

SHERIFFDOM OF GLASGOW AND STRATHKELVIN AT GLASGOW

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

DETERMINATION by
SHERIFF JAMES KENNETH
MITCHELL, Esquire, Advocate, Sheriff of
the Sheriffdom of Glasgow and Strathkelvin
following an Inquiry held at Glasgow on the
Nineteenth, Twentieth, Twenty first,
Twenty second and Twenty third days of
November and Tenth, Eleventh, Twelfth,
Thirteenth, and Fourteenth December all
Two thousand and Seven into the death of
THOMAS BOLESWORTH, aged 65 years,
who normally resided at 145 Garthland
Drive, Dennistoun, Glasgow.

GLASGOW, 23 January 2008.

The Sheriff, having considered all the evidence adduced, the competing submissions and the relevant statutory provisions, DETERMINES:-

(1) in terms of section 6(1)(a) of the Fatal Accidents and Sudden Deaths Inquiry (Scotland) Act 1976 that

(i) THOMAS BOLESWORTH, born 18 July 1940, who resided at 145 Garthland Drive, Dennistoun, Glasgow died on 6 JANUARY 2006 at 08.33 hours in the Intensive Care Unit of the Royal Infirmary, Glasgow; and (ii) the accident which resulted in his death took place at about 16.30 hours on 30 DECEMBER 2005 in the meat preparation room of the premises occupied by James McNamara trading as R. McMillan, Butchers, 434 Duke Street, Glasgow;

(2) in terms of section 6(1)(b) of the Act that

(i) the cause of Mr Bolesworth's death was multi-organ failure secondary to cardiogenic shock, secondary to myocardial infarction, secondary to sustaining approximately 38% mixed thickness scalding injuries to his face and body on his trunk, left arm and both legs; and

(ii) the cause of the accident resulting in death was that, in circumstances not fully established, whilst working in the course of his employment as a butcher alone in the meat preparation room, Mr Bolesworth, removed the lid from the Rose Cooker Mark X RE in order to stir the contents, placed it on the mincer, as depicted in the photograph comprising Crown Production 1A, then lost his footing, grabbed at this open cooker causing it to topple over towards him as he fell onto the floor of this room and the cooker to fall onto his lower body and legs resulting in some of its contents, namely, boiling meat about 65lbs in weight plus a quantity of boiling water, to spill over him causing him to sustain the scalding injuries above specified.

NOTE:

[1] This fatal accident inquiry into the death of Mr Thomas Bolesworth, aged 65 years, formerly residing at 145 Garthland Drive, Dennistoun, Glasgow was heard over the course of 10 days and concluded on 14 December 2007. Mr Steven Quither, procurator fiscal depute, conducted the inquiry on behalf of the Procurator Fiscal. Mr G Coll, advocate appeared on behalf of the Glasgow City Council and its employee Mrs Jane Dyer, an environmental health officer. Miss Louise Gallagher, solicitor, Glasgow appeared for Mr James McNamara who was Mr Bolesworth's employer when he sustained injuries in the course of his employment. Mr R E Conway, solicitor, Airdrie appeared for Mr David Bolesworth, who is the son of the deceased.

[2] The procurator fiscal led evidence from 12 witnesses, namely, Mr James McNamara, Mrs Carole McNamara, Ms Jacqueline Reid, Stewart McNaughton, Steven John McLean, Mrs Jane Dyer, Scott Thomson, Dr Martin Hughes, Peter Lavelle, Henry Lang, Josephine Anne Bell and George McCracken. Glasgow City Council and Mrs Dyer led evidence from Professor Anthony Busutill, who is the Medical Director, NHS Lothian Forensic Medicine Examiner Services and the Emeritus Professor of Forensic Medicine at the University of Edinburgh. For the son of the deceased evidence was led from Mr S Lenford Greasley and Dr Eric Livingstone, Gorbals Health Centre, Glasgow who was Mr Bolesworth's general medical practitioner. Parties entered into two joint minutes of admission, to which I shall later refer. No other evidence was led. It was agreed that the

Notes of Evidence led at this inquiry should be made available but these had not come to hand whilst I prepared this determination and I was content to rely upon my own notes.

Background matters admitted or undisputed

[3] Mr Bolesworth died on 6 January 2006 in the Intensive Care Unit of Glasgow Royal Infirmary subsequent to sustaining scalding injuries to about 38% of his body surface in an accident which occurred about 16.30 hours on 30 December 2005 whilst he was working in the course of his employment as a butcher at R. McMillan, Butchers, 434 Duke Street, Glasgow.

[4] In the second Joint Minute it was admitted that on 30 December 2005 at 16.45 hours, Mr Bolesworth was taken by ambulance from this butcher's shop to Glasgow Royal Infirmary, Castle Street, Glasgow; that he was admitted there at 17.05 hours and, on examination by medical staff there, was found to have sustained approximately 38% mixed thickness scalding injuries to his face, trunk, left arm and both legs.

[5] It was also admitted that Mr Bolesworth was admitted directly to the Burns Unit at the Infirmary, where he received appropriate fluid resuscitation and appropriate dressings. It was admitted that his progress was initially satisfactory but that his condition deteriorated on 3 January 2006 when he developed a chest infection, which showed evidence of pulmonary oedema (a gathering of fluid in the lungs) and adult respiratory distress syndrome (the rapid onset of respiratory failure). It was further admitted that on 4 January 2006, Mr Bolesworth was transferred to the Intensive Care Unit at the Infirmary where his condition was regularly reviewed. Finally, it was admitted that Mr Bolesworth's condition continued to deteriorate and that at 08.33 hours on 6 January 2006 he succumbed to his injuries and died.

[6] It was agreed by all those who appeared at this Inquiry that Mr Bolesworth had been an affable and uncomplaining man. He was an experienced, competent and hard working butcher, who was held in high regard in the place where he worked for the last 16 or so years prior to his retiral.

[7] Christmas and New Year were the busiest times of the year at this butcher's shop. Although he had retired, it was not disputed that Mr Bolesworth had remained very friendly with his former colleague and later employer James McNamara. The two of them agreed that Mr Bolesworth should come back into work for a couple of days at Christmas and again for a couple of days at the New Year. Characteristically, Mr Bolesworth had offered

to give his friend, who was the only butcher remaining in the shop, "a wee hand over Christmas and the New Year".

[8] It is not clear whether Mr McNamara or Mr Bolesworth appreciated that this informal arrangement between them constituted a legal relationship but those appearing at this Inquiry, who are regularly involved in matters of health and safety at work and accidents in the course of employment, were agreed that this informal arrangement between these two friends constituted a legal relationship whereby Mr Bolesworth was working in the course of his employment with James McNamara trading as R. McMillan, Butchers: *United Wholesale Grocers Ltd v Sher* 1993 SLT 284; *Robb v Salamis (M&I) Limited* 2005 SLT 523. Accordingly, although Mr Bolesworth was only lending a hand on a temporary basis for a few days, all the statutory duties incumbent on his employer in respect of other employees applied with equal force to Mr Bolesworth, who was entitled to the same protection from injury as any other employee.

[9] Although certain difficult issues arise for determination at this Inquiry, there was much evidence led which was not in dispute. It was accepted that the afternoon of 30 December 2005 was a busy one at this butcher's shop. Everyone was serving in the front shop except Mr Bolesworth; he was working alone in the meat preparation room, which was the back shop. Later in the afternoon, about 16.30 hours those in the front shop heard a loud noise. This was described by Ms Reid as "a bang" then she heard a "big gush of steam" then they heard Mr Bolesworth say "Carole, help me", or words to that effect. Ms Reid described both Mrs and then Mr McNamara running into the back shop to help. Mr and Mrs McNamara found Mr Bolesworth lying on his back with the Rose cooker at the top of his legs. There was gravy and stew everywhere and it was clear that some of the contents of the cooker had spilled over Mr Bolesworth's face and body.

[10] Mr Bolesworth was obviously injured. Ms Reid confirmed that Mr Bolesworth said that he did not want an ambulance. He asked her "to run him up the road so that he could get a change of clothes". He intended to come back to work. But someone had summoned an ambulance, which arrived very quickly. The ambulance personnel attended to Mr Bolesworth and, according to Ms Reid, Mr Bolesworth walked out through the shop in "tinfoil" to the ambulance. Ms Reid said she asked Mr Bolesworth if he wanted her to contact anybody, to which he replied "No hen. I'm fine". She said that as "Tommy" walked with the ambulance personnel she thought that everything would be "fine". Mr Bolesworth

was taken to the Glasgow Royal Infirmary, where he remained until his death some 6 days later.

[11] Although no police witness was led at this Inquiry, it is established on the evidence that the police attended at this butcher's shop soon after the accident. The police made it clear that nothing should be touched. At 5pm, Mr Peter Lavelle of the Out of Hours Team of the Environmental Services Department of Glasgow City Council came on duty. He was contacted by London Road police office in regard to Mr Bolesworth's accident.

Statutory responsibility of Glasgow City Council to investigate Mr. Bolesworth's accident

[12] It was not in dispute at this Inquiry that, at the material time, the responsibilities for investigation of accidents and inspection of premises in terms of the Health and Safety at Work etc Act 1974 and subordinate legislation made thereunder were discharged in respect of butcher's shops by the local authority and not by the Health and Safety Inspectorate. Reference may be made to the Health and Safety (Enforcing Authority) Regulations 1998. Accordingly, it was the responsibility of the Environmental Services Department of Glasgow City Council to investigate this accident at work.

The initial investigation by the Out of hours Team

[13] Mr Lavelle and Mr Scott Thomson attended at this butcher's shop at about 18.30 hours. The police were there. Mr Lavelle, in company with Mr Thomson, spoke to Mr and Mrs McNamara, Ms Reid and another female shop assistant, who was not adduced as a witness. Mr Lavelle and Mr Thomson then entered the back shop and Mr Thomson took photographs which comprised Crown production 1A-F.

[14] Mr Lavelle became concerned about the stability of the Rose cooker. He ascertained that it had apparently fallen over and some of its contents had injured Mr Bolesworth. Mr Lavelle was concerned in case a similar accident should happen although, on his own account "we didn't go into great detail that night" with the witnesses regarding the circumstances in which the accident had happened.

[15] At all events, upon Mr Lavelle's inspection of the cooker, he decided that a prohibition notice should be served on Mr McNamara to prevent its use. He and Mr Thomson returned to their office and met with their Team Leader, Mrs Josephine Ann Bell. She was off duty that night but had been contacted about 17.30 hours and told of the accident by Mr Thomson. She said that she had also spoken to Mr Lavelle. She stated that she had told them to go out and find out as much as they could. Mrs Bell stated in evidence that she had "told them to carry out fatal accident procedure".

[16] Mrs Bell, who stated that she had 27 years experience of carrying out inspections, including floors, went to the butcher's shop with Mr Lavelle and Mr Thomson at about 22.30 hours. At that time she saw the cooker, which was back on its stand. She supported Mr Lavelle's decision in respect of the prohibition notice. Accordingly, a prohibition notice, of which Crown production number 3 is a copy, was served on Mr McNamara prohibiting the use of the Rose cooker.

[17] Mrs Bell went on to describe in evidence how the food and debris had been cleaned up but that her "feet were going away from me". She stated that she was wearing ordinary shoes and was aware that the floor was "uneven". However, Mrs Bell did not instruct any immediate action to be taken in respect of the uneven floor or its apparently slippery state. Nor did Mrs Bell instruct that there be any follow up visit to this butcher's shop the next day. Mrs Bell stated "My main reason for being there was the boiler" (cooker). I found this a surprising position for her to take given her later evidence, in answer to Mr Conway, that the floor was slippery the night she was there; that she was aware that it was a local authority priority target to reduce slipping; and that the danger of slipping "must always be in mind".

The decision not to interview Mr Bolesworth

[18] Mrs Bell stated that Mr Thomson had spoken to the police concerning Mr Bolesworth. She said that the information given by the police was that "he was very, very poorly on the night of the accident". She stated that the information was "60% burns and that Mr Bolesworth was "too poorly to interview". Mrs Bell stated in evidence that there had been a conscious decision not to do an interview".

[19] Mr Lavelle stated that he was not aware of any effort being made to speak to Mr Bolesworth between 30 December 2005 and the end of the following week, when he had gone on holiday. Mr Lavelle stated that he had spoken to Mrs Bell about this but he did not know why it was not done. Mr Lavelle asserted that just after the New Year "we heard that he was sitting up in hospital".

[20] During cross-examination by Miss Gallagher, Mr George McCracken, Group Manager of the Land and Environmental Services Department: Enforcement Section, accepted that the local authority had a statutory obligation to investigate accidents at work. He recognised that it was important to have early investigation of an accident and that where the injured party was the only eyewitness it was "quite important but not always

possible to do so". He stated that he would have expected his officers to enquire and to check with the hospital whether it was appropriate to interview the injured party.

[21] It was not in dispute that Mr Bolesworth was working alone in the meat preparation room at the back of the premises at the time of his accident. Yet, the local authority, who had the statutory responsibility to investigate his accident at work and whose officers were aware that not only was he the only eyewitness but also that his injuries were severe made a conscious decision not to do an interview. On the evidence it appears that this decision must have been taken by Mrs Bell. In his closing submission Mr Coll, for the local authority, stated that Glasgow City Council took the view that it was very unfortunate that the opportunity which might have existed on 3 January 2006 to take a statement from Mr Bolesworth was missed. Mr Conway went rather further in his closing submission and submitted that there should have been an attempt made by the local authority to interview Mr Bolesworth in hospital as the local authority had the statutory duty to investigate this accident.

[22] In my judgment, the decision not to make any attempt to interview Mr Bolesworth in the three days after the accident before he became so unwell as to be unable to be interviewed was a most serious error of judgment. The investigation of this accident at work in a butcher's shop rested with the local authority. On the information available to Mrs Bell this was a serious scalding accident involving about 60% burns. This caused Mrs Bell to instruct fatal accident procedure. I do not know whether this instruction resulted in the failure to interview Mr Bolesworth in hospital but, on Mrs Bell's evidence, this conscious decision was taken without making any inquiry of the doctors treating Mr Bolesworth in Glasgow Royal Infirmary as to whether he was fit to be interviewed. My impression from Mrs Bell's evidence was that she considered this "conscious decision" was appropriate. In my judgment, she should reflect on that conscious decision, which was taken on incomplete information. Mr McCracken expected his officers to make inquiry by checking with the hospital to ascertain whether it was appropriate to interview the injured party. The statutory duty to investigate accidents at work, particularly serious ones, cannot ever be delayed because of public holidays. Mr Conway submitted that the investigation by the local authority lacked urgency and that contact should have been made with the Infirmary at an early stage which would have revealed that Mr Bolesworth was fit enough to be interviewed until his condition deteriorated on 3 January 2006. In my judgment, this error resulted in the local authority failing in the discharge of its statutory responsibility to

investigate Mr Bolesworth's accident at work because Mr Bolesworth was fit to be interviewed between 1 and 3 January 2006. Moreover, this inquiry has been left without the benefit of Mr Bolesworth's account of his accident as given to an independent local authority official charged with a statutory duty of investigating what had occurred.

Mr Bolesworth's condition after admission to Glasgow Royal Infirmary

[23] Dr Martin Hughes, an experienced consultant in intensive treatment medicine and anaesthesia, treated Mr Bolesworth and expressed the opinion that he had a "40/50% chance of survival from the burning injuries which he sustained in the accident". Accordingly, Mr Bolesworth's death from the scalding injuries which he sustained at work on 30 December 2005 was not inevitable. At the conclusion of his evidence, in answer to my question, Dr Hughes explained that in his opinion Mr Bolesworth suffered a hospital acquired chest infection after his admission on 30 December 2005 and that he had had a heart attack in the Burns Unit of Glasgow Royal Infirmary on the morning of 4 January 2006. Dr Hughes stated that the cause of death was different from the cause of death stated in the certificate issued by a Dr Walker after discussion with the procurator fiscal's office. I offered parties the opportunity to further question Dr Hughes but none wished to do so.

[24] Although Dr Hughes' evidence to the effect that Mr Bolesworth had suffered a heart attack whilst in the Burns Unit was not further explored, Professor Busutill made it clear that, in his experience, during a post-mortem examination heart attacks thought by medical staff to have occurred were not always confirmed. Professor Busutill made it clear that, in his opinion, as no post-mortem examination had been carried out in respect of Mr Bolesworth, no-one knew why he died. In answer to Miss Gallagher, Professor Busutill stated that it was up to the Deaths Unit, Procurator Fiscal to decide whether a post-mortem examination should be carried out. Mr Quither did not seek to challenge Professor Busutill's evidence on that matter.

[25] In my judgment, on the evidence led before me there is no basis for suggesting that either the acquiring of a chest infection or the suffering of a heart attack by Mr. Bolesworth whilst a patient was to any extent attributable to any act or omission on the part of Glasgow Royal Infirmary or any of its staff. It was not suggested by any party that the Infirmary or any of its staff was responsible for, or in any way contributed to, Mr Bolesworth's death. The Inquiry was not intimated to the Trust which is responsible for the Infirmary. In my judgment, it is necessary to make these matters clear to any person who may read this determination.

The Procurator fiscal depute's conduct of this Inquiry

[26] I wish to make it clear that Mr Quither, who conducted this Inquiry on behalf of the procurator fiscal, came into it just before it commenced and was not involved in its initial preparation stages. It should be recorded that Mr Conway stated that the conduct of the Inquiry by Mr Quither was regarded by the relatives of the deceased as "extremely good": a view with which I concur. By the time Mr Quither became involved it was impossible for him to do what had been left undone. In my judgment, he did everything he could not only to assist the deceased's relatives but also the court. The deceased's daughter-in-law sat in court throughout most of the Inquiry and listened attentively to the evidence.

The consequences of the decision of the Procurator Fiscal's office not to hold a post-mortem examination of Mr Bolesworth's body

[27] By the time of Mr Bolesworth's death it should have been clear that in terms of section 1(1)(a)(i) of the Fatal Accidents and Sudden Deaths Inquiry (Scotland) Act 1976 the holding of a Fatal Accident Inquiry was mandatory. The reason for the decision of the Procurator Fiscal's Deaths Unit not to carry out a post-mortem examination of Mr Bolesworth's body was not explored in evidence. Accordingly, I cannot go so far to hold that it was inexplicable. However, the decision not to instruct a post-mortem examination has turned out to be a most unfortunate decision which certainly resulted in this Inquiry becoming more lengthy and expensive than it need otherwise have been. Mr Conway made it clear that he was privately funded. As I understood it, the employers were funded by an insurance company and the costs of the procurator fiscal and the local authority come from public funds. The considerable expenditure of this lengthy Inquiry could have been lessened by the carrying out of a post-mortem examination which was likely to have assisted in providing answers to questions which remained to be investigated at the Inquiry. As I have said, Professor Busutill made it clear that, in his opinion, without a post-mortem examination it could not be known why Mr Bolesworth died.

The proper conduct of a Fatal Accident Inquiry

[28] Mr Conway took objection when counsel for the local authority and Mrs Dyer sought to develop the matter of whether Mr Bolesworth was suffering from hyponatremia at the time of his accident on 30 December 2005. Hyponatremia is a metabolic condition in which there is not enough sodium in the body fluid outside the blood cells. Sodium is very important for maintaining blood pressure and is also needed for nerves and muscles to work properly. I shall return to this matter later but, in a most courteous way, Mr Conway

made the point that no fair notice had been given of this line and that "trial by ambush" was inappropriate at a Fatal Accident Inquiry, particularly since counsel did not raise this matter when he had the opportunity to do so with Dr Hughes. Although I have been able to reach a conclusion on the matters raised regarding hyponatremia, Mr. Conway's fair notice point raises a fundamental issue about the proper conduct of a Fatal Accident Inquiry. I understood from Mr Conway that this matter might be taken up with the Sheriff Court Rules Council.

The absence of relevant evidence at this Inquiry

[29] This Inquiry did not hear evidence from any police officer, ambulance personnel or nurse who might have spoken with Mr Bolesworth about what happened to him in the meat preparation room at approximately 16.30 hours on 30 December 2005. I have mentioned the failure of the local authority to attempt to obtain a statement from him. There was no post-mortem examination. In the result, much evidence related to an examination of surrounding facts and circumstances from which an inference might be drawn as to how Mr Bolesworth's accident occurred.

Mrs Jane Dyer, Environmental Health Officer

[30] At an early pre-Inquiry hearing held in terms of the Sheriff Principal's practice note, the procurator fiscal depute then dealing with this case made it clear that the procurator fiscal considered that there might be responsibility for the accident attaching to Mrs Jane Dyer, to whom the Inquiry was intimated. In the event, Mr Coll was able to represent her interests and she did not require to be separately represented. In his closing submission for the procurator fiscal, Mr Quither very properly did not advance any criticism in respect of Mrs Dyer. Neither Mr Conway for Mr Bolesworth's son nor Miss Gallagher for the employer made any criticism of Mrs Dyer. Indeed, Mr Conway stated that she was manifestly a careful and conscientious food inspector. He stated that she had not been given the training nor had the tools to do the job of health and safety inspection as opposed to food hygiene inspection. Very properly, Mr Conway stated that it was his impression that had Mrs Dyer had the training and the tools to do a health and safety inspection then she would have done so properly. At this stage, I simply wish to make it clear that, in my judgment, no criticism of any kind can legitimately or properly be levelled at Mrs Dyer in respect of her inspection of this butcher's shop on 1 November 2005. Mrs Dyer was there to conduct a routine inspection for food hygiene following on a complaint made by a former employee. As Mr McCracken put it, "She was there to do an audit of the steak

pies". He did not consider that she was there to do anything else. In my judgment, proper investigation and preparation into the circumstances of Mr Bolesworth's death by the procurator fiscal's office should have revealed that it was quite inappropriate to seek to advance any criticism of Mrs Dyer. It is regrettable that as a result of a decision taken earlier by a procurator fiscal depute who did not conduct this Inquiry, Mrs Dyer has been exposed to the strain and stress which inevitably results from the very suggestion of potential culpability or inappropriate conduct, and especially so when such suggestion is without any foundation.

Further undisputed background matters

[31] It was not in dispute that a butcher's business had been carried on at 434 Duke Street, Glasgow for many years. Mr McNamara worked there from about 1974 for some 32 years until the business closed on 11 August 2006. Mr McNamara took over the business from the previous owner Mr Currie on 5 April 2003. Mr Bolesworth worked as a butcher at 434 Duke Street for about 16 years. During that time he regularly did the full range of work carried out by a butcher. He was certainly very familiar with the premises and equipment there which, on the evidence led, do not appear to have changed in any material way prior to him ceasing full-time employment around the end of 2004.

[32] On or about 27 March 2005 there was a fire at the premises at 434 Duke Street, Glasgow. The circumstances surrounding this fire were not explored in evidence during this Inquiry. However, on the evidence led, it is established that the shop was closed for some time, about 19 weeks, and that as a result Mr McNamara had to replace certain equipment including a cooker which he referred to as the "pot boiler". It is a matter of admission that in or about June 2005 Mr McNamara purchased another replacement cooker, namely a Rose cooker Mark X RE. This is depicted as the rightmost boiler shown at the back of the Rose Cooker Manual which comprises Crown production No 6. It was not disputed that this was supplied by McNaughton & Watson, 423 Gallowgate, Glasgow. Mr McNaughton confirmed this in evidence. The manual for the cooker comprises Crown production No 6. Mr McNaughton explained that if a cooking bag was used in this cooker then there was no need to stir the contents during the cooking process.

The installation of the Rose Cooker Mark X RE at 434 Duke Street, Glasgow

[33] Mr Steven John McEwan, who is an engineer employed by McNaughton & Watson, explained in evidence that along with fellow employees he delivered this new Rose cooker to the premises at 434 Duke Street, Glasgow. Mr McEwan was an experienced engineer who gave evidence in an open and straightforward way. There was no attack on his credibility or reliability. He impressed me as an honest, straightforward witness who did his best to recollect honestly and accurately the matters about which he was asked. Mr McEwan was quite clear that he personally did not install this cooker at the premises because there was still renovation work going on at the time when it was delivered. In particular he recalled that there was still an electrician employed by Mr McNamara working in the shop. Mr McEwan explained that it appeared that the whole premises were being re-fitted and they were still fixing walls and the electrician was fixing cables. Mr McEwan explained that other items, namely a sausage maker and a vacuum packer machine were delivered at the same time. He explained that the Rose cooker was taken out of its packaging and left out of the way of the electrician. He recollected the boiler was left inside the doorway depicted in Crown production 1-G. Mr McEwan recollected that the top part of the cooker was placed on the base. This was a one man lift. Mr McEwan explained that he had installed a few dozen of these cookers. He was quite clear that on this occasion he had not adjusted the legs. This was because he anticipated getting a call to go back to install the cooker once the electrician had completed his work. He explained that he never got a call to go back to install the cooker.

[34] It must be recorded that Mr James McNamara was a 53 year old witness who was hearing impaired. It must also be said that he did not always enunciate clearly and his evidence was often quite difficult to follow. On several occasions I had to remind him to tell us if he could not hear particular questions. Unfortunately, he also required glasses but did not have any available. Eventually, he was able to rely on using his wife's glasses to see particular productions which were put to him. During his evidence and, in particular, during examination by Mr Conway, Mr McNamara asserted that Messrs McNaughton & Watson "put the boiler in". On that particular matter I reject the evidence of Mr McNamara as being unreliable. I prefer the evidence of Mr McEwan which appears to me to have been given credibly and reliably. Mr McEwan's recollection appeared to me to be clear and reliable. However, I do accept that Mr McNamara did not deliberately seek to mislead this Inquiry. His recollection was that the boiler had been connected by an electrician. I have

no doubt that that is so but the electrician was not employed by Messrs McNaughton & Watson. I shall return to the matter of the stability of the boiler later.

The statutory findings sought in the respective closing submissions

[35] In his closing submission for the Procurator Fiscal, Mr Quither sought only findings in terms of section 6(1)(a) and (b). Mr Conway presented a full and helpful written submission which he amplified by a careful oral submission. Mr Conway sought findings in terms of section 6(1)(a), (b) and (c). In the event, he recognised that certain other matters which he raised under section 6(1)(a)-(e) were more appropriately dealt with by me in this Note. Mr Coll, on behalf of Glasgow City Council and Mrs Jane Dyer, presented a submission "to assist the court in its determination" and put forward a detailed review of the evidence. Mr Coll invited findings on particular matters, to which I shall later refer. He strongly submitted that on the evidence led there was absolutely no basis for any criticism of Mrs Dyer. As I have already dealt with this matter, it is not necessary for me to further expand that submission. Miss Gallagher presented a clear, detailed and focussed submission in which she sought particular findings in terms of section 6(1)(a) and (b). She further submitted that on the evidence led no findings were appropriate in terms of sections 6(1)(c), (d) and (e).

Section 6(1)(a) of the 1976 Act

[36] The finding which I have made in terms of section 6(1)(a) is uncontroversial. It is based partly upon factual matters which are admitted and partly upon factual matters which are not in dispute.

Section 6(1)(b) of the 1976 Act

[37] The finding which I have made in terms of section 6(1)(b) proceeds upon my consideration of all the evidence led and the competing submissions advanced to me. The principal issue of fact upon which competing submissions were advanced related to why Mr Bolesworth had fallen in the meat preparation room at about 16.30 hours on 30 December 2005. This involved consideration of a number of matters including the state of Mr Bolesworth's health prior to and on 30 December 2005 before he sustained the scalding injuries. Mr. Coll raised the matter of whether Mr McNamara, knowing of Bolesworth's health difficulties, should have allowed him to work on 30 December 2005. Another issue was in respect of the state of the place in which he was working.

The submission for the Procurator Fiscal

[38] Mr Quither submitted that on the acceptable evidence led I should hold that Mr Bolesworth slipped and lost his footing. He based his submission upon an entry in the medical records of Glasgow Royal Infirmary (Crown production No 14) at page 75. This entry is a "Patient Profile" relating to Mr Bolesworth, which was completed in Ward 45 at 19.45 hours on 30 December 2005 by "S/N Munro". Whilst it was agreed that this would be a staff nurse Munro, no such witness was led at this Inquiry. At page 76 it was recorded under "Conscious Level and Orientation" that Mr Bolesworth was "alert and orientated". In a box on page 75 it is noted "sustained scalds (a 38% PT-deepPT) to both legs, buttocks (L) flank & (L) arm at work when he slipped and pulled boiler of hot stew down on himself time of injuries 4.30pm 30/12/05". Mr Quither submitted that this note had been made within a short space of time after the accident and had been made by someone (staff nurse Munro) who had no interest to note incorrectly.

The submission for Mr Bolesworth's son

[39] Mr Conway submitted that Mr Bolesworth had slipped whilst approaching the Rose boiler, fallen backwards and whilst falling grabbed the boiler causing it to topple over and spill its contents over him. He accepted that there was no direct evidence of this and the question was what inferences could be drawn by the court from established facts. He submitted that it was established that the floor of the premises was slippery when wet with water or with food residue. He referred to the evidence of Mr S Lenford Greasley, the joint expert instructed. There was no contrary evidence. Mr Conway submitted that it was established that food spillages on this floor on an ongoing basis were inevitable. He referred to the evidence of Mr Greasley, Mr Lang, Mr Thomson, Mr Lavelle, Mrs Bell, Mrs Dyer and Mr McCracken. Again there was no evidence to the contrary. Next it was established as fact that a detergent based cleaner would be required to remove the grease residue. This was established by the evidence of Mr Greasley, Mr McCracken, Mr Lavelle and Mrs Dyer. Further, the cleaning regime in place was inadequate. In the first place, the clean-as-you-go system consisted solely of a brush up with no detergent used. This was clear in the evidence of both Mr McNamara and Mrs McNamara. Moreover, their evidence as to the nightly deep cleaning regime must be deeply suspect because Mr Lang said he could see specks of food on the floor at the time of his inspection on 23 February 2006. Mr Conway submitted that, when found by the McNamaras, Mr Bolesworth was lying on his back with the boiler on top of his legs. This position was consistent with the suggested

mechanism of fall given by Mr Greasley, and confirmed in Relatives production No 7, which was the Health & Safety Executive 1996 publication "Slips and trips: Guidance for the food processing industry" at para 10. Finally, Mr Conway founded upon the immediate post-accident statements attributed to Mr Bolesworth. He also referred to what was recorded by staff nurse Munro. He submitted that the context was clear and contained detail which could only have come from Mr Bolesworth. Mr Conway also pointed to the evidence of Mr Lavelle to the effect that a Police Constable Kelly had told him of a slip. He accepted that there was no clear indication of where this evidence had come from. He also accepted that the other hospital records were not as detailed but he pointed out that there was no contradictory narrative. He referred to the evidence of Mr McNamara's visit to Glasgow Royal Infirmary on 1 January 2006. According to Mr McNamara, Mr Bolesworth told him then that he had "lost his footing". Whatever view was taken of this evidence, it was not inconsistent with Mr Bolesworth having slipped.

The submission for Mr McNamara

[41] Miss Gallagher submitted that, on the evidence led and in the absence of any statement taken by a local authority employee charged with investigating the accident, there were two possibilities. In the first place Mr Bolesworth lost his footing or, secondly, he slipped. She urged me to accept Mr McNamara's evidence and pointed out that he was a long-standing friend of Mr Bolesworth. She also pointed out that Mrs McNamara's evidence supported that given by her husband. Helpfully, Miss Gallagher reviewed the evidence of the medical records, Crown production No 14 at pages 33, 45, 46, 51, 75 and 78. Very properly, Miss Gallagher accepted that staff nurse Munro may have got the information from Mr Bolesworth that he had slipped. She accepted that there was no prior entry to that effect.

Discussion of evidence led and competing submissions

[42] I have given prolonged consideration to these competing submissions and to the difficult issues raised. The notes taken by Staff Nurse Munro appear to have been taken at 19.45 hours at page 75. However, the note at 78 was taken at 7.30 pm, which is some 15 minutes earlier. At page 51, there is a note in the clinical records timed at 17.45, some two hours earlier which makes no mention of slipping. It records "large pot of stew fell onto him, fell to floor and unable to get up due to slippery floor". Moreover, the Scottish Ambulance Service patient report form states "65 year male overturned pot with 100lb boiling stew onto body". This was obviously the first note taken and the note in the clinical

records on admission to the Accident and Emergency Department, at page 47, records "boiling large pot stew – approximately 5 gallons spilled over him and boiling water as well, fell & could not get back up." As can be seen, there are various different accounts of what might have happened to Mr Bolesworth contained in the hospital records. Each of these accounts might have come from Mr Bolesworth or, alternatively, the particular author's interpretation of the patient's history. It was also recognised that the purpose of taking a history was not for medico/legal reasons but rather for the medical purpose of the patient's treatment. Accordingly, when treating 38% scalding injuries it may not matter particularly whether the patient slipped or tripped: but what substance caused the scalding injuries may have significance.

[43] Mr McNamara stated in evidence that he went up to see Mr Bolesworth in the Glasgow Royal Infirmary on Sunday 1 January 2006. Mr McNamara stated that he had spoken to Mr Bolesworth about the accident and claimed that Mr Bolesworth had stated "I lost my footing and I grabbed the boiler". Mr McNamara also stated that Mr Bolesworth had told him that the accident was not his (Mr McNamara's) fault. Mr McNamara claimed that Mr Bolesworth had told him that he was badly burnt. He then stated that there had been no discussion about what Mr Bolesworth was doing. Mr McNamara then said that Mr Bolesworth said that he went to stir the stew and that was when he lost his footing and grabbed the boiler. Mr McNamara said that he had said to Mr Bolesworth "But you weren't meant to touch it". Mr McNamara repeated that he had told him that he was only there to make the sausages. He then added "I was upset about Tommy. I wasn't worried about the stew".

[44] Mr Conway tested Mr McNamara's evidence fully during his examination of him. He put it to him that Mr Bolesworth had slipped. Mr McNamara denied this and stated that Mr Bolesworth had never said that he had slipped. It was then put to Mr McNamara that Mr Bolesworth had never said anything to him. Again Mr McNamara was emphatic that Mr Bolesworth had said the things he attributed to him. It was put to Mr McNamara that since the accident he had tried to avoid blame for Mr Bolesworth's accident. Mr McNamara stated that blame could not be put upon him for the accident.

[45] According to Mrs Carole McNamara, her husband told her that Mr Bolesworth had said that the accident was his "own silly fault": he had slipped/tripped and grabbed the boiler. Mrs McNamara went further and stated what a couple of customers who went to see Mr Bolesworth in hospital had told her. She mentioned a man "Andy" and a woman

friend of Mr Bolesworth, whose name she could not recall. Mrs McNamara claimed that these people came to the shop on Hogmanay and said to her that Mr Bolesworth had said these things. During examination by Mr Conway, Mrs McNamara made it clear that she did not know whether Mr Bolesworth had slipped or tripped. She also made it clear that she would not use the phrase "lost his footing". She also stated that this was not an expression her husband, Mr McNamara, would use. Mrs McNamara accepted that the Accident Repair Form, Crown production No 16, was in her handwriting. Her evidence was to the effect that Mr McNamara would not have given her the wording. She knew everything that happened because she was there. She stated that she would have read it out to Mr McNamara before he signed it. The account contained at part G is "Mr Bolesworth told me later he decided to check stew, removed lid from boiler, lost his footing and pulled boiler over himself. We got him a seat and rang ambulance". Mrs McNamara did not claim to have received an account of the accident from Mr Bolesworth. Her evidence was that she got an account from her husband and also from "Andy" and the woman to whom I have referred, both having visited the premises at 434 Duke Street, Glasgow on 31 December 2005.

[46] I regarded Jacqueline Reid as an honest, straightforward witness who gave evidence without any hint of elaboration. I could find no manifest falsehood in her evidence. She impressed me as a person who told the truth in answer to the questions put to the very best of her ability. However, she did not get any account from Mr Bolesworth of what had happened to him. She was in the front shop at the time of the accident. Ms Reid confirmed that "Tommy said he did not want to go in the ambulance". She stated that he had asked her if she would run him up the road so that he could get a change of clothes. She asked him if he had wanted her to contact anybody but Mr Bolesworth had replied "No hen. I'm fine".

[47] Because the contents of the Rose cooker spilled out onto the floor of the meat preparation room, it is impossible to know whether Mr Bolesworth slipped on some small piece of meat which may have fallen to the floor during the course of his work. Mr Coll submitted that on the basis of Mr Greasly's evidence, Mr Bolesworth had not tripped. Neither Mr Conway nor Miss Gallagher submitted that Mr Bolesworth had tripped. Mr Quither submitted that he had slipped. I accept Mr Coll's submission to the effect that, on the basis of Mr Greasly's evidence, it is established that Mr Bolesworth did not trip. Miss Gallagher submitted that there were only two realistic possibilities: either Mr

Bolesworth lost his footing or he slipped. She submitted that it should be held established that he had lost his footing and did not slip.

[48] But, another possibility, raised by Mr Coll, remains to be considered. Mr Conway accepted that it was possible that Mr Bolesworth had fainted or had a dizziness attack whereby he fell to the ground and pulled down the boiler on top of himself. However, Mr Conway went on to strongly submit that the acceptable evidence did not support a fainting or dizziness attack. I agree with Mr Conway that the post-accident diagnosis of hyponatremia appeared to be a component of Mr Coll's submission regarding the possibility that Mr Bolesworth suffered a fainting or dizziness attack which caused him to fall. I agree that this was not put to Mr Greasly or to Dr Hughes. Dr Hughes did accept that Mr Bolesworth's sodium readings were low. He stated that this was investigated but no conclusion was reached. But under reference to page 55 of Crown production 14 (the Infirmary records) Dr Hughes pointed out that Mr Bolesworth had denied any symptoms typical of the condition. Dr Hughes thought that a low sodium count was unlikely to be a factor having regard to the fact that there had been no previous neurological conditions. Mr Conway criticised in some detail the evidence given by Professor Anthony Busutill. His written submission is contained within the papers. Mr Conway had made it clear that he had considerable unease over Professor Busutill's evidence.

[49] I was very impressed by the evidence of Dr Eric Livingstone, who was Mr Bolesworth's general medical practitioner. He was a most experienced medical practitioner, who gave evidence clearly and in a straightforward way. Dr Livingstone was clear that a burning accident could cause a low sodium count. He pointed out that this was properly the field of a clinical biochemist or a general physician in working practice. However, I regarded his evidence as helpful because he stated that a drop in a person's sodium level was very rare. Dr Livingstone accepted that a seizure was a possibility. However, since Mr Bolesworth was able to call out for help, Dr Livingstone considered that this was an indication that Mr Bolesworth did not suffer a seizure. Dr Livingstone pointed out that normally there is amnesia after a seizure. He thought that the possibility of a seizure was contradicted by Mr Bolesworth's statement that he wished to return to work. He did not think that a dizzy spell was likely.

[50] Professor Busutill did not have access to Dr Livingstone's records relating to Mr Bolesworth nor did he speak to Dr Livingstone. I accept that the medical practitioner records show regular sodium levels for about 18 months prior to the accident and in

particular, as at 4 October 2005. Moreover, I agree with Mr Conway that Professor Busutill appeared to change position as to whether burns might cause hyponatremia. In the result, in answer to Mr Conway, Professor Busutill accepted that his hypothesis was one of a number of possible hypotheses and that Mr Bolesworth could have slipped just as easily as having fallen as a result of a fainting or dizzy spell caused by hyponatremia. Moreover, Professor Busutill accepted that most people can remember fainting.

[51] In my judgment, it is not established that hyponatremia caused Mr Bolesworth to faint or become dizzy and fall. I agree with Mr Conway that there is clear evidence that after the accident Mr Bolesworth called Mrs McNamara for assistance. It is clearly established that he was able to walk to the ambulance with the ambulance personnel. Mr Bolesworth wanted to be taken home so that he could get a change of clothing and come back to work. At no stage, either in the shop or at the hospital, did Mr Bolesworth suggest that he fainted. I accept and prefer the submissions of Mr Conway to those advanced by Mr Coll.

[52] During the course of his examination of the jointly instructed expert witness Mr Greasley, Mr Coll put that Mr Bolesworth might have slipped and fallen whilst standing and turning at the boiler. Mr Greasley accepted that this was not impossible but regarded this kind of accident as much less common in his experience. Mr Coll submitted that Mr Bolesworth's work station was close to the Rose cooker. The photographs comprising Crown production 1A and Crown production 2J were relevant. Small deposits of meat are shown on the meat table. It was possible that a small piece of meat may have fallen on to the floor and caused Mr Bolesworth to slip. Alternatively, condensation from the lid of the cooker falling onto the floor under Mr Bolesworth's feet might have caused him to slip.

[53] Mr Scott Thomson took the photographs which comprise Crown production No 1. Crown production No 1A shows the lid from the Rose cooker on the mincer. I agree with Mr Coll that, on the basis of the acceptable evidence led at this Inquiry, this lid would not normally have been there: it would normally have been sitting on the Rose cooker. Mrs McNamara was clear that the lid was on the mincer. Essentially this was for two reasons. The first was she saw it there and the second was that the lid was not on top of Mr Bolesworth's legs as he lay on the ground: the top open part of the boiler was on his legs. From this Mrs McNamara knew that Mr Bolesworth had been "in the boiler". Mr McNamara also confirmed that the lid from the Rose cooker was sitting on top of the mincer at the time of the accident.

[54] Mr McNamara was about 14 years younger than Mr Bolesworth. I accept that Mr McNamara was very friendly with Mr Bolesworth: they had been workmates for a good number of years. It was clear that he knew something of Mr Bolesworth's family although he did not know where to contact them after the accident. In my judgment, it is likely that two butchers working in a small butcher's shop together for a number of years would get to know each other quite well. Mr McNamara was aware that Mr Bolesworth was "bad with his feet". He was aware that Mr Bolesworth had certain health problems and that "he just wanted to retire". There is no doubt that Mr Bolesworth had certain health difficulties. Dr Livingstone confirmed that, although Mr Bolesworth was an infrequent attender at his surgery, he suffered from two main conditions, essential hypertension and peripheral vascular disease, both of which were diagnosed in July 1999. He also suffered from intermittent bilateral claudication and verrucas in both feet. However, confirming his written report dated 20 November 2007, Dr Livingstone did not consider that there was any real contra indication to Mr Bolesworth's working at the end of December 2005. This medical opinion is remarkably consistent with the evidence of Mr and Mrs McNamara and Ms Reid who, in my judgment, summed up the position correctly by saying "Tommy was getting old: but he could do anything he was asked to do".

[55] I accept the evidence of Mr and Mrs McNamara and Ms Reid to the effect that Mr Bolesworth was in the shop only to assist by making the sausages and was not asked to do heavy work. I am quite certain that Mr McNamara was pleased to have the assistance of Mr Bolesworth over the busy Christmas and New Year period. Normally, Mr McNamara was the only butcher working in the shop, the other butcher having left and having made a complaint about food hygiene which led to Mrs Dyer's visit. Accordingly, for all these reasons I reject Mr Coll's submission that Mr McNamara should not have allowed Mr Bolesworth to work. I am satisfied that Mr Bolesworth was fit enough to do the work which he agreed to do.

[56] In the period since Mr Bolesworth last worked regularly in the premises, there had been a fire and the pot boiler had been replaced with the Rose cooker. Whilst Mr McNamara accepted that he did not look at the manual which accompanied this new cooker, it was clear from Mr McNaughton that if a cooking bag was used then there was no need to stir the contents of the cooker during the cooking process. However, Mr McNamara did not use a cooking bag and continued to have to stir the boiler. In answer to Mr Conway, Mr McNamara made it clear that Mr Bolesworth and he had each

stirred the pot boiler hundreds of times. In my judgment, it is established that this was something that an experienced butcher would do, even although this was a new cooker to Mr Bolesworth.

[57] Mr McNamara was adamant that no-one had ever slipped in the shop over the years. Whilst this may seem surprising given the expert evidence led at this Inquiry, it was also the evidence of Mrs McNamara, who asserted that she would have heard about any slipping or tripping. Ms Reid was clear that she had never experienced the floor being slippery in the back shop whilst Mr McNamara had the shop. She was not aware of anyone having had a problem with the floor. She was clear that if any of the "boys" spilled meat debris they picked it up and put in the bin. In my judgment, if a small number of experienced butchers were working in close proximity to each other in a busy small backshop, there would inevitably be the occasional spillage of meat debris onto the floor. This conclusion is consistent with the expert evidence led at this Inquiry. But it does not follow that there was necessarily any slipping incident as a result. Providing the competent butchers took care to deal with all meat spillages as and when they occurred, any slipping incident might have been avoided. On the evidence led there had been no previous accident. I have already indicated that I accept Ms Reid as a credible and reliable witness.

[58] In my judgment, Mr McNamara did not set out to tell any deliberate lies to this Inquiry. His recollection about certain matters is plainly wrong. During Miss Gallagher's examination of him it became clear that he was completely deaf in his left ear and wore a hearing aid in his right ear. I do not think he was lying in stating that he had respect and affection for Mr Bolesworth or in stating that he was upset about the accident. I think that the fact of Mr McNamara's visit to see Mr Bolesworth in hospital on 1 January 2006 confirms his concern for him. In my judgment, Mr McNamara was doing his best to tell the truth about what Mr Bolesworth told him in hospital. I accept that Mr Bolesworth never said he slipped to Mr McNamara and that he gave the explanation which Mr McNamara attributed to him. This appears to me to be consistent with the evidence of Mrs McNamara, which I also accept as being credible and reliable. In my judgment, this account of events is further confirmed by the finding and photographing of the lid of the Rose cooker, as depicted in Crown production 1A, and by the fact that this lid was not found on the floor. In my judgment, no doubt with the best of intentions, Mr Bolesworth removed the lid from the Rose cooker to stir the contents, placed the lid on the mincer and then lost his footing, grabbed at the open cooker causing it to topple over towards him as he

fell onto the floor of the meat preparation room. The cooker fell onto his lower body and legs resulting in some of its contents spilling over him causing him to sustain scalding injuries. The circumstances are not fully established but, in my judgment, this is the probable cause of the accident on the basis of the acceptable evidence led at this Inquiry.

[59] Accordingly, I accept and sustain the submission advanced by Miss Gallagher. I should note that she had some difficulty with the issue of whether Mr Bolesworth had suffered a myocardial infarction on 4 January 2006. Whilst I accept that this is not an entirely straightforward issue given the absence of post-mortem examination, I was impressed by and accept and proceed upon the evidence given by Dr Hughes.

Section 6(1)(c) of the 1976 Act

[60] On the view which I have taken as to the cause of the accident resulting in Mr Bolesworth's death, I hold that there were not any reasonable precautions whereby the accident resulting in his death might have been avoided. I accept that Mr Bolesworth was employed only to do work in preparing sausages. But, as a competent butcher and a good and willing worker, when he thought the stew in the Rose cooker needed stirring, he set about doing it. As he was doing so he lost his footing and fell. In my judgment, it is not established on the available acceptable evidence that Mr Bolesworth slipped. Accordingly, although there were detailed submissions advanced in regard to the slip risk on the floor, I do not consider that a slip or slipping was the cause of Mr Bolesworth's accident. I accept Miss Gallagher's submission that whilst the floor had a high slip risk and it was possible for this floor to be slippery if a fatty deposit or meat residue got onto it, there is no satisfactory evidence to conclude that Mr Bolesworth slipped. I accept the evidence of Mr and Mrs McNamara and Ms Reid to which I have referred, which establishes there was no prior slipping incident on this particular floor. I also accept that the floor was not slippery when Mrs Dyer visited the premises unannounced on 1 November 2005.

[61] Mr Conway made a separate submission in regard to the Rose cooker. He accepted that if this cooker were free standing on non-slip floor it would not present any danger. He also accepted that this particular model also appeared to be a proprietary model, with an apparently accident free history. He did not suggest that there was any real risk of it overturning in day to day use. The problem which Mr Conway identified was that its usage was designed precisely for food premises, including butcher's shops, where conditions were such that spillages and consequent slips were entirely likely. Whilst the probability of the kind of fall which would cause the boiler to be upset or to topple over was not high, it

was nevertheless a real risk: and the circumstances of Mr Bolesworth's accident demonstrated that there could be very grave consequences. Mr Conway submitted that, in the circumstances, it was clearly reasonable to require this cooker to be cabled up after Mr Bolesworth's accident but he did not go so far as to invite a finding that every Rose cooker should be cabled. He submitted that where no non-slip surface was provided, serious consideration should be given to whether the manufacturers should be advising purchasers that the cooker should be restrained or cabled up. Moreover, Mr Conway submitted that every employer, including Mr McNamara, had to carry out a risk assessment. He submitted that a reasonable precaution which might have avoided this accident would have been to cable up this cooker as was later done. He submitted that I could make this finding without in any way attacking the manufacturers of the cooker.

[62] Miss Gallagher submitted that it was not relevant that the cooker may have been unstable prior to the accident because, taking account of Mr Greasly's evidence, the force of being grabbed was sufficient to destabilise it and cause it to topple over. Moreover, Miss Gallagher submitted there was not sufficient evidence to show this Rose cooker was unsteady prior to the accident. The evidence of both Mr McNamara and Mrs McNamara was that it was not unsteady. This should be accepted as credible and reliable.

[63] As I have earlier mentioned, it is clear that this cooker was not installed by the suppliers McNaughton & Watson. On this matter I accept Mr McEwan's evidence in preference to that given by Mr McNamara, who I consider was simply wrong in his recollection. There was certainly clear evidence to the effect that after the accident this cooker and its base were found wedged in a way not intended by the manufacturers. I accept that it must have been wedged in this way prior to the accident. It may or may not have been easy to wedge the cooker and its base in that way. It may or may not be that a person might be quite unaware of having so wedged the cooker and its base. There was no detailed technical expert evidence regarding this or as to how this wedging might have been avoided. Mr McNamara conceded that he did not look at the manufacturer's manual supplied to him, a copy of which comprised Crown Production No. 6.

[64] Mr McNamara was unaware of his statutory duty in terms of Regulation 3 of the Management of Health and Safety at Work Regulations 1999 to carry out a risk assessment for the purpose of identifying the measures he needed to take to comply with the requirements and prohibitions imposed by or under the relevant statutory provisions in his premises. Had he instructed a proper risk assessment, as required by these regulations, to be

carried out on his behalf, he would have received advice in respect of whether the cooker required to be cabled up in some way, having regard to the fact that the floor in the meat preparation room did not have a non-slip surface. This matter might have been taken up with or discussed with the manufacturers. But, as no formal intimation of this Inquiry was given to the manufacturers of this cooker, it is inappropriate for me to make any recommendation or observation which might affect them since they have not been given the opportunity of being represented and putting forward their position in the matter. I should add that, having had the benefit of hearing Mr McEwan's evidence, it is my impression that the purpose of having adjustable feet is to deal with uneven floors so that the Rose cooker can be set up to be in a stable condition. As appeared from Mr McNaughton's evidence, providing a cooking bag is used, there is no need to remove the lid from the cooker and stir the contents during the cooking process. Accordingly, although I see the force of Mr Conway's submission, in my judgment, it is inappropriate for me to make recommendations or observations regarding the Rose cooker arising from the evidence at an Inquiry at which the manufacturers had no opportunity to be present or represented.

Sections 6(1)(d) and (e)

[65] In my judgment, no defect in any system of working which contributed to the accident resulting in Mr Bolesworth's death has been established and no finding in terms of section 6(1)(d) is appropriate. In my judgment, in terms of section 6(1)(e), there are no other facts which are relevant to the circumstances of Mr Bolesworth's death.

Further observations

[66] However, there remain matters upon which submissions were advanced and upon which I think it is appropriate for me to comment. Whilst these are not relevant, in the legal sense, to the circumstances of Mr Bolesworth's death, I hope that my observations will assist in the prevention of accidents in the future.

Small businesses must comply with all relevant Health and Safety at Work legislation

[67] Until it closed in 2006, Mr McNamara ran a small butcher's business at 434 Duke Street, Glasgow. When he took over the business, the Health and Safety at Work etc Act 1974 had been in force for nearly 30 years but Mr McNamara did not see any need to have an accident book or to keep records of staff training for health and safety. As became clear during his examination by Mr Conway, he had no idea what a risk assessment was or what was meant by the phrase "a competent person". His position quite simply was that the

Environmental Health Officer came into the shop two or three times a year and if he was told to do anything he got it done. Beyond that, it was clear that the legislation and regulations relating to health and safety at work and particularly in relation to safety of floors and slipping risks were unknown to him. There can be doubt that this was a wholly unacceptable and unsatisfactory situation. Mr McNamara was an employer who had statutory duties incumbent upon him. No employer is entitled to remain in ignorance regarding his legal obligations and duties in regard to the health and safety at work of his employees. Whilst Mr McNamara was an experienced butcher, he had neither given thought nor taken specialist advice about how to comply with the requirements of the law regarding the health and safety at work of his employees. Mr McCracken made it clear that some small businesses did rely solely upon health and safety inspectors for advice and did nothing else to ensure compliance with their legal obligations. Miss Gallagher submitted that it may be necessary to remind small businesses of their obligations to comply with the relevant law regarding health and safety at work. I did not understand Mr Conway or Mr Coll or the Procurator Fiscal to demur at this suggestion. Accordingly, I take this opportunity to emphasise to all small businesses that it is the duty of every employer to ensure, so far as is reasonably practicable, the health and safety and welfare at work of all his employees. It is not sufficient only to rely upon advice and guidance given to by Environmental Health Officers or other inspectors charged with health and safety at work responsibilities. It is the responsibility of an employer to comply with all the requirements of health and safety at work legislation and all the regulations applicable to the particular business which is being carried on. This means that it may often be necessary for a small business to seek appropriate advice, perhaps in the first instance from a trade association or like body or from a solicitor, as to the requirements of the law in regard to health and safety at work in respect of the carrying on of its particular type of business.

Training by Glasgow City Council of its Environmental Health Officers in regard to the health and safety at work issues of slipping and tripping by employees in food premises, including butcher's shops

[68] Mr Conway made a submission in regard to the actions of the Environmental Health Department of Glasgow City Council. Mr Conway did not argue that Glasgow City Council, as the local authority, had any duty of care towards Mr Bolesworth. However, as I have noted at para [12] above, the responsibilities for the investigation of accidents and inspection of premises in terms of the Health and Safety at Work etc 1974 and subordinate

legislation made thereunder were and are discharged in respect of butchers' shops by the local authority and not by the Health and Safety Inspectorate. Mr Conway also recognised that there was no statutory requirement for a health and safety inspection in respect of any particular premises. The broad thrust of Mr Conway's submission was that Environmental Health Officers employed by the local authority were, at the material time, expected to do not only food hygiene inspections but also health and safety inspections. His submission was that they had not received sufficient training in regard to slipping hazards and had not received the necessary equipment to enable them to do what they should be doing in relation to slipping hazards during a health and safety inspection.

[69] Following upon the E-coli outbreak at a butcher's shop in Wishaw in 1997, which caused the deaths of a large number of people, various steps were taken to try and ensure that there would be no like occurrence. New, more stringent, food hygiene regulations were passed. In terms of the Food Safety (General Food Hygiene) (Butchers Licensing) (Scotland) Regulations 2000 every butcher's business had to apply to the local authority each year for renewal of its licence. Accordingly, Environmental Health Officers attached to the section dealing with butcher's shops had considerable responsibilities in respect of food hygiene.

[70] A complaint had been received by Glasgow City Council about general food hygiene matters at R. McMillan, Butchers, 434 Duke Street, Glasgow. Mr and Mrs McNamara believed that this complaint came from a disaffected butcher, who had recently left Mr McNamara's employment. However that may be, on 1 November 2005, Mrs Jane Dyer an Environmental Health Officer with over 20 years' experience, visited this butcher's shop. This was an unannounced visit and at that time she took the opportunity to carry out a full routine inspection in respect of food hygiene.

[71] The form which she required to complete comprised Crown Production No 7. It is entitled "Butchers' Licensing Inspection Form (HACCP)". This is an acronym for hazard analysis and critical control point. At all events, the form is in several different parts. Parts 1-4 relate to food hygiene. Part 5 relates to health and safety and is contained within one page. Mrs Dyer confirmed that she was there primarily to deal with a food hygiene inspection. So far as health and safety was concerned, she stated that she looked at all of the machinery in the shop. She was making sure that it was clean, having regard to its quality, stability and electrical fittings. So far as slips, trips and falls were concerned she was on the lookout for trailing leads. She was also concerned to note whether the floor was

dry and clean and whether the surface was whole or broken. She explained that she carried out a visual practical inspection of this butcher's shop.

[72] There is no doubt that Mrs Dyer carried out a very full food hygiene inspection. She completed Crown Production No 7 but also prepared a very full report on her inspection of the premises. This is comprised within Crown Production No 8. Moreover, she served an improvement notice in terms of the Health and Safety at Work etc Act 1974 on Mr McNamara because the chute guard for the gravity feed slicing machine was missing.

[73] Mr Conway made no criticism of Mrs Dyer, nor did anyone else who appeared at this Inquiry. Mr Conway criticised the evidence of Mr McCracken, the local authority Group Manager for Land and Environmental Services: Enforcement Section. Mr Conway submitted that it was clear from the evidence led at this Inquiry that health and safety in butchers' premises was not considered seriously or at all by the local authority unless it impinged upon food hygiene. Mr Conway stated that he was still in confusion as to Mr McCracken's position as regards health and safety. Mr Conway accepted that when Mrs Dyer inspected the floor of the meat preparation room in this shop on 1 November 2005 it was probably not wet and probably not slippery. This was entirely consistent with Mr Greasley's opinion evidence. However, Mr Conway submitted that what was completely absent from Mrs Dyer's report was any consideration of context, that is to say, that in a butcher's premises where spillages and slips were likely and where there was the cooker, a potentially dangerous unrestrained piece of equipment. Mr Conway submitted that it was clear from Mrs Dyer's evidence that she had neither the necessary training nor the necessary equipment to enable her to do a health and safety inspection properly.

[74] In my judgment, Mrs Dyer was a competent Environmental Health Officer who did know something about slips and trips. However, it was clear, as Mr Conway submitted, that she had not been given the training by Glasgow City Council which she required to enable her to do a health and safety inspection in the way which was expected and required by the then current advice given by the Health and Safety/Local Authority Enforcement Liaison Committee (HELA).

[75] The point which Mr Conway was making was that through no fault of her part, Mrs Dyer did not know anything about the Health and Safety Commission's agenda as regards *"Revitalising Health and Safety"*. She was unaware that she was meant to be adopting a robust and critical approach. She was not aware of roughness meters or their

use. She had not been to a specific training course on slipping in ten years. Mr Conway's submission was that the clear impression from Mrs Dyer's evidence, the evidence of Mrs Bell, Mr Lavelle and Mr McCracken was that this local authority was not doing what it should be doing as regards the prevention of slipping accidents in food premises, including butchers' premises.

[76] Relatives Production No 16 is the 2002 Annual Report of the Health and Safety Executive/Local Authority Enforcement Liaison Committee (HELA). At page 7, historical matters are narrated. It is explained that the Health and Safety Commission revised its Strategic Plan to address the recommendations arising from the Government's review of the health and safety system in Great Britain. The "*Revitalising Health and Safety*" strategy statement, published in June 2000, set challenging targets to reduce days lost from work related injuries and ill-health. These targets applied to all stakeholders and not just to the enforcing authorities. The *Revitalising* statement was intended to give fresh impetus to health and safety enforcement by local authorities. HELA revised its three-year Strategic plan to respond to *Revitalising* and to the Health and Safety Commission's revised priorities. The Annual Report states that the most common causes of injuries in the local authority enforcement sector continued to be slips and trips, falls from height and workplace transport. The Report states that "an effective local authority inspectorate is essential to the achievement of the *Revitalising* targets". HELA reviewed revised the Health and Safety Commission's mandatory guidance issued under section 18 of the 1974 Act. This revised guidance, published in 2001, set out the broad principles which the Health and Safety Commission wished local authorities to adopt in enforcing health and safety legislation and provided a framework within which local authorities should operate so that the Health and Safety Commission could be assured that local authorities were making adequate arrangements for enforcement: see 16(8). In view of the prevalence of slips and trips as a cause of accidents in the local authority enforcement section, the Health and Safety Commission asked local authorities to take the lead on the slips and trips priority programme. The local authority circular 40/5 encouraged local authorities to concentrate enforcement activity in sectors with high risk of slipping accidents (for example food retail, catering).

[77] Relatives production No 17 comprises the HELA Local Authority Circular Number 40/5, issued in March 2002. HELA developed a new strategy to cover the period 2001-2004. During that period local authorities were to have regard to certain detailed

issues set out in the annex during their preventative inspections. These issues were discussed and endorsed by HELA and provided local authorities with an agenda for inspection visits. Local authority inspectors were expected to address these issues during their inspections of premises. At para 10 it is stated that during visits to food/drink premises (including meat premises) local authority inspectors should promote/enforce compliance on the management of risks highlighted in the HSE publication, reprinted in 1999, *Recipe for Safety*. In particular they should concentrate on the management of slips risks. Further detailed guidance is given to enable inspectors to complete their task.

[78] Relatives production No 18 is another HELA local authority circular, number 77/1. It was issued in December 2004. This operational circular described a new Slips Assessment Tool (SAT) which had been developed to assist field staff in local authorities to assess pedestrian slipping risks and floors. At para 2, this circular referred to Regulation 12(2) of the Workplace (Health, Safety and Welfare) Regulations 1992 which made it an absolute requirement that floors should not be slippery so as to cause someone to slip, trip or fall. This circular pointed out that sometimes there may be little doubt deciding whether a floor is slippery, for example where there has been a history of slips, accidents or near-misses in a particular location. It continued that "in situations which are not so clear cut, for example an area of floor prone to contamination but without an accident history, it can be helpful to have some more object measure of slip risk potential. SAT provides that objective input". Mr Conway founded upon the fact that the Group Manager Mr McCracken accepted that he had not even seen this document. Moreover, as Mr Conway pointed out he had never heard of a sutronic duo meter.

[79] As summarised in his written submission, Mr Conway sought particular recommendations in respect of training of Environmental Health Officers. I have given anxious consideration to Mr Conway's submissions, which were clearly presented and cogently argued. Mr Conway invited the following recommendations:-

- (1) all Environmental Health Officers receive training on slipping hazards, with particular reference to food retail premises;
- (2) all Environmental Health Officers are made aware of Local Authority Circulars from HELA regarding the Health and Safety Executive "*Revitalising Health and Safety*" Agenda;

(3) in line with HELA Local Authority Circular 40/5 all Environmental Health Officers are encouraged to adopt a robust and critical stance to slipping hazards in food retail premises; and

(4) in line with Local Authority Circular 77/1 each team is supplied with a sutronic duo meter, that training is provided for Environmental Health Inspectors in its use and that it is used in the field in conjunction with the Health and Safety Executive slips assessment tool (SAT) described in family productions 13 and 18.

[80] As Mr Conway recognised, there is no statutory requirement for a health and safety inspection of butchers' premises. It is clear from the undisputed expert evidence of Mr Lenford Greasley that the quarry tiled floor in the meat preparation room of this butcher's shop was unsatisfactory because it presented a high slipping risk when contaminated with fatty deposits, which were likely to occur in the normal course of working and which required detergent to remove them. However, this does not mean that a visual inspection of this floor carried out without the equipment which Mr Greasley had would necessarily result in it being found to be in breach of the relevant regulations. On 1 November 2005, the floor was not slippery when Mrs Dyer carried out a visual inspection. HELA was set up in 1975 to provide effective liaison between the Health and Safety Executive and local authorities. In my judgment, it is appropriate for me to leave to that body the responsibility for giving to local authorities any further guidance or advice which may be necessary arising out of the evidence led at this Inquiry. I am also mindful of the terms of section 18 of the 1974 Act. On the undisputed evidence led at this Inquiry, those Environmental Health Officers employed by Glasgow City Council who gave evidence at this Inquiry had not been issued with a sutronic duo meter in line with operational Local Authority Circular 77/1. Further, the advice given by HELA in its Operational Circulars 40/5 and 77/1 had not reached all the Environmental Health Officers who visited butchers' shops in the course of their work by the time this Inquiry was heard. That is a matter of real concern for it reveals a failure by Glasgow City Council to follow the operational guidance issued by HELA. In the light of the content of Relatives productions 16, 17 and 18, further consideration of the instructions given to Environmental Health Officers employed by Glasgow City Council as to what they have to do when carrying out health and safety inspections in relevant premises, including butcher's shops is merited.

Conclusion

[81] In conclusion, I should like to repeat and endorse the condolences which were extended to Mr Bolesworth's son, daughter-in-law and family by those appearing at this Inquiry at its conclusion. Mr Bolesworth's son was most ably represented by Mr Conway. Mr Bolesworth's daughter-in-law was present in court throughout most of this Inquiry. I hope that this Inquiry has served to give them a clearer picture as to the circumstances of the accident and why Mr Bolesworth subsequently died. I have tried to answer all the concerns raised in so far as I can but there are limitations as to what can properly be found at an Inquiry held so long after Mr Bolesworth's death and in a situation where the evidence led was deficient in the respects mentioned at the outset of this note.

[82] I am most grateful to Mr Quither, Mr Coll, Miss Gallagher and Mr Conway who appeared at this Inquiry for the most professional way in which they each presented their respective cases and for their clear and careful closing submissions, which have been of great assistance to me in preparing this determination.