2014FAI28

SHERIFFDOM OF GLASGOW AND STRATHKELVIN AT GLASGOW

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

DETERMINATION BY Lindsay Wood, Sheriff of the Sheriffdom of Glasgow and Strathkelvin following an Inquiry held at Glasgow on the 30 June and 1, 2 and 30 July 2014 into the death of **MARK ANTHONY NEWLANDS**, born 12 September 1952 who latterly resided at 9 Bruce Road, Johnstone.

GLASGOW, 10 October 2014.

Part I: Introduction and legal framework

[1] This is an Inquiry under the Fatal Accidents and Sudden Deaths Inquiry (Scotland) Act 1976 into the circumstances of the death of Mark Anthony Newlands who died at 105 Mosspark Drive, Glasgow on 22 July 2011.

[2] Ms Eileen Beadsworth, Procurator Fiscal Depute, appeared in the public interest, Mr Alan Cowan, Solicitor Advocate, appeared for ASG Contracts Limited and Niall Macgee and Ms Laurie Traynor, Solicitor, appeared on behalf of John W Grant & Son Limited and Martin Noon .

[3] The Inquiry heard evidence and submissions over the course of four days ending on 30 July 2014. The Crown led evidence from 11 witnesses: (1) Alison Wallace or Downie; (2) Naseem Afzal; (3) Austin Hardie; (4) John Everett; (5) William Smith; (6) Niall Macgee; (7) Graeme Stewart; (8) Colin Wilkie;(9) Robert Bell;(10) Martin Noon and (11) Graeme McMinn.

[4] No other evidence was led.

Legal framework

[5] Section 6 of the said 1976 Act requires the presiding sheriff to make Determinations on the following matters: (a) where and when the death and any accident resulting in the death took place; (b) the cause of such death and any accident resulting in the death; (c) the reasonable precautions, if any, whereby the death and any accident resulting in the death might have been prevented; (d) the defects, if any, in any system of working which contributed to the death or any accident resulting in the death; (e) any other facts which are relevant to the circumstances of the death.

[6] The court proceeds on the basis of the evidence placed before it and although described as an Inquiry, the sheriff's powers do not go beyond making a Determination in relation to the circumstances established to his satisfaction by evidence following upon investigation by the procurator fiscal and any other party if so advised.

Part II: Determination as to the circumstances of the death

[7] The sheriff, having considered all the evidence adduced, FINDS and DETERMINES in terms of Section 6(1) of the Fatal Accidents and Sudden Deaths Inquiry (Scotland) Act 1976:

> (i) in terms of section 6(1)(a) that Mark Anthony Newlands, born 12 September 1952, who latterly resided at 9 Bruce Road, Johnstone died at the Southern General Hospital in Glasgow on 22 July 2011 following an accident which occurred at 105 Mosspark Drive, Glasgow at approximately 11.10 am on the same date. Life was pronounced extinct by 11.47 am.
> (ii) In terms of section 6(1) (b), that the cause of his death was 1(a) Chest injury due to 1(b) fall from height. Further, the cause of the accident resulting in the death was that while working at an open edge of a scaffolding platform, Mr Newlands lost his footing or balance and fell from the scaffolding at 105 Mosspark Drive, Glasgow to the ground below.
> (iii) In terms of section 6(1) (c), that there were reasonable precautions whereby the death and the accident resulting in death might have been avoided. In particular, Mr Newlands should have followed safe working practices, namely, he should not have used the scaffolding at 105 Mosspark Drive, Glasgow for loading when there was no up and over guardrail/gate restraint installed on the gates on said scaffolding.

(iv) In terms of section 6(1) (d), the following were defects in the system of working by Mr Newlands which contributed to the death: the lack of a safe system of work for loading onto the scaffolding.

(v) In terms of section 6(1) (e), there were no facts which were relevant to the circumstances of the death.

Part III – Findings in fact

[8] I found the following facts admitted or proved:

(1) Mr Newlands was instructed by Naseem Afzal to complete an extension at 105 Mosspark Drive, Glasgow in June 2011. Another contractor had done most of the work but it was not to the satisfaction of the house owner and his contract was terminated.

(2) Mr Newlands tendered for the job which involved mainly roof work and his tender was accepted. The tender was made on behalf of Lil Projects Limited on headed notepaper with Mr Newland's name on it. That is a company which was incorporated on 7 October 2010 by Mr Newlands' partner, Alison Wallace now Downie who gave evidence to the effect that she had done so as she intended to set up an interior design company. Mr Newlands had nothing to do with that company and she was unaware that he was bidding for work in the name of Lil Projects Limited. Ms Wallace was the sole director of that company and Mr Newlands was not an employee. The company was dissolved on 25 May 2012. Accordingly, it was Mr Newlands and not Lil Projects Ltd who was carrying out the work at 105 Mosspark Drive. Mr Newlands was the principal contractor on site and he had control and direction of the workplace and the works undertaken up to and including 22 July 2011.

(3) Mr Newlands contracted with ASG Contracts Limited to provide scaffolding which replaced the scaffolding used by the previous contractor. The work started on 25 June 2011 and it took two days to erect the scaffolding.

(4) A delivery of tiles was made to the site on 13 July 2011 and the tiles were taken to the top of the scaffolding by the use of a hoist. The delivery was made by Robert Bell for SIG Roofing Limited.

(5) Work commenced on the re-roofing and Mr Newlands contracted with Austin Hardie and William Smith to do the work.

(6) The scaffolding had been erected by John Everett and Graeme Stewart for ASG Contracts Limited. The sole director of ASG Contracts Limited was Niall Macgee who contracted with Mr Newlands and who was also involved in the scaffolding planning and subsequent erection.

(7) On 22 July 2011, a half pallet of roof tiles was delivered to the site by John W Grant & Son Ltd. The delivery driver was Martin Noon. He was driving a Mercedes Crane Mounted lorry. He met Mr Newlands when he arrived at the site and Mr Newlands asked that he lift the tiles to the top platform. Mr Noon agreed. He reversed his lorry close to the scaffolding at the house and lifted the pallet up by the crane to the top platform. At the request of Mr Newlands, Mr Hardie opened the gates of the platform. There had been two bars but they had been removed. There was no up and over bar or any form of edge protection.

(8) The crane lifted the pallet on to the platform and the tiles were taken off by Mr Newlands, Mr Hardie and Mr Smith. The pallet overhung by 6 to 8 inches. Mr Noon could not get it further onto the platform. Once the pallet was down and the tiles began to be unloaded, Mr Noon detached the crane from the pallet and raised it high with a view to bringing it down.

(9) In a matter of seconds and without Mr Noon seeing what happened, Mr Newlands fell from the platform to the ground, some 4 to 5 metres below. He landed on the ground but struck a small wall beforehand as there was some blood on the wall. A pallet with

polythene wrapping was found close to where Mr Newlands landed. It is likely that that was the pallet which the tiles were on.

(10) The accident happened around 11.10 am and at 11.15 am, a Rapid Response Unit Paramedic, Laura Flynn was called to attend at the site. She arrived there at 11.18 am. She saw Mr Newlands lying face down at the front of the house. He had a laceration to the back of his head, was not breathing and had no pulse. Other paramedics attended by ambulance and took Mr Newlands to the Southern General Hospital. CPR was administered to him en route. He arrived at the Southern General A & E at 11.40 am. He had no pulse, was not breathing and had fixed and dilated pupils. He had obvious chest, head and neck injuries. CPR was continued until 11.47 am when his life was pronounced extinct by Dr Laura Gillen.

(11) On 28 July 2011, a post mortem examination was carried out within the mortuary at Southern General Hospital and it revealed that Mr Newlands had died due to severe chest injuries entirely consistent with a fall from height. Externally, there were blunt force injuries to the head, trunk and limbs. Internally, examination of the chest revealed fractures of the ribs, particularly on the left side, a volume of blood within the left chest cavity, bruising of the lungs and tearing of the aorta, lungs, pericardial sac and heart. In addition, there were tears in the spleen. The cause of death was found to have been chest injury caused by fall from height. Blood and urine samples were taken from Mr Newlands and all analyses gave negative alcohol and drug results.

EVIDENCE OF WITNESSES:

Austin Hardie

[9] Mr Hardie is a self-employed slater who was contracted to work by Mr Newlands at the site of 105 Mosspark Drive, Glasgow in July 2011. Mr Hardie has 20 years' experience and his labourer was William Smith. Mr Hardie began work on 14 July and Mr Smith on 18 July. Mr

Hardie was acting on the instructions of Mr Newlands and he was to strip the roof and re-do it with new tiles. The scaffolding had been erected when he started working on the roof. Production 10 is a Trading and Safety Conditions Contract which Mr Hardie did not sign before the accident but he signed it before he went back to complete the job after the accident. The tower with gates was used as a loading bay for the roof tiles. Mr Hardie did not think it was for storage only. The hoist had been used to bring up the majority of the tiles. Mr Newlands put the tiles on to the hoist and these were taken off by Mr Smith who then passed them to Mr Hardie who placed them in various positions. The gates of the tower were not opened then and did not need to be given the delivery by hoist. On 22 July, there was a further delivery of roof tiles and these were brought up by the lorry crane. Mr Hardie was asked by Mr Newlands to open the gates to allow the delivery of the tiles which were on a pallet and which hung over the edge by approximate six inches. The driver couldn't get closer than that. Mr Hardie was at the left hand side of the gate, Mr Smith was behind him and Mr Newlands was on the right hand side. The idea was to take the tiles off and then close the gate. There was not a lot of room on the platform and a guardrail would have prevented the fall if the rail had been at the right height. Mr Hardie saw Mr Newlands fall. He thought that Mr Newlands may have tripped on something. He lost his footing and Mr Hardie did not look at Mr Newlands landing.

William Smith

[10] Mr Smith was a roofing labourer on the job and did casual work for Austin Hardie from time to time. He thought a loading bay and a storage bay were much the same thing. He confirmed Mr Hardie's evidence that the pallet with tiles came up via the crane. Mr Smith and Mr Hardie took the polythene off and unloaded all of the tiles. Mr Smith heard Mr Hardie say Mr Newlands name and he immediately turned round and saw Mr Newlands fall. By then all the tiles were off the pallet. Neither Mr Smith nor Mr Hardie moved the scaffolding after the accident.

Mr Smith didn't see what caused Mr Newlands to fall. He presumed he lost his footing. He could have been stretching to close the gate.

Niall Macgee

[11] Mr Macgee was the sole director of ASG Contracts Limited. He had 33 years' experience of the scaffolding industry. He only dealt with Mark Newlands and knew nothing of Lil Projects Limited. He had dealt with Mr Newlands on other jobs prior to the job at 105 Mosspark Drive. He was instructed by Mr Newlands in June 2011 to provide the scaffolding at 105 Mosspark Drive. Part of the scaffolding was to provide a tower or bay to keep the materials whilst the job was in progress. It was not envisaged that it would be used for loading tiles. ASG's terms and conditions were given to Mr Newlands and condition 8 states that the scaffolding is not to be moved but Mr Macgee said it happens a lot. Mr Macgee's position was that the tower was for storage and not loading. Mr Macgee said that Mr Newlands wasn't a trained scaffolder but had been a building contract manager and appeared to know what he was doing. Mr Macgee had visited the site with Mr Newlands and prepared a plan of the scaffolding which was approved. Mr Newlands asked for the tower to go specifically where it was put. It was a storage platform for the existing roof tiles. There were gates on the tower to stop material falling through. Mr Macgee used Mr Everett and Mr Stewart to carry out the work. He was involved also. After the scaffolding was erected, Mr Macgee checked the erection and walked round the site with Mr Newlands. On the particular storage tower, there were two handrails and toeboards at the sides and the front. The tower below was only for use by the scaffolders to assist them to carry out the erection. Photographs taken after the accident do not show any guardrails on the top tower and Mr Macgee did not know what happened to them. Mr Macgee had gone to the job on 15 July as he was in the area and found a handrail missing to the left of the top tower. He put it back on and everything else seemed in order. Mr Macgee thought that it would have been better if the tower had been to the right hand side of the house as that would have been easier for the delivery driver. Niall Macgee attended

the Part 1 Scaffolders Course between 21 March 1994 and 1 April 1994 at the National Construction College, Scotland. At this time, he was granted a Trainee Scaffolders card which expired after a three year period. He also attended a Scaffold Safety Inspection Course between 28 February 1994 and 1 March 1994 at the National Construction College, Scotland. Between 1 April 1994 and 22 July 2011, he did not attend any further scaffolding training. As at 22 July 2011, Niall Macgee's Trainee Scaffolders card had expired and he did not hold a Scaffolders card.

John Everett

[12] Mr Everett is a scaffolder with 19 years' experience and was working for ASG Contracts Limited prior to the accident. It took two days to put up the scaffolding. Mr Everett was working under the direction of Niall Macgee, Director, and working with Graeme Stewart whom he was supervising. Mr Everett's position was that the top tower was to be used for storage and not loading. He had no dealings with Mr Newlands. The tower below was to assist Mr Everett and Mr Stewart to put up the scaffolding. Mr Everett said that a loading tower would have had a swing bar. As it was a storage tower, gates were used to provide protection as it was not possible to get toeboards in. On looking at photos taken immediately after the accident, Mr Everett said that the two edge rails had been removed. He said that that happens all the time on sites. John Everett attended a Part 1 Scaffolders Course between 19 February 1996 and 1 March 1996 at the National Construction College, Scotland. At this time, he was granted a Trainee Scaffolders card which expired after a three year period. John Everett attended a Part 2 Scaffolders Course between 31 January 2011 and 11 February 2011 at the National Construction College, Scotland. Following this, he did not complete the assessment required for him to obtain a Scaffolders Card prior to 22 July 2011. Between 11 February 2011 and 22 July 2011, John Everett did not attend any further scaffolding training. As at 22 July 2011, said John Everett's Trainee Scaffolders card had expired and he did not hold a Scaffolders card.

Graeme Stewart

[13] He confirmed he worked with Mr Everett in putting up the scaffolding at 105 Mosspark Drive. Niall Macgee was supervising the erection of the scaffolding. As he was just a labourer, Mr Stewart made no decisions. It took two days to erect the scaffolding. He looked at photographs taken after the accident and noticed there were bars missing at the top and middle of the top tower. When gates are used it is too difficult to put on toeboards. Graeme Stewart attended a two week scaffolding induction course between 10 January 2011 and 21 January 2011 at the National Construction College, Scotland. Between 21 January 2011 and 22 July 2011, he did not attend any further scaffolding training. As such, as at 22 July 2011, he held a Trainee Scaffolders card. As at 22 July 2011, he did not hold any other scaffolders qualifications.

Robert Bell

[14] Mr Bell works for Sig Roofing Limited and drove a lorry crane delivering tiles to 105 Mosspark Drive on 13 July 2011. The tiles were placed on the left area of the front garden and later taken up by hoist. He is often asked to put tiles on roofs by crane but will not do it unless it is a load bearing scaffolding tower.

Martin Noon

[15] Mr Noon is a lorry driver with 30 years' experience. He delivered tiles to 105 Mosspark Drive on the day of the accident. There was half a pallet of tiles. He was asked to put the pallet on the top tower by Mr Newlands. He doesn't normally do that but he was trying to help. He reversed up the driveway and Mr Newlands asked him to put the pallet on the top tower. The gates were opened to give enough space to put the pallet on the tower. There was enough space. If there had been guardrails, that would not have allowed the pallet to be placed on the platform.

There was an eight inch overlap. That was as far as the crane could stretch. The pallet was spread evenly over the platform. Mr Noon released the pallet from the crane. There were two men on the scaffold tower. They started taking the tiles off. There were only seconds between delivery and the release of the crane. Mr Noon then saw Mr Newlands on the ground. He didn't see him falling. He did not think all the tiles could have been taken off the pallet at the time Mr Newlands fell. He did not see the pallet fall. He estimated there was only two or three seconds between the release of the pallet and the man falling.

Colin Wilkie

[16] Mr Wilkie is a retired senior scaffolding instructor with many years of experience. He latterly worked for the CITB. He gave evidence of what is required to obtain scaffolding qualifications. He confirmed that action is not taking against those who work without scaffolders cards. The scaffold erection at the locus was a Kwikstage one for which there is specific training. Mr Wilkie confirmed that neither Mr Macgee, Mr Everett or Mr Stewart had scaffolders cards at the time the scaffolding was erected. He did concede that you can be a good and competent scaffolder without training or qualification. Overall, he felt that due to lack of training and certification, the three men who erected the scaffolding shouldn't have done the job. However, with experience, they may have had sufficient competence. He confirmed that a storage base should not be used for loading and vice versa. A gate is used for loading and not for storage. He confirmed that if the tower was to be used as a loading bay, there had to be a swing over barrier to protect employees. There wasn't one on the top tower and so it shouldn't have been used for loading.

Graeme McMinn

[17] Mr McMinn is acting principal inspector with HSE having worked there for nine years and previously, he held significant health and safety roles with various organisations. His

expertise is in work at height and scaffolding. On 22 July 2011, he accompanied the police to carry out an inspection at 105 Mosspark Drive, Glasgow. He found the scaffolding to be in good condition. He said there was a loading bay on the top platform with double swing gates but there was no guardrail restraint or an up and over bar to provide protection to employees. He confirmed that it was a prefabricated system of scaffolding called Kwikstage. He confirmed that although the gates have toeboards, there were no boards at the front and left. He confirmed that it was a loading bay as there were gates used for loading. A storage bay would have had mesh guards, guardrails and toeboards. The scaffolders told Mr McMinn that the tower was only intended as a storage platform. Mr McMinn would not expect gates on a storage bay. The scaffolders said they had fitted handrails behind the gates as that would provide safety. Mr McMinn stated that it is always a danger when workers operate at an open edge with gates open. Mr McMinn could not find any missing guardrails or other scaffolding on site. Mr McMinn would have expected one of the scaffolders to be qualified. There was no evidence that they weren't competent but just that they were lacking in training. Mr McMinn concluded that the accident happened as work was going on at an open space and Mr Newlands either leaned out to close the gate or put his foot on the pallet and may have lost his balance. There was a pallet and broken tiles on the ground. He said it was common for parts of scaffolding to be removed. He confirmed that a swing over bar would have provided protection even if the pallet was still there.

Submissions

[18] The Crown – the procurator fiscal depute invited me to make certain determinations under section 6(1)(a) and 6(1)(b) which I have followed. She also asked me to make determinations under sections 6(1)(c) and 6(1)(d) which I have partly followed in respect of the actings and non-actings of Mr Newlands. The depute also asked me to make a finding under

section 6(1)(c) whereby the firm of ASG Contracts Ltd should have either attached an up and over guardrail/gate restraint to the gates on the scaffolding or to have installed toeboards and a top and middle handrail but not gates on the edge of said scaffolding. Thereafter, the depute sought to justify that such a finding should be made on the basis that neither an up and over guardrail/gate restraint was fitted and that there were no handrails in place at the time of the accident. The depute submitted that there was evidence which supports the position that ASG Contracts Ltd intended the scaffold for loading but did not equip it properly. She said it was known that a large number of tiles had to be placed on the roof. Further, the position of Graeme McMinn was that when he inspected the site, there were no handrails left lying around either on the ground or on the scaffold. This further suggested that there were no handrails fitted and challenges the position of the scaffolders who said there were.

[19] The Crown's *esto* position was that if the court is satisfied that handrails were installed behind the gates, a reasonable precaution whereby the accident and the death might have been avoided would have been for ASG Contracts Ltd not to have used gates on the scaffold. The depute suggested that the gates were at best a temptation and at worse misleading and could have given the impression that they could be opened.

[20] The depute also submitted that a further finding should be made in respect of section 6(1)(d) citing the failure of ASG Contracts Ltd to have either attached an up and over guardrail/gate restraint to the gates on the scaffold or to have installed toeboards, and a top and middle handrail rather than gates on the scaffold. This finding equates to the equivalent finding sought under section 6(1)(c) and the depute based her submission in an equivalent manner.

[21] Further, the depute submitted that findings should be made under section 6(1)(e) whereby the following were facts which were relevant to the circumstances of the death:

1 Martin Noon working for John W Grant Ltd, loaded a pallet containing tiles directly onto the bay from which Mr Newlands fell, leaving an overhang of the pallet which prevented the gates from being closed.

2 None of the three scaffolders who constructed the scaffold held a basic scaffolder's qualification. HSC Inspector Graeme McMinn would have expected one of the scaffolders on site to have held a basic scaffolder's qualification.

[22] The depute did not elaborate on these written submissions and at the hearing on submissions, she conceded that the court was unlikely to make any findings under section 6(1)(e).

[23] ASG Contracts Ltd and Niall Macgee – Mr Cowan adopted the submissions of the Crown in respect of findings under sections 6(1)(a) and 6(1)(b). As regards 6(1)(c) and 6(1)(d), he invited the court to conclude that there were no reasonable precautions which ASG or Mr Macgee could have taken which might have avoided the death of Mr Newlands and further that there were no defects in ASG's system of working which contributed to his death. He justified that by stating the evidence of Mr Macgee, Mr Everett and Mr Stewart was that the upper bay on the tower was for storage only. That is confirmed within the terms of the ASG Job Sheet and Invoice. In addition, there was no swing-bar which would be the norm for a loading bay. Further, there was photographic evidence that the bay had been used for storage and Mr Hardie and Mr Smith both confirmed that some of the roof tiles from the first delivery were stored on the bay. The fact that there were gates which provide edge protection might well indicate that the platform was a storage bay. The gates provide edge protection by way of inbuilt toe-boards and the mesh on the gates act as the equivalent of a brick-guard. There was also evidence of the difficulties in fitting toe-boards. Further, the evidence of Mr Macgee, Mr Everett and Mr Stewart was that cross-rails were fitted at the front of the bay. There is some disagreement between Mr Wilkie and Mr McMinn as to how the gates and cross-rails could physically be fitted but Mr Cowan's submission was that there was sufficient evidence to suggest that cross-rails were fitted but obviously removed prior to the accident. Both Mr Macgee and Mr Everett gave evidence that scaffolding being interfered with is a common occurrence and that was confirmed by Mr McMinn. Mr Cowan went on to say that as Mr Hardie and Mr Smith were adamant that they would not interfere with the scaffolding and remove the cross-rails, it could well have been the deceased who did that as he

was in control of the site and it was he who asked Mr Noon to deliver the tiles onto the platform. There was also further evidence that other items of scaffolding were removed post-erection and pre-accident. There was no clear evidence as to where these items ended up but Mr Cowan submitted that the Inquiry should accept that cross-rails were indeed fitted.

[24] As regards section 6(1)(c) and (d), Mr Cowan stated that ASG's role was restricted to the provision and erection of scaffolding. They had no ongoing responsibility for inspection. Responsibility for inspecting the scaffolding rested with the contractor, Mr Newlands. That responsibility began on the handing over of the scaffolding to Mr Newlands. ASG's terms and conditions include an express prohibition at clause 8 against scaffolding being interfered with. The Inquiry was invited to find that Mr Newlands' instructions were for the provision of a storage bay only. Further, Mr Cowan submitted that the storage bay was safe at the time it was handed over to Mr Newlands and Mr McMinn of the HSE said that with cross-rails, the scaffolding was safe and would comply with the Work at Height Regulations.

[25] As regards the lack of formal qualifications of the ASG people, Mr Cowan submitted that Mr Everett was a very experienced scaffolder, that Mr McMinn was content in general with the manner in which the scaffolding had been erected and that Mr Wilkie acknowledged that a scaffolder could acquire the relevant experience even if the formal training had not been completed. Both Mr Macgee and Mr Everett would have received some training in Kwikstage scaffolding and Mr Stewart was akin to a labourer with no decision making responsibilities. Although Mr Everett had not previously a built a storage bay, Mr Wilkie's evidence was that loading and storage bays were similar and that if a scaffolder could build one type, it would be expected he could build the other.

[26] Mr Cowan did not propose any finding in terms of section 6(1)(e).

[27] John W Grant & Son Ltd and Martin Noon – Ms Traynor submitted that formal findings should be made under sections 6(1)(a) and 6(1)(b). As regards section 6(1)(c), she submitted that Mr Newlands should have followed safe working practices, namely:

(i) use of edge protection on the upper scaffolding bay

(ii) installation and use of swing over guardrail/gate restraint on the upper scaffolding bay.

[28] In terms of 6(1)(d), Ms Traynor submitted that the following were defects in the system of working by Mr Newlands which contributed to the death:

(i) Lack of fall prevention in the form of a guardrail;

(ii) lack of fall prevention in the form of "swing-over guardrail/gate restraint".

[29] She submitted that there should be no findings in terms of section 6(1)(e) and no findings relevant to John W Grant & Son Ltd or Mr Noon in terms of section 6(1)(c), (d) or (e) of the 1976 Act. She justified that position by submitting that Mr Newlands was the principal contractor of the job at 105 Mosspark Drive, Glasgow. He had direction and control of the workplace and had responsibility for health and safety on site. Further, he had responsibility in relation to the Work at Height Regulations 2005 and the Workplace Health and Safety Regulations 1992. The top platform was under the control of Mr Newlands at the time of the accident. He asked Mr Hardie to open the platform gates and at that time, there was no guardrail, swing-over guardrail/gate restraint or edge protection in place. Accordingly, Messrs Newlands, Hardie and Smith were working for a few minutes at an open edge in breach of the Work at Height Regulations 2005. Mr Newlands fell to the ground as there was an open edge without protection. The working platform had a number of obstructions and this was in breach of the Workplace Health and Safety Regulations 1992.

[30] Mr Newlands had used the top platform for the loading on the day of the accident. A loading bay avoids the risk of workers climbing up ladders carrying tiles and materials. However, there was no suitable edge protection on the top platform such as a swing-over guardrail/gate restraint. When this is fitted, the worker is always behind a barrier and is not exposed to an open edge. The swing-over guardrail also provides edge protection when the worker opens and closes the gate. A guardrail or swing-over gate restraint would have prevented Mr Newlands from falling.

[31] Ms Traynor submitted that the practice of delivering a pallet to a suitably designed loading scaffold bay is standard but it should only happen if edge protection is in place. Mr Noon had complied with Mr Newlands' request and delivered the pallet of tiles onto the platform. He could not say for certain whether all the tiles were off the pallet or what happened to the pallet prior to Mr Newlands falling as he was concentrating on the crane. He did not see Mr Newlands fall and after the incident he was in shock.

[32] Ms Traynor opposed the Crown's submission under section 6(1)(e) that Martin Noon working for John W Grant Limited loaded a pallet containing tiles directly onto the bay from which Mark Newlands fell leaving an overhang of the pallet which prevented the gates from being closed. Ms Traynor stated that there was no evidence to support the fact that the pallet prevented the gates from being closed and nor was there any evidence that any attempt to close the gates was prevented by the pallet. Further, Ms Traynor submitted that a finding under section 6(1)(e) requires to be in the public interest and in the particular circumstances, the Crown's proposed finding under section 6(1)(e) is not in the public interest nor does it affect the public interest.

Conclusions

[33] There is no doubt that Mark Newlands died in an accident which should not have happened. In many ways, Mr Newlands had control over that as he was the principle contractor on site and had control and direction of the workplace and the works undertaken during the contract. He instructed ASG Contracts Limited to provide scaffolding and agreed with Mr Macgee as to what was required for the job. ASG erected the scaffolding in accordance with the agreed plan and in particular, they created a storage area on the top platform and <u>not</u> a loading bay. The construction of the top platform was such that it was not appropriate for loading as it did not have the necessary safety protection by way restraints and edge protection. The main delivery of tiles was done with safety in mind and by way of a hoist. However, further tiles were required and delivered on 22 July 2011. Mr Newlands persuaded Mr Martin Noon to lift the tiles onto the top

platform by way of his lorry crane and with the tiles placed on a pallet. In order that the pallet could be placed on the top platform, Mr Newlands' instructed Mr Hardie to open the gates and consequently there was no restraint or edge protection. The pallet was duly placed on the platform. The tiles were taken off and the crane released the pallet. In a matter of seconds after that, Mr Newlands lost his footing or balance at the top of the platform and fell to the ground whereby he suffered fatal injuries.

[34] In not having restraints or edge protection, Mr Newlands compromised the health and safety of both himself and the two employees, Mr Hardie and Mr Smith who were also working on the platform taking the tiles off.

[35] In such circumstances, I am persuaded that no criticism should be attached to either ASG Contracts Limited or Mr Niall Macgee, or to John W Grant & Son Ltd and Martin Noon. ASG Contracts Limited fulfilled their contractual obligations as to the erection of the scaffolding at the site including a storage bay on the top platform. I had no concern about the lack of current scaffolding Certification as it was clear the men had sufficient experience and competence. Mr Noon complied with a request from Mr Newlands to deliver the pallet with tiles. He did that and was not responsible at all for what happened thereafter.

[36] Given the acceptance of the above facts, the court has no difficulty in determining where and when the death took place and the accident resulting in the death. Similarly, the court is able to determine the cause of death and the accident resulting in the death. Further, the court is able to determine the reasonable precautions which Mr Newlands should have carried out whereby the accident and the death might have been prevented and can also state the defects in Mr Newlands' system of working which contributed to the accident resulting in his death. Accordingly, I do make findings as I have under section 6(1)(c) and 6(1)(d) but there are no findings to make in respect of section 6(1)(e).

[37] Finally, I wish to thank all of the witnesses for their assistance with this Inquiry and the solicitors for their valuable and professional contributions. I conclude by recording my condolences to the family of Mr Newlands.

LINDSAY WOOD
Sheriff of Glasgow and Strathkelvin

GLASGOW, 10 October 2014