SHERIFFDOM OF TAYSIDE CENTRAL AND FIFE AT DUNDEE

UNDER THE FATAL ACCIDENTS AND SUDDEN DEATHS INQUIRY (SCOTLAND) ACT, 1976

Determination and Note by Sheriff Richard Alexander Davidson into the death of Andrezej Freitag.

FORMAL DETERMINATION

Dundee, 29th. March, 2010.

In terms of Section 6 of the Fatal Accidents and Sudden Deaths Inquiry (Scotland) Act, 1976, I am required to make a formal determination setting out the following circumstances of the aforementioned death, so far as these have been established to my satisfaction, namely:-

(a) where and when the death and any accident resulting in the death took place;
(b) the cause or causes 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 avoided;
(d) the defects, if any, in any system of working which contributed to the death or accident resulting in the death; and
(e) any other facts which are relevant to the circumstances of the death.

In fulfilment of the foregoing statutory requirements, I hereby determine that:-

1. Andrezej Freitag died in the Intensive Care Unit of Ninewells Hospital, Dundee at about 13.00 hours on 30th. May, 2008 as a result of an accident in the course of his employment with Discovery Homes (Scotland) Limited, a company incorporated under the Companies Acts and having its registered office at Unit 1.1, Exodus House, 45 High Street, Kinross, Perth & Kinross, KY13 8AA, whilst working on a building site at the former Tay Spinners Limited's factory site at Arbroath Road, Dundee, undertaking the construction of flatted dwelling houses, where he fell from the top to the middle floor down a smoke extraction shaft, the edge of which was unguarded.
2. His death was as a result of sustaining multiple injuries caused by blunt force trauma caused by the fall. The accident resulting in his death occurred as a consequence of him falling down a smoke extraction shaft from the top floor of the block of flats there under construction to the middle floor, on to a concrete stair landing, a vertical distance measured at 2.91 metres. The edge of the shaft from which he fell was unguarded. It was not clear what facet of his work the deceased was undertaking at the time of this occurrence. He was supposed to be pouring and screeding concrete to form stairs whose metal outline had already been fixed into place, the stairs concerned being those leading from the landing of the top floor to the middle floor, from which top floor landing he fell.

3. It would have been a reasonable precaution to guard the unguarded edge of the smoke extraction shaft on the top floor of the flats under construction with an appropriate form of rigid guard to an appropriate height, and having regard to the provisions of the Work at Height Regulations, 2005.
4. The system of working at the site was defective in the following respects:-
    (a) there was no system for ensuring that all edges from which people at work could fall were adequately guarded;
    (b) there was no one in the employment of Discovery Homes (Scotland) Limited with sufficient competence and ability to undertake an effective risk assessment of the intended works nor was there anyone in their employment with adequate knowledge or interest in the maintenance of a safe site;
    (c) no risk assessment had been undertaken and recorded; and
    (d) insofar as there was an independent review of safety on the site carried out by Alexander Whyte of the Murray Safety Group, from time to time, there was no system for seeing to it that all the defects in the safety provisions which he brought to the attention of Discovery Homes (Scotland) Limited were rectified.
    (e) it is at least arguable on the balance of probability that the system of delivery of concrete by tub loaded on to the crane into the stairwell where the concrete was required was ill conceived and a contributory factor in this accident. There was a concern, which may or may not have had any merit, that the tub might strike and damage the existing structure of the stairwell into which it was being deposited and it is possible that at the time of his fall, Mr. Freitag was attempting to prevent the concrete tub from colliding with one of the existing brick walls of the stairwell.
    (f) Mr. Pratt, who was the designated CDM co-ordinator for the site, was not a competent person to undertake the duties imposed upon CDM co-ordinators.

5. Other facts relevant to the circumstances of the death are:-

(i) There is not an adequate number of Health & Safety Inspectors in the employment of the Health and Safety Executive in Scotland to maintain an adequate system of independent inspection of building sites to oversee the maintenance of reasonable standards of health and safety on such sites;

(ii) It is not the practice of the Health and Safety Inspectorate, after one of their number has issued a Prohibition Notice in terms of section 22 of the Health and Safety at Work etc Act, 1974, to re-inspect the site on being informed by the person on whom the Notice has been served that the defects identified have been rectified and they accept information from such persons at face value; this absurd practice must be terminated and re-inspection must take place prior to the withdrawal of the Prohibition Notice.

(iii).Not enough individuals with positions of responsibility for site health and safety are prosecuted when offences occur under the Health & Safety at Work etc Act, 1974 or associated Regulations; and

(iv) clients undertaking work of construction which requires to be notified under the Construction (Design and Management) Regulations, 2007 are only required to appoint a CDM Co-ordinator and it is that person who is responsible for completing the document notifying the Health and Safety Executive of the particular notifiable work. Regulations should be varied to require that evidence of the competence of the CDM Co-ordinator is

demonstrated to the Health and Safety Executive and that there is in existence a health and safety policy and a risk assessment particular to the site.

Richard Alexander Davidson, Sheriff of Tayside, Central and Fife at Dundee.

NOTE

1. This was a particularly sad occurrence involving the death of a Polish national, Andrezej Kazimierz Freitag, a 55 year old gentleman, born 18th. February, 1953, married with a family, who had come to Scotland to find work in the building trade, in which he had worked all his life, in an effort to better himself and to improve life for his family, only for him to meet his untimely death on 30th. May, 2008 as a direct result of a fall on the building site on which he was working, he having fallen the relatively short distance of 2.91 metres on to concrete, down a smoke extraction shaft from the top floor of a block of flats under construction to the middle floor. Had the exposed edge of the landing on which he must have been standing at the material time been guarded at the edge of the extraction shaft, then it is singularly unlikely that the death would have occurred. There were, however, no direct eye witnesses and it is simply not known exactly what Mr. Freitag was doing at the time of the fall nor why he was at this location.

2. The accident occurred at about 09.00 on Thursday, 29th. May, 2008 at a building site where there were a number of flats and town houses being constructed by Discovery Homes (Scotland) Limited, ("DHSL") whose registered office is at Unit 1.1, Exodus House, 45 High Street, Kinross KY13 8AA. The site was in Dundee where the former Tay Spinners factory had been, bounded on the south by Arbroath Road, on the east by Morgan Street, on the north by Craigie Street and on the west by Kemback Street. The work comprised the demolition of most of the former factory though with the retention of some of the original structures and the outer brick wall façade in part. Thereafter, in stages, 90 dwelling houses, being either flats or town houses, were to be constructed. DHSL were, as I understand it, the owners of the site, the developers and the main contractors. The evidence was to the effect that this was the first development undertaken by DHSL and the first where their managing director, Richard Lionel John Pratt, held the position of managing director, his recent previous experience having been of being a site agent, for a relatively short period of time, and prior to that, having been in the business of recruiting workers to work on construction sites and prior to that his experience was in the armed services. All those who gave evidence identified him as the person responsible for matters relating to health and safety on this site and he did not demur from that identification. However, despite his contrary view, he simply did not have the knowledge or experience to take on that responsibility. It is also appropriate to record that he initially lied to Police Constable Jamie Buchanan and to Murray Provan, Health and Safety Inspector, about the presence of a road traffic type barrier

which he claimed had been in position at the material time at the unguarded edge to the smoke ventilation shaft from which Mr. Freitag fell.

3. DSHL is a private limited company with the company number 300362 and which was incorporated on 6th. April, 2006. Its directors are Richard Pratt and Linda White, both of whom gave evidence to the Inquiry. It employed a workforce of about 20 building workers, nine or so of whom were Polish in origin. Mrs. White's responsibilities lay substantially in the fields of sales and marketing, though it is instructive that some people regarded her as having a responsibility for site safety when Mr. Pratt was not on site, even if she did not, she having her place of work in a portakabin on the site. It was, however, Mr. Pratt who was primarily responsible for the management and control of the work on site including site health and safety.

4. The construction project fell within the scope of the Construction (Design and Management) Regulations, initially those promulgated in 1994 but those were superseded by the 2007 Regulations which came into force on 6th. April, 2007. By these, a client is required to appoint a CDM Co-ordinator who in turn requires to give intimation to the Health and Safety Executive of the operation of a construction site where the works of construction are expected to last for more than 30 days, which intimation was duly given. Regulation 3 provides that "No person on whom these Regulations place a duty shall (b) accept such an appointment or engagement unless he is competent." Being competent means "being competent to (a) perform any requirement and (b) avoid contravening any prohibition." By regulation 14, where, as here, the project is notifiable, the client i.e the legal person who initiates the project, is required to appoint a person, to have the title "CDM co-ordinator" whose duties are set out in Regulations 20 and 21 and, read shortly, are to advise the client on the measures he requires to take to comply generally with the Regulations, ensure that suitable arrangements are made and implemented for the co-ordination of health and safety measures during planning and preparation for the construction phase, liaise with the principal contractor relating to the health and safety file, the information the contractor needs to prepare the construction phase plan and any design development which may affect planning and management of the construction work and to prepare, review and update a record, known as the health and safety file, containing information relating to the project which is likely to be needed during any subsequent construction work to ensure the health and safety of any person. While these statutory provisions are perhaps not as clearly stated as they might be, what is clear is that it is the function of the CDM co-ordinator from the planning stage, prior to any site clearance works being undertaken and certainly prior to the commencement of any construction works, until the completion of the construction phase, to ensure that in the planning of the execution of the works all appropriate health and safety measures required are recognised as being required and appropriate action is taken to provide such measures as are so recognised. In the present case, insofar as anyone was "designated" as being the CDM co-ordinator, this was Richard Pratt. Unfortunately, he was not competent to carry out this function and did not carry it out effectively. Given that, in his capacity as a director of DHSL, he was also the client and the contractor, there was, in my opinion, an inherent conflict between or among those capacities and the role of CDM co-ordinator which he would have recognised had he been competent, and ought to have appointed a suitably qualified and competent individual to carry out the functions of a CDM co-ordinator.

5. As a consequence of this failure, the consideration and recognition of the need for particular safety precautions against any given risk occurred on a haphazard and unco-ordinated basis. In the context of Mr. Freitag's accident, it is worth considering the requirements of the Work at Height Regulations 2005 and considering the duties which arise and upon whom these duties are imposed. These particular Regulations came into force on 6th. April, 2005 but there have been statutory regulations relating to work at heights since at least the 1930s. By regulation 3 the duties are imposed principally on employers, and there is no doubt that DHSL were the employers of Mr. Freitag, though they also apply to self-employed people. By Regulation 4 every employer is required to "ensure" that work at height is properly planned, appropriately supervised and carried out in a manner which is, so far as is reasonably practicable, safe. Regulation 5 again places emphasis on people involved being "competent." The Regulations require account to be taken of the risk assessment carried out under the Management of Health and Safety at Work Regulations 1999 and that gives rise in this particular case to the question what risk assessment was in fact undertaken in relation to any of the construction works. The primary legal requirement is to avoid carrying out work at height so far as practicable but where work at height has to be carried out, an employer is to "take suitable and sufficient measures to prevent, so far as is reasonably practicable, any person falling a distance liable to cause personal injury." There is a requirement to minimise so far as possible the distance and consequences of any potential fall. Collective protection methods are to be preferred to individual personal protection so far as possible. Regulation 11 requires danger areas, i.e. an area where a risk of a fall has been identified, themselves to be identified and unauthorised persons are to be prevented from entering that area. There is a duty under Regulation 14 to inspect. Where a guard rail is required, it is to be of "sufficient dimensions, of sufficient strength and rigidity for the purposes for which they are being used, and otherwise suitable, and not able to be accidentally displaced." As I understand it, the idea is that a CDM co-ordinator would, to be competent, appreciate first the need for a written risk assessment, written by someone who knew and understood the nature of the intended construction works and the sequence in which they would be carried out and who could recognise the hazards that the execution of the works would from time to time generate, and in the particular context of this case, the CDM co-ordinator would be competent to ensure compliance with the Work at Height Regulations 2005. Mr. Pratt did not prepare any written risk assessment nor was he aware of his responsibilities under the Work at Height Regulations, 2005. Therefore he ought not to have been the CDM co-ordinator or for that matter the person on site responsible for health and safety.

6. There are three sets of photographs which were referred to in evidence in the course of the Inquiry and I consider that, before further exploring the evidence which emerged at the Inquiry, it is helpful to set out the contents of these photographs, so far as possible. There are two sets of photographs which I understand were taken by Scenes of Crimes Officers employed by Tayside Police, which are Crown Productions 1 and 2, and there is a set of photographs taken by the Health & Safety Executive, and, in particular, by Mr. Provan. My recollection of the evidence is that it is unfortunately not entirely clear when the various sets of photographs were taken. Det. Cons. Graeme Wishart gave evidence to the effect that he and a number of other CID officers had become involved on 30th. May, the day after the fall, when

the extent of the seriousness of Mr. Freitag's injuries became clear and his evidence was that a uniformed officer had instructed photographs should be taken but that the CID officers instructed further photgraphs be taken, from which it seems likely that the photographs in Crown Production 1 were taken during daylight hours on 29th. May and those in Crown Production 2 were taken during daylight hours on 30th. May. P.C. Jamie Buchanan, who was one of a number of very good witnesses whose evidence I had the benefit of hearing, told me that he had first attended at the site at 12.00 on 29th. May, as instructed by radio from Police Headquarters, Dundee, and had requested the attendance of a Scenes of Crimes Officer at an early point and he was present when the photographs were taken. He had also attended the following day with CID officers whom he had briefed as to the circumstances and he understood too that they had instructed further photographs. Mr. Provan, the Health and Safety Inspector, who was an excellent witness, told me he had been directed to the site following a call from his headquarters in Edinburgh who had been informed by Tayside Police of the occurrence of an accident at the site, and he arrived there at about 13.00 hours on 29th. May. He returned on 30th. May by which time he had been made aware that the injuries sustained by Mr. Freitag were such that life could not be sustained and at that time, he seemed to think around 10.00 in the morning, he took a set of photographs which are also lodged. It would appear therefore that all the photographs to which reference was made at the Inquiry were taken with 36 hours of the fall and substantially portray the situation as it was at the time of the fall. It would appear that the occurrence of the accident was brought to the attention of the police by staff at Ninewells Hospital at a fairly early point on 29th May, 2008.

7. Crown Production 1, photograph A, depicts the site entrance off Morgan Street, Dundee. It depicts how the original brick boundary wall of the building was retained to be incorporated in the façade of the properties under construction. Photograph B is taken from within the site, looking south towards Arbroath Road, and shows from some distance the series of buildings described in the site plan, Crown Production 11, as Block A, where the accident occurred. Photograph C is an external view of the stairwell where the accident occurred and everyone who gave evidence agreed that this was the first stairwell i.e. the southmost stairwell at the rear of that part of the construction which abutted Morgan Street. It can be seen from this photograph that the construction involves flats at ground floor and on two subsequent storeys, and throughout the hearing, witnesses spoke generally of the ground, middle and top floors and I have adhered to that method of describing on which floor events occurred. Photograph D shows the top floor landing at the identified stairwell with the door of a flat on the right hand side and the exposed edge of a drop in the middle of the photograph. This is the point from which Mr. Freitag fell. The shaft beyond the exposed edge was for smoke extraction purposes – ironically, it was a safety feature, and when the stairs were completed, a blockwork wall would have been built along that edge completely enclosing the shaft. I heard no good explanation as to why that had not already been done once the landing had been screeded, but at the time of taking the photograph it can be seen that it is obvious that there is a dangerous exposed edge which is wholly unprotected. Efforts were made in the course of the evidence to ascertain the reason or reasons for the presence of the piece of plasterboard and the two pieces of blockwork but no satisfactory explanation emerged. Photograph E is not particularly clear but appears to depict the view down the shaft. Photograph F is taken at the middle floor level from the middle floor landing and shows the bottom of the shaft. At the top of the picture, one can see the

underside of the preformed metal landing into which concrete would be poured to complete the construction of the landing. The picture also depicts a wooden stick about which there was a certain amount of evidence at the Inquiry as to whether at the material time Mr. Freitag was using this to try to guide a tub of concrete delivered by crane to the stairwell at the material time to its intended location. This is a topic to which I shall return in greater detail. Photograph G shows the same area but also depicts the presence of a green glove of the type used by workmen while working with concrete and cement. On the right hand side is a door to one of the flats under construction. Photograph H is also of the same area. Photograph I shows the hallway of one of the flats on the middle floor with the blockwork at the landing seen at the far end of the corridor. Some traces of blood can just about be seen in this photograph and it is understood that Mr. Freitag made his way along this corridor immediately following his fall and was found in the room at the end of it further depicted in photographs J, K and L where further bloodstains were observed.

8. In relation to Crown Production 2, not all the photographs were referred to in evidence and I will accordingly confine myself to those which proved to be of importance to the Inquiry. Photograph F depicts the type of tub in which concrete would be delivered by crane for pouring by workers into preformed stairs and landings. Raymond Din, the crane operator employed by DHSL gave evidence that the dimensions of these tubs were 0.6m x 1m x 0.7m. Photograph G would appear to confirm that the tubs are 0.6m in depth. Photograph I would appear to confirm that the inner tub is 0.7m wide. Photograph J shows the remotely operated overhead crane which was being used by Mr. Din at about the time of the accident. Photograph M shows the block under construction with the stairwell concerned more or less in the middle of the photograph. Photograph O depicts the crane and its slinging mechanism comprising a block, hook and chains and this is seen in greater close-up in photograph P and Q. Photograph R is an external view of the stair where the accident happened. A red roadworks type barrier can just be seen apparently close to the top floor window. Photograph S depicts a set of stairs showing the metal framework into which concrete has been poured and has since set to form the actual steps of the stairway. It will be observed that the edge of this stairway is unguarded. Photograph T shows a little more of the same stairway in the same unguarded position. Photograph V shows the middle floor landing with the stick and green glove referred to in photographs F and G of Crown Production 1. Photograph W is taken from the middle floor looking up to the top floor and showing the unguarded edge of the landing where it abuts the smoke extraction shaft. Photograph X shows the measurement of the vertical distance from the edge of the landing to the floor of the landing on the middle floor at 2.91m. Photograph Y shows the stairs leading up to the top floor into the metal pre-form of which concrete has been poured, and also shows part of the landing at the top of the stairwell. The stair edge at the left hand side, being a place from which a person could fall, is unguarded. The landing edge at the top of the stairwell is guarded only by a red roadworks barrier which, it was accepted by all the witnesses, was not sufficiently rigid to be an effective barrier against a fall at that location, and which, therefore, did not comply with the requirements for barriers in the Work at Height Regulations, 2005, and which Mr. Pratt conceded while being interviewed under caution by Det. Cons Andy Adam and Keith Duncan of Tayside Police CID on 30th. June, 2008 was put there on his instructions following the accident, notwithstanding what he had originally told P.C. Buchanan and Mr. Provan. Photograph Z shows this same barrier but from the

landing. Photograph AA shows a second similar barrier located in such a way as to give some measure of protection from the edge of the landing at the smoke extraction shaft but it was conceded by Mr. Pratt that this barrier also had not been in place at the time of the accident . In any event, given its lack of rigidity, it would not have been adequate nor compliant with the Regulations. Photograph BB depicts the edge of the landing at the smoke extraction shaft and the obvious danger that it constitutes in the absence of any form of guarding. Photograph EE shows the hallway of the flat on the middle floor in which Mr. Freitag was found. FF shows its door out to the middle floor landing and GG tells us that this was the door of Plot 49 of the development. Photograph II shows the room in which Mr. Freitag was found following the accident and photographs JJ, KK, LL and MM all show various bloodstains observed in that room which are believed to have been caused by him. Photograph OO depicts a method, using tubular scaffolding poles, by which the unguarded edge of the stairs could have been effectively protected. PP shows the same method being used on the stairs leading up to the top floor landing though the edge of the landing over the stairwell remains protected only by the flimsy roadside barrier. Photograph QQ depicts a wooden frame barrier protecting the hitherto unprotected edge of the landing at the smoke extraction shaft and this is shown in close up in photograph RR. There was evidence that a joiner could have constructed this in about 20 minutes.

9. The photographs taken by Mr. Provan of the Health and Safety Executive on 30th. May, 2008 are Crown Production 5 and these are numbered 1 to 21. Again, not all of these were referred to in the course of the Inquiry and I will only refer to whose which were. Photo 1 shows the flats under construction viewed from inside the construction site, the block to the right hand side of this photograph being the block within which the accident occurred. Photograph 2 is a close-up of the same area. Photograph 4 shows the red roadworks barrier which was found in place by the police and the Health & Safety inspector on arrival to investigate the accident, but which had not been located so as to offer any protection from the unguarded edge of the smoke extraction shaft, which can be seen behind the barrier, at the time of the accident. Photograph 5 shows the same barrier and the shaft from a slightly different angle. Photograph 8 shows a second roadworks barrier at the edge of the top floor landing at the top of the stairs to the middle floor, this being the same landing as also had the unguarded edge to the smoke extraction shaft from which Mr. Freitag fell. Photograph 9 shows this same barrier from above, adjacent to the top of the stairs. Photograph 10 shows the stairs from the top landing to the half landing above middle floor level showing the concrete of the stairs in an unscreeded condition. Photograph 12 shows the smoke extraction shaft looking down it from the top floor landing to the middle floor landing. Photograph 13 shows the middle floor landing underneath the smoke extraction shaft featuring a stick and a green glove. Photograph 15 shows a number of tubs which could be filled with concrete and slung from the remotely controlled crane on site to any location on the site at which concrete was required. Photograph 17 shows the overhead crane.

10. The Inquiry heard oral evidence from a number of witnesses and also had to take account of a number of reports, affidavits and other documentary productions in excess of 600 pages. The first witness to give oral evidence was Mrs. Linda White, one of two directors of DHSL, the employers of the deceased, who told the Inquiry that her principal area of operation was in relation to sales and marketing of

properties for sale but that her place of work was a portakabin within the site at the former Tay Spinners factory. She was the sister in law of Richard Pratt, who was the only other director of DHSL. She told the Inquiry that he had joined the family business (Discovery Homes Limited) in 2004 as a site agent, that business being owned by Mrs. White and her husband. It was her position that in relation to the Tay Spinners site, Richard Pratt was in charge of the men and that that included responsibility for site safety. She said that the particular development had started in January, 2007 and that the intention was to construct, in stages, 83 flats and town houses. The work was scheduled so that no more than six flats or town houses would be under construction at any given point in time because Mrs. White and Mr. Pratt considered that that was "manageable." With regard to the accident, she knew that it had occurred in a stairwell in Block "A" of the development, being the first stairwell to the north of Arbroath Road and adjacent to the Morgan Street boundary. At the time, the construction workers were a mixture of company employees and self-employed contractors. Most of the employees, some of whom were Polish, had been with the company or with Discovery Homes Limited for "some time." The Poles were either bricklayers or labourers and she described them as "good guys." There were about 20 employees in all. Mr. Freitag was Polish and was an employee of DHSL. He had previously worked for Discovery Homes Limited since early in 2006. In particular, he had worked at a site in Trottick in Dundee on the construction of detached and semi-detached properties. He was a bricklayer and was very good at his job. He had originally been taken on by Richard Pratt. Discovery Homes Limited had been in business for about 25 years and had undertaken work on a number of different sites, particularly in private house construction. This was the first time that Richard Pratt had been in charge of work on a city centre brown field site. His previous experience was of dealing with a site where detached and semi-detached houses of no more than one storey were under construction on a green field site. He was at the site every working day for most of the day and effectively performed the functions of a site agent. There would be a foreman in charge of the site in his absence but the men were all "very experienced." Richard Pratt had been sent on a Health and Safety course run by the Construction Industry Training Board for five days when he worked for Discovery Homes Limited. He had also been on other health and safety courses, for example pertaining to the use of fork lift trucks and works involving the use of scaffolding. She did not consider that she had any responsibility in relation to health and safety on site. She was aware that a firm of independent health and safety consultants sent a representative to the site about once a month to advise on practical health and safety matters and that Sandy White was the individual who came but he almost always dealt with Richard Pratt. Richard Pratt would act upon any issues that Mr. White drew to his attention. She was of course aware that following Mr. Freitag's death and the investigation by the Health & Safety Executive both DHSL and Richard Pratt were prosecuted under the Health and Safety at Work etc Act 1974 and that both had been fined substantial sums. One or two of the Poles spoke good English and were used to translate to the others whose English was poor. Mr. Freitag's English was poor. She was not aware of any Health & Safety Inspector visiting the site prior to the accident. She was not involved in arranging employers' liability or public liability insurance in relation to the site. There had been self-employed joiners, plumbers and electrical contractors on the site on the date of the accident as well as their own bricklayers, labourers and crane operator. The John Duguid Partnership, Architects, had prepared documentation in relation to compliance with the Construction (Design and

Management) Regulations, 2007, prior to any work commencing on the site, including sending the notice of intimation under these Regulations to the Health and Safety Executive. She did not know about these Regulations or the need for a CDM safety co-ordinator on site. The Poles were the only foreign workers on the site and they had been given a booklet on site safety rules when they worked at Trottick. It is worth observing that no one from the John Duguid Partnership was called to give evidence to the Inquiry from I deduce, with regret, that the Crown did not appreciate in this context the importance of the position of the designated CDM co-ordinator in planning the execution of the works in a way which would eliminate or at least minimise risks to the health and safety of persons on the site.

11. The second witness was Dr. Ian Mellor whose evidence I will deal with in due course.

12. The third witness was Raymond Din who was the crane operator employed by DHSL. He knew that Mrs. White and Mr. Pratt were the directors of that company. He was qualified to drive a fork lift truck and to operate the remotely controlled overhead crane. He referred to the site as "Lilybank Mews off Arbroath Road" and that was how it was designed by DHSL. He had been working for them for about eighteen months and had had training on the operation of the crane and on matters pertaining to health and safety. He was not further questioned about the detail of that training and in particular about the hazards involved in depositing materials into a partially constructed building. He had been provided with a hard hat and boots by Richard Pratt who was the "site manager" i.e. he was the "day to day runner of the site and health and safety on site." The witness had been on the site on 29th. May and had started work at 07.30. He would do the daily checks on the crane and at that time its main usage was delivery of liquid concrete in tubs to various parts of the site. He agreed that Crown Production 2, photographs J, O and P showed the crane or parts of it. Photograph F showed some of the tubs used for the delivery of liquid concrete. Each tub was approximately 0.6 m x 1.0m x 0.7m. He remembered that Mr. Freitag had been working on 29th. May in the morning and that he had seen him. Mr. Freitag was a Polish national. The witness thought he was a general labourer, though he knew that he had done some bricklaying at another site at Maryfield in Dundee. Mr. Freitag and another Pole known to him as "Ziggy" were making up a mix of concrete to concrete stairs in one of the blocks of flats. The witness wore the control box for the crane around his neck. He could control the crane using it from anywhere on the site. The plan for these stairs was to deliver the fluid concrete in a tub using the crane into the as yet uncovered stairwell of the block and it could be lowered as far down the stairwell as necessary to the point where it was required though whether such a manoeuvre was free from hazard was assumed rather than explored. The witness was standing on the site in the area marked on the plan, Crown production 10, as "disabled car parking" which gave him a good view of where the load was both coming from and going to. He could not see Mr. Freitag though he had seen him earlier making a concrete mix. It was Mr. Din's recollection that he had already delivered one tub of concrete to the particular stairwell without difficulty and that this was the second tub. While he could not see Mr. Freitag, he could see Ziggy at a window space on either the top or middle floor at the stairwell to which the concrete tub was to be delivered. He was giving hand signals to the witness to direct him as to when the concrete tub was above the opening at the top of the stairwell. The movement of the crane in rotating to that point generated a certain

amount of sideways motion on the load and the tub would therefore be gently swinging from side to side. Mr. Din agreed with the suggestion that in his experience people tended to try to take hold of the load, whatever it might be, to try to stop that motion. Given the combined weight of the tub and the concrete inside it, something in the region of .75 of a metric tonne, a person would not succeed in doing that and it was really just a matter of being patient until the motion stopped. The tub was attached to chain slings from the jib of the crane with one chain through each of the hooks at either end of the tub. Shown Crown Production 5, photograph 9, he agreed with the suggestion to him that this depicted "some kind of barrier" at the top of a stairwell. He thought that the window to the top left of this photograph was the one which Ziggy was standing at but remained uncertain as to whether he had been on the top floor or the middle. Shown Crown Production 2, photograph R, he agreed that the red thing seen at the top floor window in that photograph was the same barrier as appears in photograph 9 of Crown Production 5. He thought that that was the window at which Ziggy had been standing and the stairwell into which the tub was to be delivered. He furthered confirmed that photograph PP in Crown Production 2 was a photograph of the same landing and window and barrier taken from the half landing below the top floor landing. The stairs seen on the right hand side of this photograph were the stairs from the top landing to the half landing and that is where the concrete was to be poured. He agreed that by the time of the accident that top section might have been done and that what remained to be done was the section from the half landing to the middle floor. Logically, someone concreting in the pre-formed metal outline of the stairs would start at the top and work his way down. Crown Production 5, photograph 10 appeared to show that these stairs had been concreted and that the concrete had been spread correctly. The tub would be delivered to the appropriate landing and the concrete would be removed from the tub using buckets. Once the tub was empty, it would be removed, using the overhead crane. It would take about five minutes to empty the tub. Mr. Din knew Mark Teviotdale who was a self employed joiner and who worked on the site as an independent contractor. Mr. Teviotdale had been standing beside him while he was operating the crane and delivering what was, in his recollection, the second tub of mixed concrete to this stairwell. Mr. Teviotdale had said that he thought that he had seen a hand. His actual words had been, "Fuck, there's a hand." The position, as Mr. Din understood it, for he had not seen this sight, was at the top of the breezeblock wall above the smoke extraction shaft. The exclamation from Mr. Teviotdale was a mark of surprise that a hand could be there. Shown photograph QQ of Crown production 2, it was Mr. Din's understanding that the hand had appeared over the top of the left hand wall but at a point further into the photograph than the location of the wooden frame at the edge of the shaft. As I understood his evidence, the surprise expressed by Teviotdale was on the basis that if there was a hand where he appeared to have seen a hand, then the rest of the body associated with that hand must have been dangling over the smoke extraction shaft. Mr. Din's opinion was that, whatever it was that Teviotdale saw, it could not have been a hand given the height of the wall and the relative height of the rear wall, which was higher. He thought the left hand wall was about seven feet high. Still looking at photograph QQ, he explained that the intention was to drop the tub from the crane on the other side of the left hand wall i.e. to the left of the left hand wall. He would have to get the load steady above that point to avoid damage to this wall. So far as he was concerned, this second load was also successfully delivered. So he walked into the stairwell at ground level with a view to ascertaining whether a third load would be

required and he found two of the Polish workers, Stan (Stanislav Zbedski) and Marcin (Marcin Woston), in a state of panic. He found it hard to understand what the problem was but finally realised that they were looking for Andrezej Freitag. Mr. Din noticed a cap, a set of gloves and a stick, lying at the bottom of the smoke extraction shaft on the middle floor. The cap was a yellow baseball cap that he had seen Mr. Freitag wearing. He also saw what looked like blood. The location is depicted in Crown production 2, photograph V which shows the gloves and the stick though it was lying on the ground when he first saw it. He said that he had seen both a hard hat and a yellow baseball cap. He said Mr. Freitag was in the habit of wearing the baseball cap below his hard hat. However, he had only been wearing the baseball cap when he had been mixing the concrete earlier. There was no immediate sign of him. However, there was a door leading into one of the flats open and Stan and Marcin went in there and found him. Mr. Din followed on hearing their cries and saw Mr. Freitag. There was blood dripping from his nose. He was speaking in Polish to Stan and Marcin, apparently asking to be taken home. Mr. Din thought the flat was plot no. 49. This was confirmed – see photograph GG in Crown production 2. It would appear that Mr. Freitag had crawled in here after the fall, though Mr. Din did not hear any explanation from anyone, including Mr. Freitag, as to what had actually happened. He went back down the stairs and shouted on Richard Pratt. He told him that there had been an accident. Richard Pratt went to the location. Mr. Din then remembered that the empty concrete tub was still in mid air and so he manoeuvred it with the crane back to where the concrete mixer was. Mr. Din agreed with the suggestion that there was no barrier at the edge of the smoke extraction shaft on the top floor. In his opinion there should have been some sort of permanent barrier, perhaps constructed out of scaffolding poles. The road barriers were not rigid and not suitable. He would not have worked on that top floor landing without a barrier. He understood that Richard Pratt and the Polish workers had been working on the stair at the material time. It was "common knowledge," he said, that you were responsible for your own safety. It was his general experience that if he raised a safety issue then it would be put right, especially with DHSL. Certainly, matters had improved since May, 2008. Richard Pratt was now "always on the case" about barriers, handrails and fencing and about the wearing of boots, hats etc. Mr. Din told the Inquiry that he had been working on building sites since about 2000 and had been on a significant number of sites. He said he was familiar with visits to sites by Health and Safety Inspectors, and that happened whether the sites were large or small. They usually asked to see his certification for both the crane and the fork lift truck. He had not worked a great deal with Andrezej Freitag but could say that he did not always wear his hard hat but that he did always wear a yellow baseball cap. The hard hats on this site were usually white. He had had a site safety induction from Richard Pratt when he initially came to the site. It had lasted about 30 minutes. He did not recall anything being said about work at heights but he agreed that it was unlikely that he would be working at any height. He did not consider that the fact that a number of the Polish workers could hardly speak English was of any significance in relation to the operation of works on the site or to site safety.

13. I have recorded Mr. Din's evidence at some length as I initially regarded him as credible and reliable and as being a sensible and experienced building site operative. Only after he had given his evidence, however, did the issue of the general wisdom of delivering concrete by crane into the stairwell arise and perhaps I should have requested his recall for that purpose. To compound matters, I realised that in the

statement that he had made to Det. Cons. Jennifer Kielty at the time, he had given an account which was in some respects materially different from what he said in evidence, in particular suggesting that he was operating the crane from the top floor of the stairwell, and not from outside the building as he said in evidence. In his account to the police officer, he conveyed the impression that other Polish workers were looking in a concerned state for Mr. Freitag prior to the second concrete tub being lowered in to the stairwell. Unfortunately, until I read all the statements for myself at a later stage, I was unaware of this material discrepancy and it all enhances my concern about the unsatisfactory nature of the system of work which was adopted in bringing the concrete into the stairwell by crane. It also makes me speculate, having regard to the statement taken from Mr. Pakowski, whether it may have been Mr. Din who asked Mr. Freitag to go to the top floor and help guide in the load. Such a suggestion was never put to Mr. Din and it would be quite wrong for me to express any conclusion on the matter without him having been asked what his position was, so this aspect of the inquiry can only remain in a state of uncertainty. The police officers conducting the inquiry, however, observed that there were inconsistencies in what Mr. Din had to say and to their credit re-interviewed him. On the second occasion, when interviewed by Det Cons Adam, he said that he had not at any time entered the building and observed where the load was going from inside the building. It is difficult to reconcile these two diverse positions and avoid speculating that Din recognised that he ought to have been within the building operating the remote control box for the crane, so he could see how the load was descending, rather than doing it from outside the building and relying on others, Mr. Pakowski in particular, to guide him.

14. The next witness led by the Crown was Mark Teviotdale, a 35 year old self employed joiner, who was considerably less impressive. His firm was the joinery sub-contractor at the Tay Spinners site. He recalled that he and his joiners were given a site induction on the first day they went there and everyone knew that Richard Pratt was responsible for site safety. They were all clear about the requirement to wear protective clothing on the site at all times. The town houses and flats were timber framed and so the work of the joiners was central to the work on site. He had been on the site from September, 2007 and the site had been developed in phases since then. The second phase of construction was Block A which was on the corner of Arbroath Road and Morgan Street, the south east corner of the site. There were a number of flats to be constructed there. He had been on the site on the day Mr. Freitag had his accident. He knew who Mr. Freitag was but he knew a number of the other Polish workers better. Mr. Freitag was a quiet person who worked as a general labourer. He appeared to speak very little English. On the day, Mr. Teviotdale had arrived on the site at about 08.30. At some point not very long after, he recalled speaking to Raymond Din, the crane operator. Din was operating the crane at the time. He was lowering a concrete tub into a stairwell, being the stairwell nearest to Morgan Street. Mr. Teviotdale had been working in the area and had been asked to stop while the crane was working overhead in accordance with normal precautions. Having nothing better to do, Mr. Teviotdale watched the crane operation. There was one man standing at a window guiding the operation using hand signals. Shown Crown production 5, photograph 2, he said that that appeared to him to be the view he had that day. He knew Mr. Freitag and the guide was not him. He thought it might have been Ziggy (Zygmunt Pakowski) but was uncertain. He

said that Andrezej Freitag was quite short and always wore a yellow baseball cap. Din was trying to deposit the tub into the stairwell. There is usually some degree of sideways movement of the tub. Mr. Teviotdale thought at this point he had seen a hand reaching for the tub as though to try and control the sideways motion. The hand appeared to be coming from the inside of the internal wall at the top of the stairwell about four feet from where it joined the external wall. He was surprised and shocked at what he thought he had seen. He knew that a person could not reach that position by standing on the ground and that the location was above the exposed smoke extraction shaft. Din had heard what he said but he did not know if he had seen the hand, if that is what it was, also. He said something to the effect that there could not be a person there and that Mr. Teviotdale must be mistaken. The tub was then lowered into the stairwell and the way was clear for Mr. Teviotdale to return to his joinery work, which he did. Mr. Teviotdale heard later that there had been an accident. He went into the block of flats and met Richard Pratt who was coming in at the same time with one of the Polish workers whom he knew as "Alex." (Arkadivisz Henryk Beyger) They found Mr. Freitag in one of the middle floor flats. He heard Mr. Freitag speaking in Polish to Alex who said that Mr. Freitag wanted to be taken home. Mr. Teviotdale could see that Mr. Freitag was sitting up with his back against the wall. There was blood on his head. Alex asked if he could stand up and he did. He was not given the chance to walk unaided but was supported by Alex and Richard Pratt. He was helped to the ground floor and then put in Richard Pratt's car and was taken to hospital. With hindsight, Mr. Teviotdale assumed that the hand he had seen must have belonged to Andrezej Freitag. He knew that the top of the shaft was on the top floor and that its edge was unguarded. He knew that he had found Mr. Freitag with injuries in a middle floor flat. He assumed therefore that he had fallen down the shaft while reaching up to steady the concrete tub. He considered it unacceptable that the edge of the smoke extraction shaft had been unguarded. It would have taken five minutes to erect a wooden frame barrier which would have been rigid. He had a good working relationship with Richard Pratt, believing him to adopt a common sense approach. He did not know whether Pratt had any health and safety qualifications but was quite clear that he was responsible for safety on site. He felt there should have been "a plan" which would have involved preventing unguarded edges. He had, on the other hand, little time for Health and Safety Inspectors citing their preventing joiners from using their trestles as working platforms, notwithstanding that he was aware of joiners falling from trestles while working and injuring themselves. He was aware of the monthly inspections by Sandy White.

15. I was not overly impressed by Mr. Teviotdale who did not seem to understand, given the angle of incidence from the ground to the top floor of the flats under construction and the difference in height between the internal and external walls that he could not have seen a hand where he described it as being unless the person whose hand it was was clinging to the breezeblock wall above the open smoke extraction shaft which was a virtually impossible and certainly highly unlikely state of affairs. His silly observations offering his opinion about the unnecessary officiousness of Health and Safety Inspectors did not stand up to examination.

16. The Tribunal otherwise heard evidence from the following witnesses:-
Stanislav Karol Zbedski and Marcin Woston, both of whom gave evidence with the benefit of a Polish interpreter, and both of whom were Polish bricklayers who had worked

for DHSL and had been on the site on 29th. May, 2008; Detective Constables Graeme Wishart, Jennifer Kielty and Andy Adam and Police Constable Jamie Buchanan, all of Tayside Police Central Division, Alexander Whyte, a self-employed safety Consultant, Richard Pratt, the director of DHSL responsible for health and safety on the site; Murray Provan, Health and Safety Inspector, and Dr. Ian Mellor, Consultant Anaesthetist at Ninewells Hospital, Dundee. In addition, given that these are proceedings to which the Civil Evidence (Scotland) Act, 1988 applies, (see section 4(7) of the Fatal Accidents and Sudden Deaths Inquiry (Scotland) Act, 1976,) I also had to consider statements taken by the police from Zygmunt Pakowski and Arkadivsz Beyger, taken by Det. Cons. Kielty with the assistance of an interpreter, and two statements, the second under caution, made to officers of Tayside Police by Richard Pratt, the series of site safety reports prepared by Alexander Whyte, the post mortem report, a series of plans and cross sections from the building site, the police statement of Linda White, police statements by Stanislav Zbedski and Marcin Woston, the two Polish workers who had given evidence to the Inquiry, two police statements made by Raymond Din, the crane operator, a statement made by Richard Pratt under s. 20 of the Health and Safety at Work etc Act, 1974, Mr. Provan's reports on the occurrence and, from the agents for DHSL, a document entitled "One Death is Too Many," the sub-title of which is, "Inquiry into the Underlying Causes of Construction Fatal Accidents," this being a report to the Secretary of State for Work and Pensions by Rita Donaghy, who was formerly the chief executive of the Advisory, Conciliation and Arbitration Service, some of the contents of which were put to Mr. Provan in the course of cross-examination.

17. The two Polish bricklayers who gave evidence appeared to me both to be entirely straightforward and credible individuals. They were both trained as bricklayers. Stanislaw Zdebski had been in Scotland since 2006. In Poland, he had attended what he described as a building technical high school. He had been recruited for DHSL via a recruitment agency. He had had a site induction undertaken by Richard Pratt. He had been provided with appropriate personal protective equipment. He had on occasion worked directly with Mr. Freitag, though he was not doing so on the date of the accident. He and Marcin Woston had been working together at another part of the site but when they finished their allocated work, they went to see if they could help Mr. Freitag and Mr. Pakowski who were working at the stairwell. When they arrived, Mr. Pakowski was trying to find Mr. Freitag and they found him in one of the flats, having sustained obvious injuries to his head and chest. They summoned assistance and Mr. Pratt took Mr. Freitag to hospital accompanied by Mr. Beyger, who was the best English speaker amongst the Polish workers. They had seen a glove and a piece of wood and some traces of blood on the landing of the middle floor underneath the smoke extraction shaft. Mr. Zdebski told the inquiry that he had been asked by Richard Pratt to put the barrier on the top floor landing at the top of the stairwell so that it gave some protection from the otherwise unguarded edge. He also told the inquiry that he had twenty years experience of working on building sites in Poland, Germany and Scotland and that this site had been "OK except for some minor things which shouldn't be but that happens some time." Both said that they could approach Richard Pratt if they felt there was an issue with safety and would expect him to react positively. Neither of them had any criticism to make of the work or the behaviour on site of Mr. Freitag, Mr. Zdebski saying in terms that Mr. Freitag was a safe worker. Mr. Woston was only 29 but I considered him to be an impressive witness, who had come here to earn more than he could in Poland, and who clearly regarded Mr. Freitag as a friend as well as a workmate to the extent that he struggled with his emotions at times during the inquiry. He was able

to say that the red roadworks style barrier seen in Crown Production 2, photograph AA, was not in the position shown in the photograph in which it provides a measure of protection from the otherwise unguarded edge of the smoke extraction shaft, and was not in that position when he arrived at the scene as he had an unobstructed look down the shaft where it was believed that Mr. Freitag had fallen.

18. The evidence given by Mr. Zdebski and Mr. Woston was also consistent with the contents of the statements taken by Det Cons. Jennifer Kielty from Zygmunt Pakowski and Arkadivsz Beyger, with the assistance of an interpreter. These witnesses had apparently returned to Poland and accordingly the statements made by them to the police officer was the best available evidence from them and I see no reason to regard these statements as anything other than the witnesses' honest recollections of what occurred.. Mr. Pakowski had worked for DHSL for about two years at the time of the accident. He was a qualified bricklayer with 17 years experience in the building trade. He had been on the Tay Spinners site for about 18 months. He had had a site induction and the written material had been translated into Polish for him by one of the other workers. He was issued with standard personal protective equipment – boots, hard hat, gloves and high visibility jacket. Mr. Beyger had been in Scotland for about four years at the time of the accident and spoke good English. He had worked for Discovery Homes Limited prior to starting to work for DHSL. He had been at the site for six months. He was residing in the same block of flats as Mr. Freitag and regularly walked to work with him. He too had had a health and safety induction and had been provided with the same personal protective equipment. Both had started work on 29th. May, 2008 at 07.30. Mr. Pakowski was working with Mr. Freitag. He knew from the preceding day that their first job that morning was to concrete the stairs in the stairwell nearest to Morgan Street. He and Mr. Freitag started by mixing up a batch of concrete at the concrete mixer on site. That concrete was then "airlifted" by the crane into the stairwell, the crane being operated by Raymond Din, but with Mr. Pakowski acting as his unofficial banksman from the middle stairwell window halfway between the middle and top floors. Mr. Freitag was to empty the concrete tub into the preformed stair treads and then start screeding the concrete. In his statement to the police, Mr. Pakowski said, "When I went to the window, Andrezej is supposed to go to the top floor. I saw him go there and he is supposed to guide the tub down into the stairwell." This is a critical piece of evidence in this case and it is unfortunate that Mr. Pakowski was not available for examination as to what the basis for this statement was. Richard Pratt was very clear and consistent in all the various statements he made to the police and to Mr. Provan and in his evidence in court that he did not know why Mr. Freitag was on the top floor and so I consider it most unlikely that he gave any instruction about guiding the tub in. Raymond Din was equally clear that he would not lower the tub into the stairwell until it had stopped oscillating and so there would be no need to guide the tub. In practical terms, the tub would be too heavy to be "manoeuvred" by one individual. A number of the other witnesses, both those who gave evidence in person and those who gave statements to the police, expressed surprise at Mr. Freitag's presence on the top floor and at the particular part of the top floor from which he fell and this is the only piece of evidence that goes any way towards explaining why he was there. What it does not tell us is whose idea it was that he should undertake the task of "guiding" the tub into the stairwell but there does seem to be a juxtaposition between the delivery of the second concrete tub of the morning and Mr. Freitag's fall. If he was there to guide the concrete tub and that is what he was doing at the time of his fall, then whoever directed him to be there contributed to his death. But I cannot conclude on the evidence before me that that

is why he was there and, if it was why he was there, who, if anyone, instructed him to guide the tub. Mr. Pakowski elaborates on all of this. He went on to say that Mr. Freitag was using a stick to make sure that the tub did not strike the wall. There is no doubt that a stick was found at the bottom of the shaft nor that that stick which was produced to the inquiry is a broken piece of roof batten for which there would be no obvious purpose in the stairwell. Mr. Pakowski is recorded as having said to Det Cons Kielty, "When I left the stairwell (to mix the next batch of concrete) I saw Andrezej with the stick (from where he saw this is not clear) and he was using it to move the crate (logically, this would be the empty crate as it was being lifted out by the crane and it is not clear to me why that would be done without Mr. Pakowski as banksman.) I actually only saw the stick being pushed against the crate." (That appears to imply that he could not see Mr. Freitag, only the stick, from wherever he was then located.) "Andrezej was standing on the other side of the wall where the hole was. Andrezej had moved round as when he first started he was on the stair landing guiding the crate." To improve understanding of what this witness appears to be saying it is necessary to consider Crown Production 19, the stairwell plan, and also to look at Crown production 2, photographs F (which portrays the concrete tubs) and Y, Z and AA which show the top floor landing. From the plan we can see that stair 36 is the top of the stairs and that at the top of the stairs the outside wall turns through 90 degrees to the left and then through a second 90 degree turn to the left, with the landing coming to an end at the smoke extraction shaft. The plan shows a wall along the top of the stairwell but Photograph Z shows us that this portion of the wall has not been built yet though the wall comprising the second ninety degree turn has up to a point – the ends of the breezeblocks of this wall can be seen behind the piece of chipboard in that photograph – and if one then considers photograph AA it can be seen that the wall from the second 90 degree turn has been constructed (though perhaps not to its full height) to the point where it joins the outer wall (or, strictly, the inner half of the double outer wall,) so that that wall forms the left hand side of the wall of the smoke extraction shaft from the perspective of someone looking towards the smoke extraction shaft from the landing. As can also be seen from photograph AA, the wall shown on the plan which is to enclose the smoke extraction shaft has not yet been built. Had it been built, this accident could not have occurred. So what the witness is saying, as I understand it, is that Mr. Freitag was initially standing at the top of the stairwell, as shown in photograph Z, where the red roadworks barrier is seen, though that was not there at the time, and then moved through 90 degrees to be behind the breezeblock wall which encloses the landing from the stairwell, at a point close to the top of the smoke extraction shaft. Why he would do that and whether anyone told him to do that remains unknown. Mr. Pakowski said that Mr. Freitag was wearing a hard hat and a baseball cap, a high visibility vest and wellington boots. He said that there were no barriers at all in place at the third floor landing either at the exposed edge of the stairwell or at the exposed edge of the smoke extraction shaft. Mr. Pakowski expressed the opinion that "Andrezej has fallen due to losing his footing. The boots he had were three sizes too big for him." The boots are lodged as Crown productions 39 and 40 and appear to be size 8, about average size. I do not recall any evidence from any other source about the suitability of the boots which appear on examination to be otherwise in good condition. Mr. Pakowski had gone off to mix the next batch of concrete, leaving Mr. Freitag to screed what had been poured from the last lot. He was accordingly away from the stairwell for about 40 minutes. When he returned to the stairwell he met Mr. Zdebski and Mr. Woston who had come to help but there was no sign of Mr. Freitag. For reasons that are not clear, they all then went to the top landing and looked down the smoke extraction shaft – I say for reasons that are not clear for, logically, they walked past the stick and glove and blood on the middle floor

landing to get there – but in any event he became aware that something was wrong when he saw the items at the bottom of the shaft and Mr. Freitag was then traced to the nearby flat. Mr. Freitag said in Polish to Mr. Pakowski, "I just want to go home." He was then taken to hospital by Richard Pratt and Mr. Beyger. The witness, at the conclusion of his statement to the police, says that he could not understand why Mr. Freitag had been near the smoke extraction shaft, saying in terms, "That is not where he needs to be to guide the cement crate into the stairwell." I make no criticism at all of Det. Cons Kielty, for this must have been a difficult inquiry for her, and she has clearly noted several statements with care and patience from a number of Polish speaking witnesses, but it would on the face of it have been illuminating to know why Mr. Freitag was trying to direct the concrete tub at all and who, if anyone, gave him instructions to do so. Also, I do not understand why Mr. Pakowski would think that standing near the smoke extraction shaft would "not be where he needs to be to guide the cement crate into the stairwell." That begs the question whether there was any merit in trying to guide the cement tub at all, and it also begs the question whether at the material time it would not be the case that the tub was being brought out of the stairwell rather than being guided into it, but if there was any point to trying to guide the tub and it is the landing wall to the left of that portion of the landing leading to the smoke extraction shaft which is most in need of protection from the swinging tub, then standing behind that wall to try to push the tub away from that wall seems to make sense. What would have been important would have been to know whether this "system of working" was known to anyone in authority and thus should have been the subject of risk assessment given the inherent risk of falls from the exposed edges of the stairwell and the smoke extraction shaft. On the face of it, such a "system of working" was both dangerous and unnecessary. It was dangerous on account of the unguarded locations from which a person might fall. It was unnecessary if the delivery and removal of the tub could be achieved by the crane operator without further human intervention as was claimed. This also therefore gives rise to the bigger question whether delivering concrete by crane into the stairwell was a sensible thing to do and for reasons which I will later explain, I came to be increasingly of the opinion that that was not a sensible thing to do and is the real cause of Mr. Freitag's accident.

19. Mr. Beyger's statement does not add anything to our knowledge of the precise mechanism of the accident. He had been working at another part of the site at the material time and only became aware that something was amiss as he headed for his tea break. He went to the flat where Mr. Freitag was and asked him what happened in Polish and he replied, in Polish, "I fell." Mr. Beyger asked him how this had happened because Mr. Freitag knew that the hole was there, to which he replied, "I know. Take me home. I want to sleep." I think this could properly be regarded as an acceptance by Mr. Freitag of his own contribution to the occurrence. He was asked where it hurt and he replied, "Everywhere." Then he said, "Chest, stomach and head." He was able to move his hands and legs. As time went on he appeared to become more confused and it was decided that he should be taken to hospital. I make no criticism of anyone but it is instructive that there was no immediate appreciation of the seriousness of the injuries sustained and it is important that information is disseminated about the need to get proper medical assessment and attention for anyone injured in a fall from height with the risk of serious internal injuries. Mr. Freitag was helped to Mr. Pratt's car and Mr. Beyger went with him to hospital where he acted as interpreter for the assistance of the medical and nursing staff and later for Mrs. Freitag when she came to the scene. Dr. Mellor said that he was of huge assistance to the medical and nursing staff and his presence of mind and fortitude in such difficult circumstances is to be commended. A number of the Polish workers, including

Mr. Beyger, were present at the hospital on the Thursday evening when a Polish priest who had been found by the hospital's administrative staff attended and gave Mr. Freitag the Last Rites. Mr. Beyger also went to Glasgow Airport on Friday morning to help Mr. Freitag's sons who had flown in from Poland and to get them to their father's bedside in Dundee prior to life support being terminated. Mr. Beyger also rendered considerable assistance to the police by undertaking informal translations. It is unfortunate that the Inquiry did not have the benefit of his oral evidence.

20. The next batch of evidence I want to consider relates to the inquiries carried out by the police. The starting place for that is the evidence of P.C. Jamie Buchanan who was the first police officer on the scene and for whose careful observations I was grateful. He was a 32 year old constable with four years service. He was instructed to attend at the locus after the police had been alerted by hospital staff. He arrived at the site about 12.00 noon on 29th. May. He did not know at that point that the injuries sustained by Mr. Freitag were terminal. All he knew was that a Polish building worker had had an accident in which he had sustained injury leading to his admission to Ninewells Hospital. He understood the victim had fallen from height. He met Richard Pratt. He understood that Mr. Pratt was the "site manager." Mr. Pratt gave him an account of what had occurred. They went to the locus of the accident. He was shown what he was told was a ventilation shaft down which Mr. Freitag had fallen. He visually estimated the drop to be about 2.5 metres. The landing surface was concrete. He could see a wooden stick and a green glove lying on that surface. There was nothing else there. He decided it would be appropriate to have a forensic team and a Scenes of Crimes Officer attend. There was a red roadworks barrier protecting the edge of the ventilation shaft. There was a second such barrier at the otherwise exposed edge of the top of the stairwell. He said that at this stage he thought that he was dealing with some kind of unfortunate accident but he knew from his training that the Health & Safety Executive should be informed and it was at his request that Mr. Provan attended. He specifically asked whether each of the roadworks barriers had been in the positions in which he had seen them at the time of the accident and was told and noted that they were. He did not enquire of Mr. Pratt how he thought Mr. Freitag could have circumvented the barrier. He was made aware that there was some suggestion that Mr. Freitag may have been trying to guide a concrete bucket that was being delivered by crane to the stairwell. Mr. Provan from the Health & Safety Executive arrived at about this point and he agreed that he required to carry out his own investigations. P.C. Buchanan then left the site. When he came on duty at 07.00 on 30th. May, 2008, there was a message awaiting him to the effect that Mr. Freitag was considered to have suffered brain stem death but that confirmatory tests were being carried out. He spoke by telephone with Mr. Provan, informing him of the grim position and admitted being surprised to learn from him that Mr. Pratt had confessed to putting the barriers in place after the accident. Given the near certainty at that time of Mr. Freitag's death, and that he had been deliberately misled by Mr. Pratt, he fully briefed CID officers on the events and passed on the process of further inquiry to them.

21. The inquiry was then taken over by a CID team based at Police Headquarters, Dundee, led by Det. Sgt. (now Det. Insp.) Kevin McMahon. The team included Det. Cons. Graeme Wishart, Jennifer Kielty and Andy Adam. Those three gave evidence to the Inquiry and all were entirely credible and reliable. As I have already said, Ms. Kielty demonstrated a huge degree of skill and patience extracting detailed statements from the Polish workers with the help of an interpreter. Mr. Adam proved to be a remarkably able witness in this context given that he was the holder of an honours degree in

architecture. Mr. Wishart was a clear and concise witness who made a careful examination of the locus and instructed further photographs. He also obtained a voluntary statement made under caution from Richard Pratt at Police Headquarters, Dundee. I think it is clear that at that stage, insofar as the CID officers considered they were involved in an inquiry that might lead to criminal proceedings, the main focus of their attention even at this early stage was Mr. Pratt. Crown production 9 is the statement noted by Mr. Wishart and Mr. Pratt signed each page of this statement having been given the opportunity to read it through first. In it, he acknowledged responsibility for health and safety at the site on a day to day basis. He produced a file containing method statements and risk assessments carried out by various other people and organisations in relation to the use of equipment e.g. crane, abrasive wheels, scaffolding etc but there appears to be nothing which originates from DHSL or him about the specific site operations. He said he gave all employees an induction but could not produce any record of Mr. Freitag having had an induction to the site. He considered that employees should be aware of hazards on the site. The Polish connection had been initiated by Grant White, a director of Discovery Homes Limited, going to Poland and recruiting building workers directly. That connection had been continued by DHSL. It is worth noting that he said, "Their skills are taken at face value and proven on site." Another way of regarding that would be that he made no effort to find out whether those he was employing had any idea what they were doing and any qualifications or experience, which, as an approach, is scarcely consonant with his acknowledged responsibility for site health and safety. However, he conceded that Mr. Freitag had been a good worker who had been employed either with DHSL or Discovery Homes Limited for five years. He indicated that his health and safety training was confined to a five day course run by Construction Skill, which I understand to be a training operation run by the Construction Industry Training Board. He had also employed the Murray Safety Group from Edinburgh to undertake regular inspections of the site. That firm had last inspected the site on 13th. May, 2008, when they drew attention to areas where people could fall through scaffolding or fall from height. He claimed that, by virtue of usage, including usage by him, he was checking the scaffolding on a daily basis. The same was true of the lifting equipment. So no record of checking their viability was kept. The alleged good condition of these items, especially the scaffolding, by dint of inspection in the course of daily use, did not square with the regular inadequacies noted by the Murray Group. He said that on the preceding Saturday, 24th. May, 2008, he had worked with Mr. Freitag and Mr. Pakowski concreting the top floor landing in the stairwell where the accident occurred. He is recorded as having said, "As far as I was aware, Andrezej and the other workers were experienced in concreting a stairwell and were aware of the hazards and at the time of the accident I left them to do the job while I carried out other jobs, as they didn't need supervised." There is a clear implication to be drawn from this that Mr. Pratt did not know what experience, if any, Mr. Freitag had in concreting stairwells and did not know what awareness he had of hazards. There is a clear implication from what he is recorded as having said that there were hazards. Nothing is said about what was done to eliminate or minimise the hazards or even to make people such as Mr. Freitag aware of them. He acknowledged that the stairs had no handrails to protect anyone from falling and is recorded as having said, "I was aware there were not handrails and this was a task I was wanting to do, but hadn't instructed anyone to do it or had the time to do it." That appears to be an acknowledgement that a known risk was ignored through lack of time. He went on to say, " There's a smoke extraction vent at the back of the stairwell where I had been told Andrezej was working. Again, this was to be bricked up but I hadn't got around to it. I was aware that there was no scaffolding or handrail over the top of the

smoke extraction vent. I was aware this was a hazard, but I was going to be getting around to it. But again, this was a hole that everybody knew was there as they had put it in." Again, there is an acknowledgment of the existence of an unguarded hazard, in this case specifically the hazard where the accident occurred. It is simply unacceptable to say on the part of the person responsible for site health and safety that he had not got round to eliminating the hazard but everyone should have known about the hazard anyway because they created it. In reality, the emergence of the hazard was a product of the system of working. There is no good reason why the smoke extraction shaft was not bricked up immediately after the landing had been concreted. Had that been done, this accident could not have happened. If there was some good reason for that not being done, then to do nothing to minimise the risk from the hazard was grossly negligent. It is to Mr. Pratt's credit that he took prompt and effective action to get Mr. Freitag to hospital and that when he became aware of the devastating nature of the injuries sustained by Mr. Freitag, he made arrangements for his sons to attend at his expense from Poland and also dealt in due course with the funeral arrangements. It is not however at all to his credit that he told both P.C. Buchanan and Mr. Provan that the red roadworks barriers had been in place at the time of the accident nor is it to his credit that he explained this lie to Det Cons Wishart by saying, "What can I say – you try and cover your own arse," though that is as clear and timely an admission of having got the whole issue of site health and safety badly wrong as was ever wrung from Mr. Pratt.

22. Det Cons Adam in the presence of Det Cons. Keith Duncan detained Mr. Pratt under and in accordance with the provisions of s. 14 of the Criminal Procedure (Scotland) Act, 1995 on 30th. June, 2008 and conducted an interview with him at Police Headquarters, Dundee. It was made clear to Mr. Pratt that the officers were investigating a crime. He made it clear in the course of that interview that there were times when he was not on the site during which periods no one was designated as being responsible for site health and safety. He had previously worked as a site agent but this was his first experience of being ultimately responsible for site health and safety. He accepted that he had direct control over the way work was carried out. There was no site programme of works, but he decided the sequence of works. He had "control" over risk assessments and method statements and claimed to carry out risk assessment to ensure safe working practices. He was asked about the production of method statements for working at height and said that would be produced, "in an ideal world." He then suggested that it was "common sense." He further suggested that he would see things because he was on site daily and would do something about those things. He conceded that he kept no record about rectifying inadequacies in health and safety on site drawn to his attention in the Murray Group reports. He said the same applied to rectification required by HSE and this, sadly, appears to be correct. He confirmed that Andrezej Freitag was not fluent in English and communication was via other Polish workers on the site. I think it is fair to say that I did not hear any evidence from which I could conclude that difficulties in communication played any part in the occurrence but I observe that there is statistically a high incidence of foreign and migrant labour involvement in fatal construction accidents. Mr. Pratt went on to admit that there were no safety precautions for people working in the stairwell where Mr. Freitag's accident occurred. There had been no risk assessment done for that stairwell. However, he conceded that he did not believe the stairwell to be safe. He conceded, again, that he had put the red roadworks barriers in place following the accident. Asked about a lack of scaffold barriers on the stairwell, he explained that this was "so that we could pour the concrete easier down the stairs." Later he said, "I knew the potential of a hazard and I was endeavouring to get round to putting the barriers

there. Unfortunately I never got round to doing it and that is the plain and simple answer to it." It will be evident that these two statements are inconsistent. The former implied a positive decision not to put up protective barriers as they would inhibit the work being carried out on the stairwell. The latter implies a theoretical decision to put up protective barriers some time given the recognition of the hazard but a failure to implement that decision. In my opinion, it was the former rather than the latter position which generated the lack of protection i.e.an enthusiasm to get on with the work with a lack of appreciation of safety implications. Asked about the lack of risk assessment in relation to the work in the stairwell he said, "Too busy – hadn't got round to it, laziness, em, didn't think people could fall down the stairs. Don't know, don't know why I hadn't done it."

23. Det Cons. Adam spoke to certain other productions including plans, especially Crown production 45 which he described as being a bird's eye view of the stairwells at each of their three levels. He also spoke of his visit to the site and, in particular, to the stairwell. He described having seen the metal pre-formed landing and stairs and how these had been filled in with concrete with the result that there were a number of locations from which a person could fall which were unguarded. In his architectural experience, such locations would normally have been protected by the erection of temporary handrails, normally constructed from scaffolding poles. In his opinion, the need for such protection was obvious. In his opinion, the need for such protection would have been obvious to anyone carrying out a risk assessment of the task. He agreed with the suggestion, given that there would be a number of stairwells constructed throughout the site, that there would have been merit in a generic risk assessment for all stairwells. There was none. Shown Crown Production 2, photograph PP, he agreed that that depicted the type of temporary barrier he would expect to be provided, this one having been erected after the accident. He said he had never seen nor heard of a roadside barrier being used as a protective barrier in this context. Such a barrier could not offer the kind of protection required for someone losing their balance as they were lightweight and lacking rigidity. He agreed that if a person was concentrating on trying to protect the walls of the stairwell from a load being delivered by crane, it would be easy for them to forget about the smoke extraction shaft and fall down it with it being unprotected. He was surprised that there was no programme of works, a pre-determined schedule of the order in which work would take place, which, in his opinion, was essential where the "workforce" consisted of both direct labour and sub-contractors, to avoid conflict arising from the order in which tasks were undertaken. He agreed that there would be scope for conflict between a site agent and a health and safety manager and that it was unwise for one person to occupy both roles. He acknowledged that Mr. Pratt had not found the experience of being involved in the death of Mr. Freitag and the subsequent police and HSE investigation either happy or comfortable. He had never been cautioned and charged, the matter simply having been reported to the Procurator Fiscal and then the indictment had in due course been served. He was aware that both DHSL and Mr. Pratt had pled guilty to contraventions of section 2 of the Health and Safety at Work etc Act, 1974. He also considered that the process of introducing the concrete to the stairwell by crane gave rise to the need for awkward manual handling and that there was an obvious inherent risk in the whole process which made protective barriers all the more essential. Alternatively, a different way of delivering the concrete, most obviously by crane to the ground outside the building at the stairwell, should have been utilised. That, of course, would have been slower and more labour intensive. Mr. Adam was an excellent witness who made an important contribution to this inquiry.

24. Before I turn to the evidence from Mr. Provan from the Health and Safety Executive, I want to make brief reference to the evidence from Alexander Whyte from the Murray Safety Group. Mr. Whyte was a self-employed safety consultant with relevant qualifications in occupational health & safety which qualified him to act as a safety officer. He also had 28 years of practical experience having been employed throughout that period at the then BP Refinery at Grangemouth. He had been working on a self-employed basis as a safety consultant since 1995. I think, without prejudice to his expertise and his credibility and reliability as a witness, it is important not to overstate his position as Mr. Pratt was rather inclined to do. His brief was to come to the Tay Spinners site about once a month and to examine the site for safety defects. The various inspections were time limited and he did not pretend that they were comprehensive. Having said that, he accepted that his site reports demonstrated recurring defects, especially in relation to the integrity of the scaffolding, exactly the type of situation which can give rise to serious accidents, and which occurs, in the absence of a programme of works, when one trade is trying to do one thing and another trade wants access to do something else at a different location. Another recurring theme in the reports related to risk of falls from height. It is worth recording that his visits were random and not in accordance with any prior arrangement, so he saw it as it was and not in a condition which anticipated his arrival. He was, of course, aware that Richard Pratt was in charge of the site for he reported to him as often as he could, though sometimes Pratt was not on the site. Sometimes Pratt came with him on his inspections and had defects pointed out to him. Mr. Whyte had been led to understand that Mark Teviotdale, the self employed joiner with a very limited understanding of health and safety practice, was in charge in the absence of Mr. Pratt and Teviotdale was certainly prepared to sign for copies of his report. Copies of Mr. Whyte's reports between September, 2006 and August, 2008 were lodged as Crown production 11. These were in the form of checklists. While I can see merit in generic checklists, it does to some extent discourage individual assessment. His experience on this site was that workers were prepared to draw issues to his attention and they all knew who he was and what his function was. He had no responsibility for ensuring that defects drawn to Mr. Pratt's attention were rectified and it is worth observing that that part of the reports which he would leave headed "Action Taken," was not always completed. He would normally discuss problems and possible remedies with Mr. Pratt. It was not his practice to take a copy of the previous report to the next inspection though when that was suggested to him, he conceded that that would be a sensible practice. He accepted without demur that the unprotected edge at the top of the smoke extraction shaft was a "serious defect." Had he seen it, he would have drawn it to the urgent attention of Mr. Pratt. He had co-operated with the Health & Safety Executive in connection with their enquiries in the wake of the accident and had provided them with copies of his reports. He was aware in general terms of the frequency of industrial accidents involving falls from heights, observing that in the last annual period for which statistics were available, spanning 2006/2007, some 86,000 had been seen at hospital suffering from some kind of injury following a fall from a height. In relation to his inspection on 3rd. April, 2008, the last one he conducted prior to the accident, he had noted, "There are a number of places where it is possible to fall from apertures," this being a reference to window apertures which were unguarded. There were also major concerns, not for the first time, about gaps in the scaffolding. He was aware that the site should have had a CDM co-ordinator but that it did not other than theoretically. No one was performing the fuctions attributed by law to a CDM co-ordinator. In his report of 13th. August, 2008, he was still writing, "too many places where

it is possible to fall." He had no reason to believe that Mr. Pratt did not understand, at least in broad terms, what his responsibilities in relation to site health and safety were. He had formed the view that Mr. Pratt was "a bright person" but that he was "wearing too many hats." He agreed that the roadworks style barriers were inadequate for use as edge protection. He said that the accident which occurred was eminently foreseeable. He was currently inspecting about sixteen building sites a week, the majority of which were house building sites and so had considerable experience in this field. He had not offered nor been asked to offer any advice in relation to risk assessment or methods of working. He was aware that every employer had a statutory responsibility to carry out a risk assessment. His experience was that, while things were improving, particularly as younger workers with college training were informed about health and safety issues, having a safe site was not yet at the top of every builder's agenda. Interference with the condition of scaffolding remained a significant problem. He suggested, interestingly, that there might be merit in a philosophical change from an approach based on punishment for getting things wrong to bonuses for getting things right. The bigger contractors were better organised when it came to providing and maintaining safe working systems and practices and the Health and Safety Inspectorate continued to play a major part in improving site safety but there were not enough inspectors and therefore there were not enough inspections where pro-active as opposed to reactive work could be undertaken. He understood that statistics demonstrated currently about 60 deaths per annum on UK construction sites, 15 or so of which were as a result of falls from height. He thought it would be a good idea for all construction workers to go on safety refresher courses from time to time. I regarded Mr.Whyte as a fair and knowledgeable witness who made a valuable contribution to the inquiry and who, for the avoidance of any doubt, had no responsibility for the circumstances leading to Mr. Freitag's accident.

25. Mr. Murray Provan, a 53 year old health and safety inspector with the Health & Safety Executive told the Inquiry that he had been an inspector since 1993 and that he had a B.Sc. in Mining Engineering. He also held the Diploma in Health and Safety. He had worked as a mines inspector with the National Coal Board from 1974 until 1990, and then in the tyre industry until taking up his present post. His main duties currently were as a construction site inspector. On top of that he had to carry out accident and complaint investigation. He was a member of the HSE Construction Division based in Edinburgh. His work covered building and civil engineering construction works. In his time at HSE he had had to investigate 15 fatal accidents. His territory extended from the Scottish borders to the Shetlands. It was part of his remit to visit sites without prior notice. Given the scarce resources of HSE, these had to be selected on the basis of certain criteria. There were certain builders in whom HSE had an interest and certain types of work about which HSE had concerns. He was familiar with the Construction (Design and Management) Regulations, 2007, and their predecessor and with the requirement in terms of the Regulations for notification to be given to HSE where operations on site were likely to exceed a 30 day period. He had approximately 27 colleagues in the Construction Division in Scotland and they received notification of about 7,000 sites per annum throughout Scotland which works out at 233 sites per inspector so it was not practicable for every site to be visited on a regular basis. Small companies engaged in housebuilding was one of the target groups. This was determined partly by accident statistics and partly by inspectors' experience.

26. Before going further, it is worth noting the terms of the Construction (Design and Management) Regulations, 2007, so far as relevant. The Regulations apply throughout

Great Britain to "notifiable projects." A notifiable project is one likely to involve a construction phase of more than 30 days or 500 person days. Where the regulations apply, and it is evident that they will apply to all but the smallest of building projects, a responsibility is placed on all persons to whom the Regulations apply to ensure that anyone appointed as CDM co-ordinator, designer, principal contractor or contractor "is competent," and concomitantly, no one in any of those roles, prospectively, is to accept appointment unless they are competent. They are to be competent to perform any requirement and avoid contravening any prohibition. One of the principal functions of appointees is to "seek the co-operation of any other person concerned in any project involving construction work at the same or an adjoining site so far as is necessary to enable himself to perform any duty or function under these Regulations." There is a concomitant duty to co-operate with anyone else on whom there is a responsibility to perform duties and functions under the Regulations. Regulation 5(2) also creates a duty applicable to every person concerned in a project who is working under the control of another person to "report to that person anything which he is aware is likely to endanger the health or safety of himself or others." There are duties to co-ordinate activities to ensure health and safety and to take account of the general principles of prevention and ensure that these are applied. The first class of persons on whom duties are placed are "clients" i.e those who, in the course or furtherance of a business, seek or accept the services of another which may be used in the carrying out of a project for him or carries out a project himself. In the present case, DHSL are clients in both these categories given their employment of both direct and sub-contract labour. By Regulation 9, every client has to take reasonable steps to ensure that the arrangements made for managing the project, including the allocation of sufficient time and other resources, by persons with a duty under these Regulations are sufficient to ensure that the construction work can be carried out so far as is reasonably practicable without risk to the health and safety of any persons; that the requirements of Schedule 2 are complied with in respect of any person carrying out the construction work and that any structure designed for use as a workplace has been designed taking account of the provisions of the Workplace (Health, Safety and Welfare) Regulations, 1992 which relate to the design of, and materials used in, the structure. Schedule 2 concerns itself with the provision of welfare facilities and is of no immediate relevance to the present circumstances. But in broad terms what this Regulation requires is that, in the management of a given project, there is built in both sufficient time and sufficient resources for health, safety and welfare planning. Regulation 10 imposes on the client a duty to ensure that every person designing the structure and every contractor who has been or may be appointed – so that would seem to extend the requirement to any contractor invited to tender for a given project – is promptly provided with pre-construction information, which is to consist of (a) any information about the site or the construction work; (b) any information concerning the proposed use of the structure as a workplace; (c) the minimum amount of time before the construction phase which will be allowed to the contractors appointed by the client for planning and preparation for construction work; and (d) any information in any existing health and safety file – all of this for the purposes of ensuring the health and safety of persons engaged in the construction work, liable to be affected by the way in which it is carried out and who will use the structure as a workplace. Again it is clear that the Regulations are designed to emphasise the importance of planning the safe execution and co-ordinated progress of any works of construction prior to their commencement. Duties are also placed on contractors and clearly DHSL were contractors in this instance. A contractor is prohibited from carrying out work unless the client is aware of his duties under the regulations – in other words it will be part of

the duty of a contractor to ensure that the client knows what duties lie with clients. More specifically, by Regulation 13, every contractor shall "plan, manage and monitor construction work carried out by him or under his control in a way which ensures, so far as is reasonably practicable, that the work is carried out without risks to health and safety." That regulation very clearly imposes upon the contractor for any given building project responsibilities for planning a safe and healthy construction operation prior to its commencement and as it proceeds from stage to stage and to manage and monitor that the steps incorporated to ensure such safe and healthy construction can occur are in place and are maintained throughout the works. Contractors are required to give sub-contractors time to plan the safe and healthy execution of their sub-contract. They are also to give to "every worker carrying out the construction work under his control " information and training which he needs for the particular work to be carried out safely and without risks to health including suitable site induction, information on risks to their health and safety identified by his risk assessment under Regulation 3 of the Management of Health and Safety at Work Regulations 1999 or arising out of the conduct of another contractor of which he is or ought to be aware, the measures identified to obviate the risks and to comply with health and safety legislation, any site rules, emergency procedures and the identity of persons nominated to implement emergency procedures. By Regulation 14, where, as here, a project is notifiable, the client is to appoint a CDM co-ordinator to carry out the duties imposed by these Regulations. The client is also required to appoint a principal contractor. Where a client does not do so, the client is deemed to have been appointed as CDM co-ordinator and principal contractor and all the statutory duties will fall on him. The client is to give the CDM co-ordinator the pre-construction phase information and all available information relating to site health and safety. The client is to ensure that the construction phase does not start until the principal contractor has provided a construction phase plan. A health and safety file should be kept. The contractor should not start work without being aware of the identity of the CDM co-ordinator and having access to the construction phase plan, if he is not the main contractor. The CDM co-ordinator is then to advise the client on undertaking the measures he needs to take to comply with the Regulations and to ensure that suitable arrangements are made and implemented for the co-ordination of health and safety measures during planning and preparation for the construction phase including facilitating co-ordination among contractors and sub-contractors and the application of the general principles of prevention. He is also to liaise with the principal contractor regarding the contents of the health and safety file and the provision of information required for the preparation of the construction phase plan. The CDM co-ordinator is responsible for compiling and maintaining the health and safety file. The CDM co-ordinator is responsible for ensuring that notification of the project is given to the Health and Safety Executive in accordance with the requirements of Schedule one of these Regulations. In the present case, while Mr. Pratt may have been deemed to be the CDM co-ordinator, there was no construction phase plan written down and little sign of any other pre-construction phase health and safety planning. By Regulation 22, duties during the construction phase then fall on the principal contractor to plan, manage and monitor the construction phase in a way which ensures that, so far as is reasonably practicable, it is carried out without risks to health and safety including co-operation and co-ordination of the activities of sub-contractors. He also has duties to liaise with the CDM co-ordinator especially in relation to any change in the plan, to ensure welfare facilities are provided, to draw up site safety rules, to instruct a contractor to act in a manner which complies with the principal contractor's duties in relation to health and safety and to consult on health and safety with such contractors, to ensure that such contractors have enough time to make their own welfare provisions for their employees

and have plans to carry out the work with proper regard to risks to health and safety, to ensure that all contractors know the identity of the CDM co-ordinator, that all workers undergo site induction and to ensure that their employer has provided them with health and safety training and, where necessary having regard to the conditions on the site, to supplement that health and safety training. The principal contractor is also to prepare a construction phase plan and keep that plan under review. The plan should identify the risks to the health and safety of persons on the site arising from the construction work, (including the risks specific to the particular type of construction work concerned) and include suitable and sufficient measures to address such risks, including site rules. The principal contractor also has a duty formally to consult with workers or their representatives on health and safety issues. Little, if anything, was done by DHSL or Mr. Pratt in implement of the duties of client or principal contractor under the CDM Regulations so far as concerns the general part. There are also a series of specific Regulations particular to particular aspects of construction work including the provision of safe access to and egress from places at which a person has to work, safe places to work, sufficient safe space in which to work, safe maintenance of a site, stability of structures on the site, the planning of demolition and dismantling having regard to safety, the provision of traffic routes, the prevention of fire and the provision of fresh air, weather and temperature protection and lighting. Plainly the unguarded edge of the smoke extraction shaft was not a safe place at which a person could work.

27. Mr. Provan happened to be in Dundee on 29th. May, 2008 when he received a telephone call from his Edinburgh office about a report from Tayside Police of the accident to Mr. Freitag, though there was no information as to its seriousness beyond that the employee had been taken to hospital. Mr. Provan had previously been to this site. He had been there while the site was in the possession of a demolition contractor undertaking site clearance and asbestos removal. He attended and met Mr. Pratt. He had encountered him before when he had worked for Discovery Homes Limited as a site agent. He also met with P.C. Buchanan who gave him the information he had so far acquired. He ascertained that DHSL were the principal contractors. He, P.C. Buchanan and Pratt all then went to the locus of the accident where he saw the top of a smoke extraction shaft on the top landing of the flats under construction which was protected by a red roadworks barrier. There was a similar barrier protecting the edge of the landing at the top of the stairwell. The hole constituting the top of the shaft was 1.56m broad by .93metres deep. The drop was 2.9 metres. He was initially told by Pratt that the two barriers were in the places in which he saw them at the time of his inspection at the time of the accident, but later Pratt admitted that that was a lie. Crown production 2, photograph T, in addition, showed the unguarded edge of a flight of stairs from which a person could fall down the stairwell. He was shown a stick and a green glove at the point at which it appeared Mr. Freitag had landed. He was then taken to the flat where Mr. Freitag had been found and could see blood stains on the floor. He was given the name of the injured worker. No one had actually seen the fall. He confirmed that Mr. Freitag was legitimately employed by DHSL as a bricklayer. In the light of what he had seen on site, Mr. Provan prepared and issued a prohibition notice which effectively brought work on site to a halt. He had been particularly concerned about the defective state of the scaffolding. It also required DHSL to re-assess the access and work at height arrangements for a stairway under construction. He later received confirmation from Mr. Pratt that the steps necessary to address all the issues raised by the prohibition notice had been taken and the notice was withdrawn. I understood from Mr. Provan, to my alarm, that it was normal for inspectors to withdraw prohibition notices without re-inspecting. I recognise the limited resources available to the Health

and Safety Executive but consider this practice is unacceptable having regard to the public interest and recommend henceforth that in every case where a prohibition notice is issued that there should be a re-inspection before the prohibition notice is withdrawn to ensure that all matters which gave rise to the issue of the notice have been rectified. Mr. Provan acknowledged that this practice was not entirely satisfactory. It was his recollection that while he was preparing this notice that word of the major deterioration in Mr. Freitag's condition was received and that his injuries were likely to prove fatal. Mr. Provan and Mr. Pratt then both went to Ninewells Hospital. Mr. Provan hoped he might have an opportunity to speak to Mr. Freitag. He discovered instead the full gravity of the injuries. It was at the hospital that Mr. Pratt admitted he had lied about the barriers. Mr. Provan admitted that he was surprised, having formed the view that Mr. Pratt had been honest and co-operative. Mr. Provan instructed him that the site was to remain undisturbed and that he would return with a colleague in the morning to conduct further inquiries.

28. Mr. Provan returned to the site on 30th. May with a colleague and they took a number of photographs and measurements. The most significant one was the distance from the floor of the top floor to the floor of the middle floor, the distance fallen in other words, which was only 2.91 metres. Mr. Provan spoke to P.C. Buchanan and was updated on the latest information about Mr. Freitag – essentially that he was on life support, that his sons were travelling from Poland and that brain stem death tests were scheduled to take place later. Mr. Provan recognised that the circumstances were such that there should be a police enquiry as to whether any question of corporate culpable homicide arose under the newly in force provisions of the Corporate Manslaughter and Corporate Culpable Homicide Act, 2007 and that was when the CID team led by Det Sgt. McMahon took on responsibility for the enquiry. Mr. Provan rendered them assistance and while it is encouraging to record that level of co-operation, I observe, and do no more than that, that some thought may need to be given to developing some sort of protocol for joint investigation between police and HSE in such circumstances, if it does not already exist. This was the first occasion on which Mr. Provan had had to apply his mind to the new provisions. One of the things he discovered in the course of the site examination he conducted that day was a second stairwell where there was a similar lack of edge protection as in the stairwell where the accident occurred. Mr. Provan submitted a series of three reports to the procurator fiscal and put in an enormous amount of careful work and thought into this case and it is appropriate that I should acknowledge his valuable contribution to this inquiry. When it came to his conclusions, he was quite clear that there were no adequate precautions taken to prevent Mr. Freitag or anyone else from falling down the smoke extraction shaft. It would have been both reasonable and practicable to have a temporary rigid barrier installed there, for example one comprising scaffolding components or using a wooden framework which was what was put in place. The red roadworks barriers were insufficient protection, even had they been in place, which they were not as they were readily moveable, flimsy and not securely footed. They were not designed for edge protection. The health and safety management, in the form of Mr. Pratt, was poor. He may have been on the five day course but it was not obvious that he had absorbed much of its content. He had a poor understanding of the functions and responsibilities of a principal contractor, particularly in relation to the design of systems of work and inter-relationships among the various sub-contractors on the site. He paid lip service only to health and safety considerations. He did not undertake risk assessments prior to the commencement of the work. He paid little attention to the failures identified by Mr. Whyte from the Murray Safety Group when he carried out site inspections, with the same

faults recurring and little evidence of action to rectify the defects so identified. He appeared to leave safety to individual employees and sub-contractors and failed to address, during the progress of the works, any process designed to eliminate or minimise risks which were arising. The accident was entirely foreseeable. There were no precautions at all taken at the locus of the accident to prevent a person from falling down the shaft. There was a clear breach of section 2 of the Health & Safety at Work etc Act, 1974. There was no safe system of work. Parts of the site were unsafe. Mr. Pratt appeared to be unaware of the existence of the Work at Height Regulations, 2005 and the Management of Health and Safety at Work Regulations, 1999. There had been no risk assessment for the purpose of identifying places from which persons could fall. He had failed to undertake the duties incumbent both upon the client and the principal contractor under the Construction (Design and Management) Regulations, 2007 in relation to planning and management of the work from the health, safety and welfare perspective. He should have known, given the position he purported to be fit to occupy, what measures were reasonable and practicable and should have taken them. Mr. Freitag's death was directly occasioned by these failures.

28. Mr. Provan put this in context informing the inquiry that there was an annual toll of between 70 and 75 deaths on construction sites and that inspectors were increasingly instructed, since the figure was not reducing, to consider the culpability of individuals, particularly in the area of risk management. He referred to a publication, HSG65, entitled, "Successful Health and Safety Management," which inspectors tended to use as a compliance or non-compliance checklist and which, in his opinion, contained in straightforward, readily understood language a basic guide to the requirements on those responsible for health and safety generally which they required to undertake to satisfy the statutory provisions. First there had to be a health and safety policy, which had to be in writing where an employer employed more than five employees. There had been none found in the case of DHSL. Then there had to be an organisational structure relating to site health and safety so that everyone on a given site knows what their responsibilities are and who else has responsibilities and what they are. There was little sign of such a structure on this site. Third, there had to be planning in the form of risk assessment followed by action to address the elimination or minimisation of identified risks. That simply had not occurred on this site. Fourth there had to be a monitoring process. It is accepted that Mr. Whyte provided a degree of monitoring, but he was merely using his own knowledge and experience rather than working from any written system of work or risk assessment document from which he could have spotted, for example, out of sequence working which is a well known cause of prejudice to site safety and finally there should be a review process – a safety audit as it is now commonly referred to – so that one can assess whether the safety plan was successful. It is accepted that Mr. Pratt undertook site inductions, albeit apparently not for Mr. Freitag. He had undergone some relevant training. He took some steps to try to ensure compliance with the use of personal protective equipment with limited success, according to the evidence. He recognised some risks, though usually once they had been created rather than beforehand. He ensured that employees carrying out specialist tasks had the requisite certification, e.g. in relation to the use of the remotely controlled tower crane, though I retain significant reservations about the wisdom of using it to lower loads into the constricted space of the stairwell and think that should have been obvious to a trained operator. But there was no overall safety plan; there was no risk assessment; there was no plan to minimise or eliminate risks. There was no consideration given to the legal requirements for protection for people working at heights. Mr. Provan made the point that the only

notification required in relation to a construction site was form FP10 under the Construction (Design and Management) Regulations, 2007 which did little more than identify various parties on a construction site and provide very basic information about the location of the site, a brief description of the project, the planned date for the start of the construction phase, the identities of contractors other than main contractors and an estimate of the number of people who would be working on the site, though it does contain a declaration on behalf of the client that the client is aware of his duties under these Regulations. There was no requirement to exhibit to HSE or anyone else anything like a method statement or schedule of works, safety policy or risk assessment. A requirement to show such documentation would be helpful. He put little store in the obligation to produce a written safety policy. Most of the ones he had read were hopelessly lacking in specification. Large entities in the construction industry generally had a recognised management structure where matters relating to health and safety had their place and the legal requirements were understood and complied with. Small companies like DHSL had no management structure to speak of and it was sadly commonplace for such operators to have no systematic approach to site health and safety. In the instant case, the state of the scaffolding, as he found it on 29th. and 30th. May was a good illustration of the problems, though I need to make it clear that the condition of the scaffolding was not a factor in the accident. Various trades were using the scaffolding in different ways, some as means of access and egress, some as a working platform and there was no control over who was on a given part of the scaffolding at any point in time, so if someone had removed a handrail to gain access to a particular location, there would have been no warning to those using the scaffolding as a working platform and there appeared to be no control system to ensure that any handrail or other feature which had to be temporarily removed was put back. The five day training course for site agents on health and safety run by the CITB did not in his opinion on its own equip someone to be solely responsible for site health and safety. Most site safety officers came from a background of experience on the tools supplemented by extensive health and safety training courses. Again, with the smaller operators, there did not tend to be safety officers. The HSE were trying to address this by serving Improvement Notices under section 21 of the Health and Safety at Work etc. Act, 1974 requiring the employment of someone competent to be a CDM co-ordinator. They also wrote to company directors expressing concerns following site visits about the lack of any competent people from the health and safety perspective on sites. It appeared with small operators that HSE were commonly told that no one had the time to address these issues.

29. Statistics did tend to show an increasing proportion of accidents in construction involving migrant workers, that expression being defined for these purposes as meaning someone who was not a British national. This was believed to be associated with a lack of stability of employment. Mr. Provan acknowledged that so far as the employees of DHSL were concerned, the workforce appeared to be relatively stable and he could find nothing to suggest that this accident had occurred because of any problem of comprehension on the part of the Polish workers or any cultural issue or different method of working. There was said to be a trait among Polish workers to get on with the work and the point was made that there have been a significant number of accidents which occurred because people were in too big a hurry, but the evidence does not particularly suggest anything of that sort i.e. there was no question of misunderstanding instructions and no question of shortcuts being taken or corners being cut. While the method of introducing the concrete to the stairwell by crane may not have been well

considered, I accept that that method was preferred because it was thought to be the easiest way to undertake the work – though not necessarily the quickest, but there was some suggestion that to deliver the concrete from outside the stairwell would have been more labour intensive and therefore more expensive.

30. Richard Pratt have evidence to the inquiry to the effect that he was a 39 year old currently employed as a director of DHSL. He had a B.Sc in Mechanical Engineering from 1996. He had spent time in the armed services. He had operated a construction workers recruitment agency. More recently, he had worked as a site agent for Discovery Homes Limited, the parent company of DHSL. DSHL was a vehicle specifically designed to acquire and develop the Tay Spinners site. He had not previously been involved in the construction of buildings more than one storey high and these had been detached and semi-detached houses on a green field site. He had never worked on a brown field site. The plan was to build approximately 90 dwelling houses comprising a mix of flats and so-called town houses with a total resale value of approximately £2.9 m, so it was a project of some substance.

31. He was shown Crown production 4 and agreed that this was a form F10, notification to the Health and Safety Executive of the commencement of work on a construction site. The form makes reference to a CDM co-ordinator, which is a term of art used in the Regulations and it might be supposed that anyone completing this form with any care might apply their mind to the need to have a CDM co-ordinator. In the form, the planning supervisor was said to be the "John Duguid Partnership." No evidence was led from anyone there so I am in the dark as to what their role in safety planning may have been and Mr. Pratt did not suggest that they had any major role. Mr. Pratt had signed the declaration as principal contractor confirming that DHSL were both client and principal contractor. Mr. Pratt said in evidence that the "planning supervisor" had "quite a specialist role but he could not describe what that role was. He regarded himself as the site health and safety manager but he seemed to have spent a lot of time being himself involved in basic site works. DHSL had about 20 direct employees on the site plus sub-contractors. About nine of the direct labour force were Polish nationals including Mr. Freitag. He had given all the employees a site induction, though he could find no record of that for Mr. Freitag. He accepted, that given his responsibility for health and safety on site, it should have been part of his responsibility to undertake risk assessments of the work to be carried out. He was unfamiliar with the Management of Health and Safety at Work Regulations, 1999 and had not made any written record of risk assessment. He had not appointed any competent person as the Regulations require to assist him in ensuring compliance with their terms. Regulation 7(5) required that to be a competent person the individual would require to have sufficient training and experience or knowledge to enable him properly to assist," in ensuring compliance. Mr. Pratt was unaware of this requirement. His understanding of risk assessment was that it was something you undertook once you had created the risk, if you noticed that you had created a risk but the employees were all experienced and should have seen the risks for themselves. He seemed to have difficulty in understanding that the best building trade employees in the world would have difficulty in working safely in the absence of a sequenced working plan and an assessment of the risks to which the plan meant they were likely to be exposed. The concept of conflict among various trades appeared to be unknown to him, yet the problems with the scaffolding, on the evidence I heard, seemed to be as a direct result of conflict among different trades using the scaffolding. It

became very clear that Mr. Pratt did not have the knowledge, training or experience to take on responsibility for the health, welfare and safety of the workforce. He could not therefore fulfil the role of "competent person" and could not therefore be a CDM co-ordinator. He did not recognise this and therefore did not employ anyone else to fulfil this function and, as I understood his evidence, nothing had changed in the aftermath of the fatal accident. There were no method statements, no programme of works, no safety policy, nor risk assessments. In particular, no thought had been given to what risks might arise in the course of concreting stairs made of pre-formed metal. It should have been obvious that a person working on concreting stairs and landings would have been working at height without any guarding to prevent a fall. It should have been obvious that a fall from height was a risk. It should have been obvious that it was a risk which could reasonably and practicably be eliminated. Instead, he saw the introduction of protective barriers as something which would interfere with his plan to deliver concrete by crane into the stairwell. He did not appear to have discussed the wisdom of that plan with any of his employees or sub-contractors. They found out about it when it happened. So it was an *ad hoc* system of working which ignored obvious safety risks. This was the same approach as applied to his *ad hoc* risk assessment. In that respect, his evidence was that employees should recognise the risk of falling. Of course everyone should recognise the risk of falling but, using the HSE figures, that does not prevent some 86,000 people a year turning up at hospital casualty departments having fallen from height. The whole ethos of the Regulations is to designate people in particular positions of authority to take responsibility to prevent individuals failing to take care for their own safety and that of others, not to leave that responsibility to each individual. He knew that the inspections carried out by Mr. Whyte from the Murray Safety Group were time-limited and could not therefore be comprehensive but insofar as the reports produced drew his attention to defects, he still had no system for remedying them and recording that he had done so. Nor was there any investigation or follow up as to why the defects occurred and therefore no system was devised to prevent recurrence. He could not even explain why the police could not find a report for every month.

32. He had been on the site on 29th. May, 2008. He was aware of the work in the stairwell as it had started the previous day. One of the workers engaged in this activity was Mr. Freitag. This was the third stairwell, two others having been satisfactorily completed using the system of delivering the concrete by tub from the crane into the stairwell. The landings had already been done and it was only the individual steps which required to be concreted. He had no explanation for the failure to guard the smoke extraction shaft. The tub from the crane was being delivered into the stairwell at the other side of an internal wall from the smoke extraction shaft. So a preventative barrier there would not in any way inhibit the crane operation. He was at a loss to understand why Mr. Freitag had been there yet the evidence of Mr, Pakowski in his statement to the police suggests that someone had directed him to go there when the crane loads were being delivered, just as he had been directed to act as banksman. Mr. Pratt accepted that he had had no discussion and had not issued any directions about dealing with the arrival of the loads by crane. In particular, no instruction had been given to leave the tubs alone and let the crane operator do his job. It is also hard to understand, if the location of the load as it descended into the stairwell was critical, why Raymond Din, who with his remote control panel could operate the crane from anywhere on the site, did not go into the stairwell where he could have instructed others to leave the load alone and to stay out of the way until it was deposited on a particular flat area. Mr. Pratt was made aware of the accident and found Mr. Freitag and a number of other workmen in Flat 49. He was on his hands

and knees with blood on his nose and head. It was reported to him that Mr. Freitag was saying in Polish that he was tired and wanted to go home. His breathing was laboured. Mr. Pratt was properly concerned about the head injury and decided that Mr. Freitag should go to hospital and that he should take someone with him who could act as Polish translator – Mr. Beyger. He took Mr. Freitag in his own vehicle to Ninewells Hospital. He did not appreciate at that point the enormity of the injuries which Mr. Freitag had suffered. I should record, for the avoidance of doubt, that there was no suggestion of any state of injury being worsened by not calling an ambulance and conveying him in a private vehicle. Mr. Pratt then returned to the site, later getting a telephone call from Mr. Beyger informing him that Mr. Freitag might die. In the meantime, P.C. Buchanan had arrived on the scene and he was followed by Mr. Provan and Scenes of Crimes officers. He had taken both of them to the locus and had misled them about the presence of the roadworks barriers which he had instructed should be placed where they were following the accident. He accepted that there was no excuse for not having a barrier there. Mr. Provan issued a Prohibition Notice and worked stopped. Subsequently, Pratt was interviewed by the police, initially the following day by Det. Cons. Wishart, and about a month later having been detained under s. 14 of the Criminal Procedure (Scotland) Act, 1995, at Police Headquarters, Dundee by Det Cons. Adam and Duncan.
There had been a prosecution against both himself and DHSL resulting in fines of £4,000 and £5,000 respectively. He was aware after the event about the speculation that Mr. Freitag had been using a stick to guide the tub suspended from the crane and he could not understand why anyone would try to do such a thing. His previous experience of Mr. Freitag when he had been the site agent at the green field site was that Mr. Freitag was safe and dependable. He accepted that Mark Teviotdale required some education in the field of health and safety. There was no good reason why the smoke extraction shaft had not been bricked up at top floor level as soon as the landing at that level had been screeded. It would take about 15 tubs of concrete per stairwell. The repetitive nature of this operation over not only each stairwell but a whole series of stairwells seems to me to have been crying out for, at the very least, a generic risk assessment. He was now preparing and working in accordance with prepared method statements. He acknowledged that his five day course had not even begun to address the process of risk assessment. He had been trying to get on a risk assessment specific course but had been told that it had been cancelled through lack of interest. He disputed the suggestion that he had failed to respond effectively to the defects listed in Mr. Whyte's reports but was unable to explain adequately why faults of the same nature kept recurring. The Polish workers were, in his assessment skilled, intelligent and reliable though sometimes they were so keen to get on with things that safety might take a back seat. He accepted that he had to do something to improve his own stock of knowledge about health and safety issues and recognised that he was very much now on the HSE radar. He welcomed the continued involvement of health and safety inspectors in site inspections. There is no doubt that Mr. Pratt has some impressive qualities but I was disappointed that someone with his background had deliberately lied to the police and had faked the position in relation to protective barriers in what he thought was a move which would protect his own interests. He seemed to me to continue to have an unreal assessment of his own abilities amounting to something approaching blind faith. I am afraid that I would have little faith, in the absence of someone else as CDM co-ordinator/safety officer, in his ability to run a safe construction site.

33. One of the most important and most gifted witnesses to give evidence t o the Inquiry was Dr. Ian Mellor, Consultant Anaesthetist, at Ninewells Hospital, Dundee who described

not only the heroic fight to save Mr. Freitag's life, in which he played a vital part, but also the courage and devotion of Mrs. Freitag and her sons and of the other Polish workers, particularly Alex Beyger, who, on account of his ability to translate English, was utilised by medical and nursing staff at the hospital to convey the news of the gravity of Mr. Freitag's condition to Mrs. Freitag, a task he undertook with dignity and care. Staff at Ninewells also deserve huge credit for finding a doctor on their staff who spoke Polish and for finding a Polish speaking priest whose services were a comfort to the family and to Mr. Freitag's workmates, all of whom were deeply saddened by these tragic events and all of whom did what they could to support the family.

34. Dr. Mellor, apart from having the standard medical degree, was also a Fellow of the Royal College of Surgeons (Edinburgh) and Fellow of the Royal College of Anaesthetists. He had been qualified since 1990 and had spent the bulk of his professional career at Ninewells Hospital.

35. On 29th. May, 2008 he had been requested to attend at the Accident & Emergency Unit at Ninewells to assist in the treatment of Mr. Freitag. He was given a history that Mr. Freitag had fallen from a height. Beyond that he had little in the way of history. He and a colleague, Dr. Hutcheson, went to assist and found that he was very very unwell. He was unconscious. He had been intubated to assist breathing and a chest drain had been inserted by the A & E Consultant and staff there. He was receiving intravenous fluids. He may have been given blood but Dr. Mellor did not think he had at that stage. His blood pressure was low and he was given a small dose of adrenaline. They were told that he had been conscious but confused on admission but had had a fit and that his condition had then rapidly deteriorated. He was continued on intravenous fluids and given two units of blood. A second chest drain was inserted. It appeared that the patient had a number of fractured ribs and possibly punctured lungs. Both lungs were being artificially inflated. The trauma to the right chest was obvious. Of greater concern was a boggy haematoma behind his right ear and a left side haematoma. A CT scan of the right haematoma demonstrated a significant head injury. Drs. Mellor and Hutcheson had worked on Mr. Freitag for about an hour trying to stabilise his blood pressure and he was being managed with the use of an adrenaline syringe driver. The CT scan showed an area of diffuse blood in the sub-arachnoid space. There was blood in the cerebral fluid. There was marked bruising to the right side of the brain, to the cerebellum and to the brain stem. His head was swollen on account of intra-cranial pressure. It was recognised that it was necessary to improve his blood pressure to maintain circulation in the brain. There appeared to be bleeding around the aorta which was probably the explanation for the low blood pressure. In fact when he was admitted to the Intensive Care Unit and another chest train was inserted, it filled rapidly with about two litres of blood. His haemoglobin and platelet levels were low and his ability to coagulate was compromised. A transfusion of a significant amount of blood was organised. As this was being transfused and the complications in the chest appeared to be improving, there were fresh signs of pressure affecting his cranium which was a bad indicator and the prognosis was worsening. Medication was attempted to try to reduce the cranial fluid and efforts were made physically to drain blood from the cerebellum using a syringe. They also had to deal with further episodes of fitting likely to have been caused by insufficient oxygen to the brain. A further CT scan demonstrated that internal bleeding including bleeding in the brain was continuing and that there had been further swelling. This was in the area which controls brain mechanism and when that area ceased to function, then the cessation of brain function was inevitable. One pupil was "blown" ie completely bloodshot, which was

another poor sign. It was an indicator of brain stem failure. Fixed, dilated pupils is a sign of death. It was at that stage determined that he could not be saved and the family were informed and asked about organ donation. Mrs. Freitag was anxious that her sons be present and he was kept alive overnight and remained fairly steady with adrenaline being introduced to maintain blood pressure. By morning, however, both pupils were fixed and dilated. Two sets of brain stem tests were carried out without response and life was pronounced extinct on 30th. May at 13.00 as a consequence of multiple injuries sustained as a result of a fall from height.

36. Dr. Mellor was asked about the difficulties of dealing with a patient whose first language was not English. He made the self-evident point that, given Mr. Freitag had never been conscious at any point at which he had been dealing with him, that in this case it had made no difference but he was aware from his colleagues in A & E that they were increasingly having to deal with lots of foreign nationals, with a large number of Poles in particular. Interpretation facilities existed by telephone 24 hours a day but that was not the same as a person being present. In this case a person he understood was a family friend helped with interpretation and he said that that person (Alex Beyger) had done very well in very difficult circumstances. He said a Polish speaking doctor had been found who came and lent assistance. Dr. Mellor regarded it as important to have someone who could interpret for the family. Ninewells had a sort of informal system where doctors and other staff who were foreign nationals would help where they could. He was unaware of any other better system anywhere in the United Kingdom and regarded the language barrier as an increasing problem, though he was not in a position to say that this was a systemic problem which required to be addressed. The family had agreed to organ donation post mortem and that had been carried out. As I have said, Dr. Mellor was a very able and gifted witness who gave his evidence with care and evident sadness about the outcome of this case.

37. Crown Production 6 was the post mortem report. Post mortem examination was undertaken on 3rd. June, 2008 by Dr. David Sadler, Consultant Pathologist, assisted by Dr. Elizabeth Wen Lien Lim. They had been given background information from Ninewells Hospital to the effect that Mr. Freitag had been pronounced dead at 13.08 on 30th. May, 2008 following the termination of life support. The cause of death was described as "multiple injuries caused by blunt force trauma sustained in a fall from height while at work on a construction site." Mr. Freitag had suffered a fracture of the skull with underlying brain injury and fractures to the spine and ribs. His condition deteriorated markedly shortly after his admission to hospital and he never regained consciousness. Tests for brain stem activity were negative. Consent was given for organ donation and the liver and kidneys had been removed. Examination of the body demonstrated bruising to the back of the right shoulder, an abrasion on the right hand side of the scalp and a minor abrasion on the outside of the left elbow. There was a severe skull fracture with underlying brain injury and swelling. There were numerous fractured ribs within the chest and extensive bruising over the back of the rib cage. There was a fracture of the thoracic spine. There were signs of a moderate degree of artheroscelerosis affecting the coronary arteries, to a degree typical of a man of his age. There was major damage to the brain stem.

38. An examination of the 14 reports prepared by Mr. Whyte of the Murray Safety Group relating to his site inspections at Tay Spinners between 6th. September, 2006 and 13th. May, 2008, demonstrated safety defects of a recurring nature. There are frequent

complaints about the condition of the scaffolding, about there being areas from which a person could fall from height and about unfenced excavations. It is a reasonable inference to draw from these reports that the kind of hazards which arise on account of the dynamic nature of a building site on which a variety of different trades were operating were allowed to arise without inspection and rectification and without consideration of the risks that they created for everyone working on the site. The picture portrayed by these reports is certainly not one of a well run site where the safety of the personnel was paramount. Quite the opposite.

39. Crown Production 12 is a statement taken by the police from Linda White, the only other director of DHSL. She stated that Richard Pratt was responsible for health and safety on the site and that he had attended a number of courses and was qualified in this field, though she did not know, when asked, what courses he had actually attended. She considered he had been on enough courses to allow him to operate as a site agent. She considered that the "onus was on him" to address safety issues. In other words, she took no responsibility for health and safety and did nothing to check that a safe system of work was being operated.

40. Mr. Boyle who appeared for DHSL lodged only one production, in relation to which he cross-examined Mr. Provan to some extent. This was a document entitled, "One Death is Too Many," and comprised a report to the Secretary of State for Work and Pensions by Rita Donaghy, who was formerly head of the Advisory, Conciliation and Arbitration Service, the document being sub-titled, "Inquiry into the Underlying Causes of Construction Fatal Accidents." My immediate reaction was to be concerned that such a report patently had a significantly wider remit than that of this fatal accident inquiry. However, having read it, I found its contents both absorbing and illuminating but also resonating with some of the principal issues arising in this particular case, suggesting that there are issues which feature in this inquiry which have been replicated in similar cases throughout the United Kingdom. Some of these worth highlighting are:-

(i) the high incidence of foreign or migrant workers involved in UK fatal accidents on construction sites;

(ii) the concern about the limited resources made available to HSE to carry out its vital work both pro-actively in terms of advising and policing construction work and reactively in terms of accident investigation, reporting and, where appropriate, prosecuting;

(iii) the need for the imposition of a positive duty on all directors of companies involved in construction to ensure good health and safety management through a framework of planning, delivering, monitoring and reviewing;

(iv) the need for prompt, effective investigation of accidents and for court proceedings to be initiated and concluded expeditiously;

(v) the need to enhance the understanding of management that most accidents occur because of poor planning including, without prejudice to the foregoing generality, poor risk assessment;

(vi) the need to appreciate that the consequence of the wide use of self-employed tradesmen on a job to job basis, as opposed to having a directly employed workforce, is that it is

more difficult, in the absence of continuity, for a safety culture to flourish, to get the workforce to engage with the process and more difficult to motivate people to provide, on the one hand, or undertake on the other, any training in issues pertaining to safety at work;

(vii) the need to recognise that there is a shortage of good site managers;

(viii) the fact that construction deaths appear to be regarded as socially acceptable rather than as a public outrage in the way that road traffic deaths now are;

(ix) the need to recognise that the main problems arise in the small building and refurbishment sector;

(x) the lack of a provision in the Health and Safety at Work etc Act, 1974, as amended, empowering a court to disqualify a director held responsible for a contravention of the Act; or other health and safety legislation or regulation;

(xi) the need to promote a better awareness and understanding of the purposes and requirements of the Construction (Design and Management) Regulations, 2007;

(xii) the need to recognise that, where strong leadership does not exist, and site conditions and supervision are poor, all construction workers are vulnerable and that statistics demonstrate that this is particularly true of self-employed contractors;

(xiii) the need to ensure that the tertiary education process for those who seek to be involved in the construction industry includes an introduction to the Construction (Design and Management) Regulations, 2007 and to the process of risk assessment;

(xiv) the need to recognise that the work of the Health & Safety Executive is crucial to safety management and compliance, enforcement and, to an extent, culture change; the further need to recognise that the inspector resource has been allowed to slip below an acceptable level; and

(xv) the need to recognise that most fatal accidents are foreseeable and preventable; what is missing is a safety culture as a result of inadequate training, experience and supervision.

Conclusions:

1. Superficially, this appeared to be a straightforward set of circumstances wherein an experienced building worker who happened to be a Polish national met his sad and untimely death by falling a relatively short distance on to a concrete surface from a gap where either there ought not to have been a gap at all or which gap should have been the subject of substantial, rigid edge protection in accordance with the provisions of the Work at Height Regulations, 2005. However, an investigation of the circumstances appears to suggest a number of deeper and wider issues which give rise to considerable cause for concern.

2. There is no doubt that Mr. Freitag fell to his death from the top floor of the stairwell near the south east corner of the Tay Spinners construction site when he was supposed to be concreting stairs. There is equally no doubt that the smoke extraction shaft down which he fell was unguarded and constituted an obvious risk which should have been eliminated and

which could have been eliminated both reasonably and practicably. Responsibility for that failure rests with DHSL and, in particular, with Richard Pratt, who accepted that he was responsible for site health and safety.

3. The Health and Safety Executive and Miss Donaghy's report both identify small building companies as statistically significant in relation to accident statistics. It is suggested that this is on account of flat management structures with poor understanding of the law, the regulatory framework and the practical benefits of adhering to a culture of safety at work. Whereas larger companies in the construction industry can devote a management team to these considerations, small companies simply do not and so compliance with the Construction (Design and Management) Regulations, 2007, which are all about planning safe systems of work from the design stage through to the completion of the construction phase, is poor to the extent of being either non-existent or superficial, and where there is no sign of consideration being given to the place of safety in the design and organisation of the work, little is done in the way of effective risk analysis and management and people in management, like Mr. Pratt, are hopelessly inexperienced and ill equipped in terms of training to understand and implement systems and regulations relating to safety. In his case, this was best illustrated by his complete ignorance of the contents of the Work at Height Regulations, 2005, notwithstanding he was engaged in the construction of a development with a value of almost £3m, comprising flats and town houses where a significant element of the work required to be executed at height. His failure to recognise or deal with risks whether he identified them himself or whether they were identified for him by Mr. Whyte leads to the cynical conclusion that he was more interested in making money from the development than ensuring the safety of his workforce. What was disconcerting was to hear from some of the workers that this was regarded as being a relatively good site to work on. What that suggests is that there are huge issues which require to be addressed by Government and the regulatory authorities if the lack of a culture of safety is to be changed.

4. There is already a good deal of regulation around the process of construction. In the present case I had to consider the requirements of the Construction (Design and Management) Regulations, 2007, which, for what it may be worth, do not strike me as being easy to comprehend, the Management of Health and Safety at Work Regulations, 1999 and the Work at Height Regulations, 2005. There is no doubt that, had the requirements of these three sets of regulations been adhered to, then this accident would not have occurred. That superficially suggests that there is no need for further regulation but there are two areas in which I would respectfully suggest that further consideration is required. The first relates to intimation to the Health & Safety Executive of a notifiable work of construction. By the stage that that is to be given, since intimation is supposed to be given by a CDM co-ordinator, there should be in existence on the part of the principal contractor, a health and safety policy in writing and something in the way of a method statement or system of working. All the present notification system does is inform HSE of the identity of certain parties to a work of construction. It tells them little, if anything, of the proposed means of executing the works. It tells them nothing about the ability of those who will have statutory responsibilities for health and safety to carry out those responsibilities. It was instructive to learn from Mr. Provan that HSE have been using Improvement Notices to require the introduction of competent persons to sites where they have found none, but that depends on the inspector reaching and having the time to undertake an inspection of the site concerned. Government needs to consider introducing requirements whereby there is produced to HSE a safety policy, a method statement and certification of the competence of the CDM co-ordinator for any notifiable work of construction before the commencement of the works can be authorised. That way the companies who are not prepared to take their responsibilities to their workforce seriously will

not get past the starting line. In addition, there is a greater need for regular site inspection by HSE which is the only independent agency in this field with people of the necessary quality to make sensible assessments of the satisfactory or unsatisfactory nature of arrangements on given sites for worker safety. I recognise that this has substantial resource implications but in the long term, this should lead to a well organised and highly skilled and trained construction labour force and management, better equipped for the future and able to carry out work safely.

5. I think it also needs to be said bluntly that the attitude of Mr. Pratt in relation to his first thoughts and acts of trying to re-arrange the accident scene by erecting barriers after the event and initially lying to the police and Mr. Provan, the health and safety inspector, requires outright condemnation and denunciation for its illegality and total lack of morality. Fortunately for him, he decided not to persist with it, but he was still fortunate not to find himself charged with an attempt to pervert the course of justice, and anyone inclined to conduct themselves similarly should be aware of this.

6. It was not clear from the evidence that much had changed at DHSL since the occurrence of the accident. I did not hear, for example, of the introduction of any monitoring of Mr. Pratt's performance as "health and safety manager," which, given the inept way in which he had performed hitherto, casts grave doubts about the interest of the management of this company generally in the safety of its workforce and suggests that there is merit in introducing a form of statutory responsibility applicable to all directors to implement and monitor health and safety policies and requirements. Mr. Pratt was continuing to be solely responsible for site health and safety though he still had no training on the process of risk assessment. He continued not to recognise his own limitations. While this state persists, there must be a risk of further accidents on this site.

7. There was nothing however to suggest that the poor state of safety on the site was caused by or contributed to by the Polish workers. While it was a further demonstration of Mr. Pratt's limitations that he made no inquiry of the Poles about their technical qualifications or experience, most of them had in fact undergone the equivalent of apprenticeships and the younger ones had been to what they described as "building college." There was no evidence from which I could conclude that there was a problem or contribution to the poor site safety on account of language difficulties. These in fact appear to have been reasonably well surmounted by the use of those who spoke good English being the channel of communication. In this context it is apt that I make special mention of Mr. Beyger. I did not have the good fortune to have the benefit of his direct testimony, but from what I heard from others, particularly Dr. Mellor, his assistance to the medical and nursing staff at Ninewells Hospital in communicating to Mrs. Freitag, and in assisting Mr. Freitag's sons to get to the hospital prior to their father's passing was outstanding and deserves special commendation.

8. I was fortunate in having a number of excellent witnesses to this inquiry. First among these was Dr. Mellor who was a clear, articulate, professional witness who described the immense struggle undertaken by him and his colleagues at Ninewells Hospital to save Mr. Freitag's life and then to deal as sympathetically and yet positively with his inevitable demise in assisting the family come to the conclusion about permitting organ donation and, of course, the family are to be commended for this act of life-saving generosity. Ninewells Hospital has for a variety of reasons been the butt of criticism of late but on this occasion it should be acknowledged by me that medical and nursing staff performed excellently in the most difficult of circumstances and it is to the credit of the administrative staff that at various times they were able to find a Polish speaking doctor to help the family understand what was

occurring and to find a Polish speaking priest who was able to bring some comfort to the family and to administer the final Sacrament to Mr. Freitag.

9. Mr. Provan was also an excellent and thoroughly professional witness whose answers to a number of difficult questions were sensible and measured. He is a credit to the Health and Safety Inspectorate and both in relation to his thorough enquiry into this unfortunate accident and to his work generally, he deserves to be commended.

10. I should also record that I was impressed by the quality of the evidence from the officers of Tayside Police who were involved in this inquiry and if I single out P.C. Jamie Buchanan and Det. Cons. Andy Adam for particular praise, the others should still regard themselves as having conducted a difficult enquiry with care and professionalism. Given that the nature of the enquiry was out of the ordinary for the police, P.C. Buchanan demonstrated significant insight about what was required from the moment he arrived at the scene and his prompt and effective intervention secured the preservation of important evidence. Not for the first time, he impressed me with his recollection of a remarkable amount of detail. Det. Cons Adam, while peculiarly qualified to assist in an enquiry that involved building issues, nonetheless used his knowledge to ensure that a proper and thorough police enquiry was conducted, examining all the relevant angles. The co-ordination between the police officers and Mr. Provan sharing each others' expertise was also welcome and effective but I have already observed that some thought might be needed to put that on a more formal basis for the future to ensure a high level of co-operation continues.

11. Mr. Freitag died as a result of an accident which was entirely foreseeable and entirely preventable. That is a public scandal and those responsible, particularly Mr. Pratt, should be utterly ashamed of their failures. From this tragedy, like too many others, the lesson most in need of recognition is that Governments can regulate until they are blue in the face but unless means are put in place to police compliance with these regulations, some people in the construction industry will continue to assume that they can ignore the rules about workforce safety, can get away without undertaking risk assessments, can ignore the requirements of health and safety regulations and can get away with it, except when some unfortunate individual, busy concentrating on his work, falls down another unguarded hole or from incomplete scaffolding. I urge that there be improvements in the certification of competent staff and the policing of health and safety legislation. That will be some small comfort to Mrs. Freitag and her family, to all of whom the Court extends its condolences.

SHERIFF COURT

JUDGMENT RECORD AND CATEGORISATION SHEET

CASE NAME:	FATAL ACCIDENT INQUIRY INTO THE DEATH OF ANDREZEJ FREITAG
AUTHOR	SHERIFF RICHARD A DAVIDSON
DATE SIGNED BY AUTHOR	29th. March, 2010-04-01
DATE RECEIVED BY MRS. CRANSTON	
DATE PUBLISHED ON WEB	

SHERIFF'S EDITING COMMENTS:

Was editing necessary ? NO

Judgment has been edited as required. NOT NECESSARY

CATEGORISATION OF JUDGMENT:

The judgment should be recorded under the following category

FATAL ACCIDENT INQUIRY – ACCIDENT AT WORK.