next cut.

[36] Mr Menhinick stated that he is trained to cut timber using the recognised freefall technique. An alternative is the rigging technique, where sections of timber are lowered on ropes so that they do not freefall. He accepted that the rigging method limits the risk of harm to anyone on the ground.

[37] So far as the fatal incident was concerned Mr Menhinick's evidence was that, having removed the limbs from the tree, he had started work on the trunk. Before making his final cut he checked and saw that both Andrew Pirie and Kevin O'Donnell were safely out of the drop zone. He then made a "step cut" to remove the top section of trunk. This involved making a horizontal cut from one side of the trunk to slightly over half of the thickness of the trunk, and then another horizontal cut from the opposite side of the trunk, again to slightly over half of the thickness of the trunk, but at a slightly different level from the first cut. The end result was that the cut section of trunk was

held in place by the thin piece of timber near the centre of the trunk which had been left intact by the two previously described cuts. Mr Menhinick explained that this technique allows the arborist to "rock" the cut section in order to dislodge it under its own weight. However, just as he had completed the second part of his step cut, the spikes attached to his legs, which he used to hold himself in position, slipped. He switched his chainsaw off and let it swing from his harness. He repositioned his spikes and dug them into the tree trunk. Before he had the opportunity to "rock" the cut section in order to dislodge it, there was a gust of wind which caused the entire trunk to rock slightly, as a result of which the cut section became dislodged and fell. According to Mr Menhinick, it was only then that he realised that Andrew Pirie had re-entered the drop zone and was using his chainsaw to cut a section of timber near to the base of the tree. The section of trunk cut by Mr Menhinick fell and struck Mr Pirie. There was no time for Mr Menhinick to shout any verbal warning.

[38] When reminded of his earlier description of the safety procedures which he had said that he had put in place that morning, whereby no one was to enter the drop zone until he had switched his chainsaw off and given the double thumbs up signal and he would not begin any further cutting until those on the ground had finished working on the cut timber and had left the drop zone, Mr Menhinick was asked what Andrew Pirie would have been working on within the drop zone at that moment. His response was that Mr Pirie appeared to have chosen that moment to enter the drop zone, approach the base of the tree and roll two pieces of cut timber which had been lying on a grass verge

close to the base of the tree out from the verge so that he could cut them into smaller pieces with his chainsaw.

[39] According to Mr Menhinick, the safety procedures he described had allowed this work to proceed safely for approximately 2 hours until this fatal incident. He attributed the fatal incident to a moment of poor judgment on the part of Andrew Pirie, who had entered the drop zone when it was not safe to do so, contrary to the procedures which Mr Menhinick had stipulated.

[40] When asked to comment on the evidence given by Leonard Smith and Kevin O'Donnell to the effect that there had been no discussion of methods of communication prior to the commencement of the work that morning and on the fact that neither of those witnesses had referred in their evidence to Mr Menhinick having gathered them at the base of the tree for a discussion of the extent of the drop zone and the safety procedures to be followed, including the use of hand signals, Mr Menhinick suggested that they must simply have forgotten that part of the morning's events.

Niall Douglas Miller

[41] Niall Douglas Miller, aged 57, HM Principal Inspector of Health and Safety, gave evidence in relation to the investigation conducted by the HSE. The HSE became involved because Mr Pirie's death occurred as a result of an accident in the course of his work. HSE inspectors attended the scene on the day of this incident and commenced their enquiries, including taking a number of photographs which were referred to in evidence. Mr Miller explained that, when investigating any fatal incident in the course

of employment, the HSE would look in particular at how the relevant worksite was managed, whether any potential risks to safety were identified, acknowledged and managed and whether those who undertook the work which was ongoing at the time of the fatal incident were competent.

[42] Photographs 2, 3, 4, 7, 10, 11, 20, 22 and 26 from Crown production 3, taken by an HSE inspector on the day of this fatal accident, appeared to show cut branches piled in a somewhat chaotic manner close to this tree. In Mr Miller's opinion this appeared to indicate that the worksite was messy, with no clear demarcation of the drop zone relative to the cutting operation.

[43] Having regard in particular to the proximity of the tree to a road and to overhead powerlines, it was important that the work was well planned in advance. As part of that planning, Mr Miller would have expected the drop zone to be physically marked in order to make its scope and limits clear to anyone who may have been in the vicinity, whether involved in the work, motorists or pedestrians. Responding to evidence given by Mr Menhinick, Mr Miller confirmed that he had never heard of any rule whereby a drop zone did not require to be physically marked so long as fewer than five people were on site. No such rule had been identified by Paul Hanson, the expert instructed by HSE to provide an opinion. The single cone placed on the roadway of Touks Road adjacent to the tree was not adequate as a means of marking the drop zone. Consideration should have been given to a suitable means of physically marking out the limits of the drop zone, for example by placing a number of cones around the limits of the drop zone and connecting the cones by coloured plastic tape or rope wrapped

around the top of the cones, a method which Mr Miller has previously seen used during work of this kind.

[44] In Mr Miller's opinion, the "tree-cutting in progress" sign placed several hundred yards along Touks Road from the tree was ineffectual as a safety measure. It did not provide a proper warning to motorists of the precise nature of the hazard, and it was not situated close enough to the worksite to have any meaningful impact.

[45] Mr Miller described a process of work whereby timber is cut using the freefall method and individuals on the ground work in the drop zone below as "incredibly dangerous" with the result that, if the freefall method is to be used, very careful consideration requires to be given to the management of the resulting risk to people on the ground. In particular, effective lines of communication between those conducting the cutting and those on the ground require to be carefully planned and clearly disseminated to and understood by all concerned in advance. In Mr Miller's opinion, the preferred means of communication for larger tree-cutting operations is the use of radios. If radio communication is not possible, some other clear method of communication requires to be identified and clearly understood by everyone involved in the work, to ensure that no cutting at height is undertaken when anyone is working on the ground within the drop zone and that no-one enters the drop zone whilst cutting is being carried out. That can be achieved by verbal communication or the use of hand signals, so long as the method chosen is clearly understood and consistently adhered to by everyone involved in the work.

[46] The photographs referred to by Mr Miller (photograph 26 in particular) appeared to indicate that timber had been cut from the tree in large sections, which had been allowed to fall to the ground. The risks to people on the ground arising from this approach could have been reduced by cutting the timber in smaller sections or by lowering larger sections using ropes or a pulley system.

[47] Mr Miller made reference to production number 8, an expert report provided on the instruction of HSE by Paul Hanson, a highly qualified and experienced expert in relation to arboricultural and forestry practice. Mr Hanson's report was instructed in order to ensure that the HSE's investigation had the benefit not only of HSE's general expertise in relation to safe working practices but also Mr Hanson's particular expertise in relation to the work which was being undertaken at the time of this fatal accident. Mr Hanson was provided with all of the witness statements and photographs which were gathered during the investigation. Mr Miller commended the conclusions expressed in Mr Hanson's report.

[48] In conclusion, Mr Miller expressed the opinion that precautions that could have avoided this fatal accident would have included a comprehensive discussion onsite involving all of those present which agreed the size of the sections of timber which were to be allowed to fall and the direction in which they were to be allowed to fall, the dimensions of the drop zone, the means of marking the limits of the drop zone (preferably by means of a physical barrier such as plastic tape or rope attached to appropriately positioned cones or markers), a properly planned and understood system for taking down cut timber, whether by allowing it to fall or by lowering it using a rope

or pulley system and clear agreement, understanding and adherence to an effective means of communication between Scott Menhinick and those working on the ground, whether involving radio communication, a reliable means of verbal communication or the use of clearly understood hand signals.

[49] Mr Miller identified a number of guidance documents, either issued by the HSE or with input from the HSE, concerning best practice in relation to tree-felling work conducted at height, all of which are freely available via the HSE website. The most directly applicable source of guidance is the Industry Code of Practice for Arboriculture, Second Edition (2020) published by the Arboricultural Association with input from the HSE. Although the guidance in that document focuses largely on the safety of workers conducting tree-cutting operations at height, section 3.4.6 ("Site conditions") sets out best practice in relation to the identification and control of the drop zone, so as to address the risk of injury from falling objects.

[50] Mr Miller observed that Mr Hanson's report identified a number of defects in the system of work which had contributed to this fatal accident. At its most basic, if effective steps had been taken to keep ground workers out of the drop zone whilst tree-cutting was being undertaken, this fatal accident could not have happened.

Expert report by Paul Hanson dated 5 May 2021

[51] Mr Hanson's report dated 5 May 2021, prepared at the request of the HSE, designs him as an "Arboricultural Engineer" and his CV (beginning at page 19) confirms that he is a highly qualified and experienced expert in relation to arboricultural and

forestry practice. In addition to the witness statements, reports and photographs which were made available to him for consideration, Mr Hanson also had access to information about Scott Menhinick's experience and training in arboriculture in his capacity as an employee of Aberdeen City Council.

[52] Paragraph 2.a.2 of the report identifies impact from falling material as a recognised "major hazard" associated with sectional felling work of the kind undertaken during this incident (along with falls from height and injuries caused by chainsaws). Paragraph 2.a.3 of the report notes that:

> "The fatal injury rate (7.73 per 100,000 workers) [remained] higher in 2020 than any other main industry sector and around five times as high as the rate in construction and 18 times as high as the all-industry rate."

[53] Paragraph 2.b.1 of the report commends the Industry Code of Practice for Arboriculture, Section Edition (2020), published by the Arboricultural Association with input from HSE, as a source of guidance in relation to fundamental principles of planning work of this kind.

[54] Paragraph 2.b.2 of Mr Hanson's report is in the following terms:

> "Work at height planning should consider the access and egress, terrain and available working space. In particular, careful consideration must be given to the area in which the material severed at height is to be dropped or lowered – a 'drop zone.' A means to prevent unauthorised or accidental access/entry to the drop zone is essential, this may take the form of physical barriers or a pre-determined method of communication between aerial and ground-based operators may be adequate."

[55] Paragraph 2.b.3 of Mr Hanson's report is in the following terms:

> "Where there are constraints to the establishment of a drop zone, it is good practice to reduce the size/weight of the material being removed to that which

> can comfortably be hand-held or controlled, this allows the arborist to visually check the drop zone is clear before casting the severed material into it."

[56] Section 2.c of Mr Hanson's report confirms, on the basis of review of Scott Menhinick's professional experience and training, that he appeared to have been comprehensively trained for aerial work of this kind and that, taking account of his long experience of conducting this work, "it is reasonable to assume that his skill level and understanding of sectional felling was that of a competent operator."

[57] Paragraph 2.c.6 of the report identifies a number of examples of poor practice from the photographs reviewed by Mr Hanson. These include the fact that the work was undertaken at all in close proximity to overhead electricity cables, inadequate arrangements for the management of traffic passing the worksite on Touks Road and the fact that large pieces of timber, including the section of trunk which struck Mr Pirie, were allowed to fall to the ground. Best practice required that, given the proximity of the tree to the road, timber should have been removed either in smaller hand-held sections or by lowering larger sections on ropes in order to avoid potential damage to the road surface, quite apart from the risk of injury to anyone working on the ground.

[58] In the context of responsibility for ensuring that this work was undertaken in a safe manner, paragraph 2.d.1 of Mr Hanson's report is in the following terms:

> "The responsibility for safeguarding the danger zone (drop zone) presented by falling timber is in all cases the responsibility of the competent person on site. [Scott Menhinick] was the only competent person on site in respect of sectional felling works and was, as the operator at height, entirely responsible for the control and timing of the severing and falling of tree material. It is reasonable to expect [Scott Menhinick] to have exercised control of the design and implementation of suitable measures [to] prevent anyone entering the drop zone unexpectedly. Best practice dictates that a drop zone is agreed with the entire

> working party and an appropriate means of controlling access to the drop zone is agreed and understood by all members of the working party before works commence. The ground-based operators and [Scott Menhinick] should have agreed a suitable means of communication between them to ensure that any falling timber could only be released into the drop zone once [Scott Menhinick] was certain it was safe to do so. It is reasonable to expect [Scott Menhinick] to have taken the lead in managing this aspect of hazard and risk management (as it relates to sectional felling) as he is appropriately trained and experienced in this type of operation."

[59] With regard to the fatal incident, Mr Hanson noted at paragraph 2.e.1 of his report that "in general terms none of the work appears to have been properly assessed, planned, controlled or executed." He did however conclude (paragraph 2.e.4) that sectional felling was an appropriate method for removing this tree, given its proximity to a public road and overhead electricity lines.

[60] At paragraph 2.e.7 of the report Mr Hanson expresses the following opinion:

> "No generic or site-specific risk assessments or method statements have been presented; the witness statements produced do not suggest that even an informal risk assessment had been undertaken. Even the most basic risk assessment would have involved a conversation about the location of the drop zone and control of access to it. I would expect [Scott Menhinick] to be very familiar with site-specific risk assessments as part of his main employment and to have taken the lead in circumstances where the members of the working party were less experienced. The tasks that [Scott Menhinick] was engaged to perform at Kirkton of Fetteresso were those with the greatest potential to cause harm, injury or damage and he was best placed to identify suitable controls to minimise the associated risk."

[61] Mr Hanson expresses the following conclusions in part 3 of his report:

> "3.1 The working party did not plan the work required on 25 June 2020 in accordance with legislative requirements and current best practice.
> 3.2 [Scott Menhinick] was appropriately trained, experienced and competent in the work he was employed to undertake. [Scott Menhinick] was trained in the area of hazard and risk assessment particular to tree work at height. He was required to participate in a site-specific risk assessment in some form on 25 June

2020, it appears he did not. [Scott Menhinick] was in a position to call off the works due to poor planning, he did not.

3.3 [Scott Menhinick] ascended/descended to various working positions that allowed him to make branch removal cuts, he then proceeded to remove vertical timber sections. The timber lying beneath the ash tree is of a large size and weight that is not feasible to be removed in hand-held sections, rather it was removed using free fall techniques. Good practice dictates that in the circumstances timber sections should have been removed in smaller sections to avoid uncontrolled timings and directions of fall and damage to the road surface; [Scott Menhinick] ignored this good practice.

3.4 The injuries to the deceased were caused through the actions of the working party in that they:

3.4.1 Failed to undertake an adequate assessment of hazards and risks.

3.4.2 Failed to identify, mark and agree an appropriate drop zone.

3.4.3 Failed to secure the drop zone to prohibit any unauthorised or unplanned access to it.

3.4.4. Failed to establish an effective means of communication between the aerial and ground-based operatives.

3.4.5. Severed very large sections of timber with no practical means of controlling the timing or direction of fall.

3.4.6. Specifically failed to prevent the deceased working in the drop zone whilst timber was being felled above him."

Comments made by Scott Menhinick during the investigation

[62] A statement given by Detective Inspector Jackie Knight described that officer's attendance at the scene at about 11.25am on 25 June 2020. In addition to a description of the unfolding investigation, the statement also records the brief account given at the scene by Scott Menhinick, to the effect that he checked the drop zone prior to cutting the section of timber which struck Andrew Pirie, that he noted that Mr Pirie was standing approximately 10 metres away outwith the drop zone but that, after making the final cut, he realised that Mr Pirie had walked into the drop zone.

[63] A statement given by Police Sergeant Thomas Bashforth stated that he attended at Mr Menhinick's home on Saturday 27 June 2020 in order to advise him that the HSE

would be leading the investigation of this incident. Sergeant Bashforth did not question or note a statement from Mr Menhinick but Mr Menhinick, who was visibly upset, told him that prior to making the final cut of the section of timber which struck Andrew Pirie, he had made a final check of the area into which he expected that section to fall and saw that it was clear and that it was safe to proceed.

[64] The accounts given by Mr Menhinick to these officers, although brief, appear to me to have been generally consistent with the evidence he gave at the inquiry hearing.

Statement of Michael Pirie

[65] Andrew Pirie's son Michael Pirie provided a witness statement on 6 January 2021, during which he described an incident in May 2020 when, during a period of furlough from his regular employment during the COVID-19 pandemic, he assisted his father on a casual basis with outdoor gardening and groundwork. One day in May 2020, Andrew Pirie was engaged on a job in the Stonehaven area, during which tree-felling work was required. The tree-felling was undertaken by Scott Menhinick, who was to be paid by the property owners for his work. Michael Pirie's statement described that work as having been undertaken by Scott Menhinick in a manner which failed to address the risks posed to Michael and Andrew Pirie as a result of falling timber.

[66] According to the statement, there was no system in place to prevent Michael or Andrew Pirie from entering the drop zone beneath the trees whilst cutting was in progress, Scott Menhinick did not tell Andrew and Michael Pirie where to stand during

the cutting work and did not direct them to stay away from the drop zone. Although Mr Menhinick did look in their direction a few times, he generally cut timber without checking whether they were in the drop zone below. He did not tell them when he was cutting, or when he had stopped cutting. In a similar manner to the work undertaken on 25 June 2020, Michael and Andrew Pirie entered the drop zone during the cutting operation to remove cut timber, some of which was put through a woodchipper. According to Michael Pirie's statement, he and his father had to maintain observations of Scott Menhinick's activities in order to address the risks to them. His impression was that Mr Menhinick "just wanted the job over and done with. He was doing a lot of cutting in a short space of time."

Crown submissions

[67] Ms Ross-Davie helpfully prepared written submissions on behalf of the Crown, which were lodged in process and presented on the second day of the inquiry. No purpose would be served by rehearsing those submissions in detail here. They are generally consistent with my analysis of the evidence and with my determination.

Analysis and conclusions

[68] I accepted the expert evidence of Niall Miller and the opinions expressed by Paul Hanson in his report and I have incorporated those into my determination.

[69] I accepted the evidence of fact given by Leonard Smith and Kevin O'Donnell as credible and reliable. It was clear that both were profoundly affected by the events of

25 June 2020. In addition to their general descriptions of the events of that day, which featured a number of predictable and understandable contradictions in relation to matters of surrounding detail, I accepted their evidence that they were not involved in or made aware of any discussions concerning the dimensions or demarcation of the drop zone, when and where they should expect felled timber to land, the use of hand signals or any other means of communication between Scott Menhinick and anyone working on the ground, or indeed any other safety measures beyond rudimentary arrangements for traffic management and a basic understanding that they should maintain observations and generally look out for their own safety.

[70] It follows that, although I accepted Scott Menhinick's evidence with regard to his general description of the work which he undertook that day, I did not accept as credible and reliable his evidence to the effect that he gathered the others together at the base of the tree before he commenced cutting, pointed out the drop zone, told the others not to enter the drop zone whilst his chainsaw was running, and told them only to enter the drop zone when his chainsaw had been switched off and he had given a "double thumbs up" hand signal. I prefer the evidence of Leonard Smith and Kevin O'Donnell that there was no such discussion prior to the commencement of the work.

[71] I also do not accept as credible and reliable Scott Menhinick's evidence that he did in fact use the "double thumbs up" hand signal to indicate to the men on the ground that it was safe for them to enter the drop zone, prior to the fatal accident. This work had been under way for around 90 minutes by the time of the fatal accident, during which time all of the limbs of the tree had been removed. If the hand signals described

by Scott Menhinick had been used by him during that period, I would have expected Mr Smith and Mr O'Donnell to have seen them and to have referred to them in their evidence. They did not refer to them, which leads me to conclude that no such signals were used by Mr Menhinick.

[72] This analysis of the eyewitness evidence in relation to these significant issues is supported by the terms of Michael Pirie's witness statement concerning Scott Menhinick's apparent approach to safety issues on an occasion in May 2020 when he had carried out sectional tree-felling work as part of another job undertaken by Andrew Pirie in the course of his business. In combination, Michael Pirie's statement and the evidence of Leonard Smith and Kevin O'Donnell point to the conclusion that, on 25 June 2020, Mr Menhinick's approach to the assessment and management of risks to those working on the ground did not reflect best industry practice.

[73] As Paul Hanson concluded in his report, the responsibility for the safe execution of this work on 25 June 2020 rested with the work party as a whole. However, as Mr Hanson also observed, given that the focus of the work was tree-felling at height and that Scott Menhinick was the only person present who was qualified to undertake that work, it seems reasonable to conclude that he bore a particular responsibility for the assessment and management of the obvious risk, to himself and others, arising from the work which he alone undertook that day, including the risks to those working on the ground from falling timber.

[74] It appears to me that the evidence fully supports the conclusions reached by Mr Hanson with regard to the defects in the system of work which contributed to this

entirely avoidable fatal accident. I accept Mr Hanson's conclusions and they are reflected in my determination.

[75] There are two issues which could not be definitively established by the evidence with regard to the circumstances of this fatal accident. The first was precisely why the section of timber which struck Andrew Pirie fell at the point in time when it did; in other words, whether it fell as a result of Mr Menhinick's deliberate act in the course of his work, when he was unaware that Andrew Pirie was working on the ground below, or whether, having been cut by Mr Menhinick, it fell at that precise point in time due to the rocking motion of the trunk as a whole rather than as a result of Mr Menhinick's deliberate act, as suggested in Mr Menhinick's evidence.

[76] The second issue is precisely why Andrew Pirie chose to enter the drop zone when he did, at the time of the fatal accident. According to the evidence of Leonard Smith, Kevin O'Donnell and Scott Menhinick, Mr Menhinick was either in the course of cutting the final section of trunk or had just finished cutting it, but the section had not yet fallen, when Andrew Pirie entered the drop zone. The evidence did not indicate the presence of any particular obstruction which would have prevented Mr Pirie from being able to see, at the point when he entered the drop zone, that Mr Menhinick was either still cutting or had just finished cutting a section of timber, which had not yet fallen.

[77] However, neither of these unresolved issues obscures the essential cause of this fatal accident, which was that the final section of trunk cut by Mr Menhinick fell into the drop zone whilst Mr Pirie was working on the ground at the base of the tree. Whatever

the reason for the final section of timber falling when it did and whatever the reason for Andrew Pirie entering the drop zone when he did, had there been a clearly identified and understood method of communication between Scott Menhinick and the others to indicate when it was safe for anyone on the ground to enter the drop zone - which I am satisfied there was not - the scope for anyone working on the ground to have entered the drop zone whilst there existed any risk of injury from falling timber would have been removed or at least reduced. I am satisfied that there was no clearly identified and understood method of communication and that this created scope for misunderstanding as to when the drop zone could safely be entered by Andrew Pirie or any of the others working on the ground.

[78] The drop zone should have been, but was not, clearly marked out. However, on its own the marking of the drop zone would have represented a limited means of reducing risk without a clearly identified and understood method of communication between Scott Menhinick and the others to indicate when it was safe for anyone on the ground to enter it.

[79] Limiting the size of sections of timber which were to be allowed to fall into the drop zone, or lowering larger sections of timber on ropes or pulleys rather than allowing them to fall into the drop zone is another measure which is likely to have reduced the risk to workers on the ground, even in the event that they entered the drop zone when it was not safe to do so.

[80] My determination identifies a number of precautions which could reasonably have been taken and, had they been taken, might realistically have avoided the accident

which resulted in Mr Pirie's death, and a number of defects in the system of working which contributed to this fatal accident, all of which are informed by my assessment of the evidence generally but more particularly by the evidence given by Niall Miller and the conclusions expressed by Paul Hanson in his report.

[81] It is clear from the evidence that Scott Menhinick was experienced in this work and that he was adequately trained and competent to carry the work out safely, although the evidence points to the conclusion that the work was not carried out safely. It is also clear that the leading industry code of practice, namely the Industry Code of Practice for Arboriculture (Second Edition), published in May 2020 by the Arboricultural Association with input from the HSE, particularly section 3.4.6 "Site conditions," provides clear and easily accessible guidance on the identification and management of the very risks which were highlighted by the circumstances of Andrew Pirie's death. That guidance is consistent with the conclusions expressed in Paul Hanson's report. The evidence demonstrates that the guidance set out in the code of practice was not followed when this work was undertaken on 25 June 2020.

[82] I do not feel that I am in a position to make recommendations which would improve upon the contents of the code of practice. However I am concerned to ensure that the terms of the code of practice are disseminated, understood and followed as far as possible by those who undertake tree-felling work at height, with all of the resulting risks to themselves and to people on the ground.

[83] Having regard to section 26(5)(b) of the 2016 Act and having taken advice from the HSE, it appears to me that the Arboricultural Association is the leading professional

body in the UK arboriculture industry and that it has a particular interest in the prevention of deaths in similar circumstances to those which resulted in the death of Andrew Pirie. Accordingly, in terms of section 26(1)(b) and (4) of the 2016 Act and with a view to preventing other deaths in similar circumstances, I have recommended that the Arboricultural Association considers whether there are further steps it can take to maximise awareness within the arboriculture industry throughout the UK of the contents of the Industry Code of Practice for Arboriculture, and in particular section 3.4.6. If there are further steps it can take to that end, I recommend that those steps be taken. I have also recommended that the Arboricultural Association considers whether the code of practice requires to be amended or revised in light of the circumstances of the death of Andrew Pirie, as set out in this determination.

[84] I wish to extend the court's condolences to Mr Pirie's family, who have suffered the loss of Mr Pirie in these most tragic and unfortunate circumstances. I wish to record that Ms Ross-Davie also extended the condolences of the Crown to Mr Pirie's family during her submissions on the second day of the inquiry hearing.