

SHERIFFDOM OF GLASGOW AND STRATHKELVIN AT GLASGOW

2014FAI36

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

DETERMINATION by Sheriff John Neil
McCormick following an Inquiry held at
Glasgow between 22 and 26 September and
27 October Two Thousand and Fourteen into
the death of **PATRICK PETER SMYTH**

GLASGOW, 3 December 2014.

In terms of section 6 of the Fatal Accidents and Sudden Deaths Inquiry (Scotland) Act 1976, the Sheriff, having considered the evidence and the submissions, FINDS AND DETERMINES:

(1) In terms of section 6(1)(a) of the Act (where and when the death and any accident resulting in the death took place) determines that Patrick Peter Smyth, date of birth 7 July 1953, of, died at the Southern General Hospital, Glasgow at 15.41 hours on 21 June 2011. The accident resulting in the death of Mr Smyth took place at approximately 13.12 hours on 31 March 2010 at the area known as the Pickfords' tunnel, Lomond St, Glasgow.

(2) In terms of section 6(1)(b) of the Act (the cause or causes of such death and any accident resulting in the death) determines that the cause of death was bronchopneumonia due to head injury caused by a fall from height through a chrysotile asbestos roof known as the Pickfords' tunnel at Lomond St, Glasgow, on 31 March 2010.

(3) In terms of section 6(1)(c) of the Act (the reasonable precautions, if any, whereby the death and any accident resulting in the death might have been avoided) finds as follows:-

- (i) That Patrick Peter Smyth should not have been instructed to work at height unless Allied Vehicles Limited were satisfied (a) that Patrick Peter Smyth was competent to prepare a method statement, risk assessment and to carry out such work, (b) that an employee of Allied Vehicles Limited with relevant health and safety experience in organising, planning or supervising such activity, was competent to assess Mr Smyth's competency, and (c) that Patrick Peter Smyth had acquired, or was provided with, training and safety equipment appropriate to the task.
- (ii) That Patrick Peter Smyth, a self-employed handyman, should have refused to work at height without training, Youngman boards with hand rails, a safety harness and an appropriate roof ladder as a minimum.

(4) In terms of section 6(1)(d) of the Act (the defects, if any, in any system of working which contributed to the death or any accident resulting the death) finds as follows:

- (i) That no method statement or risk assessment was prepared for working at height.
- (ii) That no safety, preventative or protective measures were in place on 31 March 2010.
- (iii) That on 31 March 2010 Allied Vehicles Limited did not have personnel with experience of the Management of Health and Safety at Work Regulations (including the Work at Height Regulations 2005/735) sufficient to organise, plan or supervise Patrick Peter Smyth's competency in relation to work at height.

(iv) That such safety equipment as had been provided by Allied Vehicles Limited was neither sufficient nor appropriate and was left unused on 31 March 2010.

(5) In terms of section 6(1)(e) of the Act (any other facts which are relevant to the circumstances of the death) finds that there were no other facts relevant to the circumstances of the death in respect of which any determination requires to be made.

SHERIFF

NOTE:

[1] This Fatal Accident Inquiry called before me on consecutive days between 22 and 26 September 2014 and, in respect of submissions, on 27 October 2014.

[2] The procurator fiscal depute, Ms L Jamieson represented the Crown. Mr R Conway, Solicitor, represented Mr Smyth's widow, Catherine Smyth; Mr Smyth's daughter, Stephanie Smyth, his step daughter, Maria Cassidy and her daughter Brooke Robertson. Ms A Bonomy represented Allied Vehicles Limited. Ms J Dickson represented the Health and Safety Executive.

[3] The duty on a sheriff presiding at a Fatal Accident Inquiry is set out in section 6 of the Fatal Accidents and Sudden Deaths Inquiry (Scotland) Act 1976 ("the Act"). The sheriff is to hear all the evidence and any subsequent submissions made on that evidence and then to make a determination setting out the circumstances of the death of Patrick Peter Smyth under

reference to the five considerations set out in section 6 insofar as they have been established to the satisfaction of the sheriff. The sheriff's purpose and function within the confines of a Fatal Accident Inquiry are determined by section 6.

[4] In particular, the function of the sheriff at a Fatal Accident Inquiry is not to make a finding of fault or to apportion blame between persons who might have contributed to the accident. The Act does not empower the sheriff to do that.

[5] A Fatal Accident Inquiry is not a fault finding Inquiry. The standard of proof of the circumstances of the death is on balance of probabilities. The onus rests on the Crown because, by virtue of section 1 of the Act, the duty of investigating those circumstances lies with the Crown.

[6] I heard oral evidence from the following witnesses for the Crown:

- 1 Desmond McAvoy, Facilities Coordinator with Allied Vehicles Limited
- 2 Cheryl Wood, formerly Facilities Administrator with Allied Vehicles Limited
- 3 James Gear, formerly Production Vehicle Assembler with Allied Vehicles Limited
- 4 Alan Dunn, Paramedic
- 5 James Mitchell, Self-employed decorator
- 6 James Jarvie, formerly Facilities Manager with Allied Vehicles Limited
- 7 Gerald Facenna, Joint Chairman of Allied Vehicles Limited
- 8 Robert Campbell, Director, CVS (Europe) Limited
- 9 Ronald McEwan, formerly Branch Manager, Pickfords Limited
- 10 Steven McCooey, Police Constable
- 11 Alan Gibb, Detective Sergeant
- 12 Gerald McCulloch, HM Inspector with Health and Safety Executive
- 13 Murray Provan, formerly HM Inspector, Health and Safety executive
- 14 Michael Facenna, Joint Chairman of Allied Vehicles Limited

[7] I considered affidavit evidence from the following witnesses:

- 1 Donald McGhee, Yard Coordinator, Allied Vehicles Limited
- 2 George Kirk, National Transport Manager, Scottish National Blood Transfusion Service
- 3 Edwina Perry, Detective Constable

[8] Allied Vehicles Limited led evidence from Barry Bruce who, since June 2010, has been the Health and Safety Manager with Allied Vehicles Limited.

[9] The parties had entered into a substantial joint minute in relation to undisputed facts. I am grateful to the parties for doing so.

[10] On the whole, I found the witnesses credible but in certain respects not reliable. For example, Mr Jarvie had difficulty reconciling his initial evidence to the Inquiry with the statements he had given to the police and to the Health and Safety Executive. Ultimately, he accepted that the information which he had tendered to the police on 31 March and 1 April 2010 should be preferred. In relation to Messrs Gerard and Michael Facenna, their demeanour and evidence did not convey the force of character which other witnesses had related. Of course, giving evidence to a court and motivating staff are different environments and I am conscious that neither witness had their evidence tested in-depth as might have occurred in a different forum. Also, when assessing witnesses, I have had regard to the time lapse between the date of the accident, 31 March 2010 and the date of the Inquiry in the autumn of 2014. Allowance has to be made for the fact that routine workplace conversations may otherwise have been unremarkable, were it not for the subsequent fatal accident. Only years later might such conversations assume an evidential importance which may not have been apparent in the immediate aftermath.

Undisputed background and facts relating to the death of Patrick Peter Smyth

[11] The Inquiry focused on section 6(1)(c), (d) and (e) of the Fatal Accident and Sudden Deaths Inquiry (Scotland) Act 1976, namely, on the reasonable precautions, if any, whereby the death and any accident resulting in the death might have been avoided; the defects, if any, in any system of working which contributed to the death or the accident resulting in the death and any other facts which are relevant to the circumstances of the death. This included consideration why Patrick Peter Smyth was on an asbestos roof, alone and without appropriate safety equipment.

[12] I do not propose to reiterate the evidence of each witness. Many of the facts surrounding the death of Patrick Peter Smyth are not in dispute and are summarised in the following paragraphs.

[13] Allied Vehicles Limited was established in 1991 by Gerard and Michael Facenna with a handful of employees. The company grew substantially and currently employs in the region of 470 personnel.

[14] Patrick Peter Smyth had formerly been employed as a handyman for the Facilities Department of Allied Vehicles Limited at Lomond Street, Glasgow. On 19 December 2008 his employment was terminated due to an economic downturn.

[15] Patrick Peter Smyth became self-employed and, in the course of 2009, he was contracted by Allied Vehicles Limited to undertake general handyman tasks for them at their premises at Lomond Street.

[16] On 31 March 2010 Patrick Peter Smyth was working at the company's premises at Lomond Street when, at approximately 1312 hours, he fell through a roof which comprised of

chrysotile asbestos situated above the area known as the "Pickford's Tunnel". He landed on the ground approximately ten metres below.

[17] As a result of the fall, Patrick Peter Smyth was taken by ambulance to the Glasgow Royal Infirmary. His Glasgow Coma Scale at that time was 3/15. He was transferred to the Southern General Hospital on the same day for neurosurgical consultation. No neurological surgery was carried out on Mr Smyth and he was discharged back to the said Glasgow Royal Infirmary on 24 April 2010. Mr Smyth was then re-referred back to the said Southern General Hospital on 11 June 2010 for long term continuing care.

[18] As a result of the fall, Patrick Peter Smyth suffered massive trauma and multiple injuries. His brain was affected the most. The injuries he sustained included brain injury, multiple maxilla-facial fractures, intra-abdominal injuries, chest injuries, knee fractures, damage to his optic nerves, a right elbow fracture and a pneumothorax. Mr Smyth had liver, kidney and brain lacerations.

[19] On 7 April 2010, Mr Smyth had an orthopaedic operation to his right thigh when a plate was inserted and to his right elbow when a wire and plate were inserted. He had a tracheostomy fitted to assist with his breathing and a gastronomy peg fitted to enable him to be fed.

[20] Patrick Peter Smyth suffered intermittent chest infections between 31 March 2010 and 21 June 2011 which were mainly episodes of pneumonia and bronchitis. These were treated with antibiotics, physiotherapy and oxygen as appropriate.

[21] Patrick Peter Smyth was unable to regulate his body functions properly. For example, he had difficulty maintaining his body temperature. Patrick Peter Smyth showed signs of

gradual improvement in his level of awareness from around December 2010 whereby he attempted speech and was able to follow commands.

[22] On 7 April 2011 Patrick Peter Smyth became unwell again and suffered a gross chest infection. Throughout his time in hospital Mr Smyth had been in an unstable medical state which was compatible with the consequences of brain injury. The state of his health and eventual demise were the consequence of the injuries sustained as a result of the said fall on 31 March 2010.

[23] On 19 June 2011, Patrick Peter Smyth was no longer responding to antibiotics and he died within the said Southern General Hospital at 15.41 hours on 21 June 2011.

[24] On 5 July 2011 a post mortem examination was carried out on the said Patrick Peter Smyth by Dr Julia Bell and Dr Marjorie Turner, Forensic Pathologists who identified the cause of death as bronchopneumonia due to head injury resulting from a fall from height.

The roof

[25] Within the substantial site occupied by Allied Vehicles at Lomond Street, Possilpark, Glasgow there are a number of buildings as shown within Crown production number 9(X1) being an aerial photograph of the site. This Determination will focus on a building with a chrysotile asbestos roof ("the Pickfords' tunnel") situated between two buildings with modern metal roofs known as the "production building" and the "Pickfords' warehouse".

[26] Pickfords limited were tenants of Allied Vehicles Limited. They have subsequently vacated the premises. The chrysotile asbestos roof of the building where the accident occurred

was, as at March 2010, known as (and referred to throughout the Inquiry as) the “Pickfords’ tunnel”. Accordingly I refer to the building as the Pickfords’ tunnel within this determination.

[27] The Pickfords’ tunnel was used for access/egress to other parts of the site and for storing vehicles by both Allied Vehicles Limited and Pickfords Limited.

[28] Seagulls gathered and nested on the asbestos roof covering the Pickfords’ tunnel. The presence of the seagulls brought with it maintenance problems. Debris associated with such nesting gathered on the roof and found its way into gullies between sections of the roof and downpipes which caused blockages and flooding. In addition, droppings from seagulls affected paintwork on vehicles manufactured by Allied Vehicles Limited.

Roof work.

[29] I heard evidence from James Mitchell that during about August 2009 he and Mr Smyth had cleaned the gullies running at each side of the Pickfords’ tunnel roof. He explained that this involved lifting nests, grass etc. and bagging the debris. He would work with Mr Smyth on this work. Mr Smyth had made a tool for the purpose of scraping a corrugated style roof. That tool was sighted on the roof after the accident.

[30] In August 2009, neither Mr Mitchell nor Mr Smyth used harnesses. A harness and a roof ladder had been acquired by Allied Vehicles Limited for Mr Smyth but according to Mr Mitchell the harness was not used. I heard evidence from Gerard McCulloch, HM Inspector with the Health and Safety Executive, that the roof ladder acquired in 2009 was inappropriate for accessing an asbestos roof. The ladder was too short to reach the apex of the Pickfords’ tunnel roof.

[31] On the day of the accident, the roof ladder was found lying on top of the asbestos roof but not hooked over the apex. It is unlikely that Mr Smyth had accessed the roof via the roof ladder. This is because the roof ladder has small wheels near the hook-end by which it can be manoeuvred into place and then flipped over allowing the hook to attach itself to the apex of the building. The ladder was not hooked over the apex. The ladder was lying with its wheels on the asbestos roof. These are small wheels similar in size to castors. It is likely that, had someone used the ladder in that position, those two small wheels would have punched through the asbestos roof (because of the concentration of weight under the small wheels lying upon asbestos sheeting). The photographs taken after the accident indicate that this had not happened.

[32] Furthermore the roof ladder was located some distance away from where Mr Smyth fell. The roof ladder was on the opposite side of the roof to where the accident had occurred.

[33] Accordingly, although it cannot be said with certainty how Mr Smyth manoeuvred himself while on the roof before the accident, it is unlikely that he had used the roof ladder.

[34] Additionally Mr Mitchell described the method of removing the black bags of debris from the roof as at August 2009.

[35] A skip would be located at ground level. Mr Mitchell would remain at ground level. Mr Smyth would throw the bags from roof level into the skip. Mr Mitchell would remain at ground level to ensure that the area was free of pedestrian or vehicular traffic.

[36] Mr Smyth and Mr Mitchell had taken access to the roof via ladders. They used neither harnesses nor duck boards. There was no roof edge protection.

Health and safety work at height – August 2009 to March 2010

[37] The person responsible for health and safety on site during March 2010 was Mr James Jarvie. Mr Jarvie was the facilities manager. Mr Jarvie had been given a range of responsibilities which included health and safety, in addition to facilities infrastructure, quality management, procurement and an involvement with an electric vehicle project.

[38] Health and safety was one of a number of pressing demands on Mr Jarvie's time.

[39] His evidence is essential to an understanding of the events on 31 March 2010.

[40] Mr Jarvie explained that he had commenced work as a facilities manager with Allied Vehicles Limited in 2008. He left the company in February 2013.

[41] Mr Jarvie had undergone a management safety course lasting five days in 1998. He did not regard his experience as up to date. He conceded that he was neither competent to assess work at height issues nor to assess or supervise the competency of Mr Smyth.

[42] In 2009/10 Mr Jarvie was struggling to come to terms with the wide range of his responsibilities. There had previously been a health and safety officer engaged in 2008 but he had been made redundant due to the economic downturn.

[43] Mr Jarvie had found a file on the computer relating to health and safety issues. Mr Jarvie was referred to Crown productions 1, 2 and 3. Crown productions 1 and 2 had been prepared by the former health and safety officer.

[44] Importantly, for these purposes, there had been no work at height method statement prepared prior to the accident.

[45] When Mr Jarvie had commenced his employment, Mr Smyth had also been an employee. Mr Smyth had been made redundant in 2008 but was re-engaged in 2009 on a self-employed basis. Mr Jarvie felt that Mr Smyth looked for work from him only after he (Mr Smyth) had exhausted work given to him by two directors, Michael and Gerald Facenna.

[46] In August 2009 Mr Jarvie had “intercepted” a discussion concerning roof work which had involved the proposal to remove debris from a section of the Pickfords’ tunnel roof.

[47] Mr Jarvie said that he did not know where the instruction to do the work had come from. Mr Jarvie had wanted to know how the work was to be carried out by Mr Smyth and Jim Mitchell. Mr Jarvie was concerned at a lack of proper equipment. Accordingly, a harness and a 4.6 metre aluminium roof ladder were ordered and paid for by Allied. On 19 August 2009 a webbing ladder lanyard was also ordered. However, during his evidence, Mr Jarvie accepted that he was neither qualified nor competent to assess, organise or supervise roof work and that he was not aware of anyone within Allied who would have been. Significantly, neither Mr Smyth nor Mr Mitchell was instructed not to do roof work in August 2009.

Roof Cleaning – a safe alternative.

[48] In about August 2009 the work went ahead without incident but was left unfinished. It had been a large job. Mr Robert Campbell from CVS (Europe) Limited (someone experienced and qualified to express an opinion) estimated that two or three men using youngman boards and harnesses would take between two and three weeks to clean the roof. He explained that a scissor lift would be an appropriate device for taking the workers and the equipment to height. Youngman boards with rails would have been used so as to prevent workers going on to the

fragile roof. In addition, workers would be harnessed to the rails as a safety measure. Edge protection would also be required. While it would be possible to install netting under the roof (to catch a person, or debris, in the event of a fall) that procedure would not be a preferred option. Mr Campbell explained that his employees would not have been given metal implements for use on the roof. The use of metal implements may disturb asbestos dust, something which would be reduced by the use of other materials, such as plastic implements. I have not made reference to a number of the safety measures suggested by Mr Campbell in my determination. This is because, for example, although the lack of edge protection may evidence a casual approach to health and safety that lack of edge protection did not directly contribute to this accident.

Had Patrick Peter Smyth been instructed, or authorised, to work at height in March 2010?

[49] It was not disputed that Patrick Peter Smyth had worked on other roofs at the site and on the Pickfords' tunnel roof the previous August. However, Mr Jarvie was sure that Mr Smyth would have been aware of a dispute between Allied Vehicles Limited and Pickfords Limited whereby an instruction had been issued that no work was to be carried out on any property leased to or occupied by Pickfords Limited. This instruction had been issued during late 2009 and remained in place in March 2010 according to Mr Jarvie. Mr Jarvie's initial position before the Inquiry was that Mr Smyth had not been instructed to do roof work in March 2010 (whether or not on the Pickfords' tunnel roof). Moreover, Mr Smyth would have known not to work on the Pickfords' tunnel roof because of the dispute.

[50] That position has not been consistent. Mr Jarvie had given two statements to the police on 31 March 2010. The first is timed at 13.38 immediately following the accident but is of no significance to this part of my determination.

[51] The second statement was given at 14.30 hours also on the day of the accident.

Two excerpts from the statement are of significance. The first:

"Today (31/3/10) about 9 o'clock this morning I think I spoke to Pat and told him his jobs today were moving the scrap metal from the site and putting it into the skips. Then his job his next job would be to clear the gutters on the production building. Then at 11.15 hours (31/3/10) I phoned Pat on his mobile and asked him to move the mobile skip to the main skip which happens to be at the rear of the production building. That was the last time I spoke to him today."(sic)(My emphasis)

[52] The second excerpt:

"Pat goes on to the roof to clean the gullies. This happens once a year around about this time. That's the protocol of cleaning the gullies cause the roof is double skinned and classed as being safe to walk on. Pat has done this job at least once before to my knowledge but probably done it prior to me starting with the firm."(sic)(My emphasis)

[53] For the sake of completeness, Mr Jarvie gave a further statement the following day, 1 April 2010, though I do not require to quote from it. He gave a fourth statement this time to the Health and Safety Executive ten months later on 2 February 2011. On this latter occasion Mr Jarvie said to the Health and Safety Executive:

"I gave clear verbal instructions to the people who worked for me, definitely including Pat Smyth, that no work had to be done on any of the Pickfords' leased buildings. I reinforced the message several times and I would say it was common knowledge. I first issued this instruction in February 2010. I recall clearly that Pat Smyth came to me...that he had seen choked ground level drains in the Pickfords building. He asked me if he could deal with it but I made [it] clear to him that no work was to be done in the Pickfords buildings and reminded him of my earlier instruction". (My emphasis)

[54] Again, later within the fourth statement, Mr Jarvie said:

“At the start of the day Pat asked me if he could do the job and I said no. Pat was aware that there was no method of work for the job. Pat was to be doing scrap removal on the day of the accident. ...*Pat was not to day any roof work at all – that was my clear understanding*”. (My emphasis)

[55] Both the terms and the tone of the second statement, given in the immediate aftermath of the accident, differ markedly from the statement given to the Health and Safety Executive the following February. The issue is which, if either, of the statements is accurate.

[56] There are compelling reasons to believe that Mr Smyth was on the roof doing as he had been instructed - by someone. I conclude this for the following reasons.

[57] Firstly, those witnesses who were in a position to express an opinion were of the view that Mr Smyth was not a person to do work without instruction. To quote Mr Gerald Facenna, Mr Smyth was not a person who would “do work off his own back”. He might have suggested work which needed attention but Mr Smyth would have sought approval before starting.

[58] Secondly, CCTV from the morning of 31 March 2010 shows Mr Smyth placing a ladder against the wall and taking a mortar trowel and a brush up to the roof with him. Mr Smyth was not discreet as if he was disobeying an instruction. Photographs of the roof taken on the day of the accident disclose other tools belonging to Mr Smyth lying on the roof.

[59] Thirdly, crown productions number 8(34) – 8(41) show a small skip containing bags of grass etc. from the roof. These were found beside the wall of the production building near Mr Smyth’s ladder. It is not disputed that the material within the polythene bags came from the gullies adjoining the roof and from the roof itself.

[60] Mr Jarvie said that he had previously seen the bags of grass (which were lying in the skip on the day of the accident) days before, at the edge of the roof. His opinion was that those bags must have been at the roof edge since the earlier cleaning in August 2009. If that were correct, Mr Jarvie had only noticed those days before the accident.

[61] This evidence does not bear scrutiny. It is unlikely that Mr Mitchell and Mr Smyth would have left bags of debris at the roof edge from the preceding autumn. Indeed, Mr Mitchell gave evidence as to how he and Mr Smyth had removed bags of debris from the roof during August 2009 – by throwing them from the roof into a skip below. Although Mr Jarvie may well have instructed Mr Mitchell to remove bags of debris from the roof edge in the days before the accident, it is likely that those bags had been filled by Mr Smyth in March 2010, not the previous August.

[62] Fourthly, crown production 8(9) shows a clear plastic bag lying on the roof on the day of the accident. I heard evidence from Mr Gerald McCulloch of the Health and Safety Executive, that the bag in the photograph was (partly) filled with similar debris to that within the plastic bags in the skip. With reference to the same photograph, Mr McCulloch spoke of debris on open view which had been removed from a gully, awaiting bagging. Furthermore, Mr McCulloch gave evidence that there was a stash of unused plastic bags wedged under a scaffolding board located on the asbestos roof above the Pickfords' tunnel.

[63] Fifthly, Mr McCulloch did not think that the grass and other debris in the skip on 31 March had composted in any way. Although he was no expert, applying his gardening knowledge and common sense, he formed the impression that the bags in the skip contained

material recently removed from the roof rather than material which had been bagged months beforehand.

[64] Accordingly I consider that Mr Jarvie is mistaken in his conclusion that the bags which he saw at the roof edge in March 2010 had been at that location since the preceding August. I do not accept that any instruction not to do work on the Pickford's tunnel roof remained in place as at March 2010.

[65] I think it more probable that the bags in the skip had been filled by Mr Smyth as part of an ongoing roof and gutter cleaning process in March 2010. That conclusion is consistent with Mr Jarvie's second statement to the police quoted above. It explains the debris removed from a gulley awaiting bagging; the partly filled bag, the tools and the stash of bags (yet to be filled) all lying on the roof.

[66] Mr Smyth did not conceal his presence on the roof. His ladder (placed against the wall of the productions building) was obvious. His van was nearby. I heard evidence from Desmond McAvoy and Cheryl Wood that they had been walking towards the production building when Mr Smyth had shouted a joke from the roof. They thought nothing of it and walked on. Mr Smyth did not conceal his presence on the roof of the production building. Mr Smyth had worked on other roofs at the site.

[67] Mr McCulloch said that from his inspection and in his opinion, the Pickfords' tunnel roof appeared to have been cleaned in part which was consistent with the photographs of the roof and the evidence that the work was unfinished from the previous autumn.

[68] Tying these strands together, Mr Smyth had, as at March 2010, been in the process of completing unfinished roof work from the autumn before. I conclude that Mr Smyth had been

instructed to carry out work on the Pickfords' tunnel roof. Standing the wealth of circumstantial evidence, it is not a difficult conclusion to draw. Ultimately Mr Jarvie accepted that his second statement to the police was to be preferred as accurate rather than his statement given the following February to the Health and Safety Executive.

[69] That said the reason why Mr Smyth was at the particular part of the roof which gave way below him, is unclear. When Mr Smyth fell he was carrying neither tools nor bags of debris. Mr Conway suggested that Mr Smyth may have crossed the roof to examine what was required on the other side. It would be conjecture for me to express any view.

[70] There is no evidence to show whether, for example, Mr Smyth stumbled, falling through the roof or whether he was traversing the roof when the asbestos gave way below him. I was invited to infer something from the fact that a glass roof panel adjoining the accident site had been damaged. Again that would be to speculate. I have no evidence to indicate that the glass panel was un-cracked before the accident or whether, for example, Mr Smyth hit the glass panel cracking it as the roof gave way below him.

[71] CCTV from the day of the accident shows Mr Smyth going to roof height with a brush and a trowel. These items are not shown on any photographs of the roof and I was invited by Miss Bonomy to conclude that Mr Smyth must have been working on the metal roof of the productions building and that no conclusions can be drawn from the presence of other tools or debris on the Pickford's tunnel roof. I do not agree.

[72] The fact that Mr Smyth took a brush and mortar trowel to roof height adds credence to the circumstantial evidence that he was engaged on roof work and contradicts the instruction which Mr Jarvie said he told Mr Smyth, namely that "Pat was not to do any roof work at all -

that was my clear understanding” (his fourth statement, 2 February 2011). If Mr Smyth was disobeying direct instructions, this would have been out of character. Furthermore, his presence on the roof was obvious. His van was parked near to the ladder where Mr Smyth took access to the roof. The skip containing material removed from the roof was also nearby and he had shouted a joke from the roof. I also heard, without objection, evidence that he may have dropped a seagull’s egg through a hole in the roof towards an unnamed employee below.

[73] Allied initially maintained that Mr Smyth should not have been doing roof work at all but this position evolved to one where Mr Smyth may have been engaged on roof work but exclusively on the roof of the productions building. Standing the disappearance of the trowel and brush it may well be that Mr Smyth had been working on the roof of the productions building as well as (not instead of) on the Pickfords’ tunnel roof. There is a wealth of circumstantial evidence indicating that no matter where else Mr Smyth had been working, he had been working on the Pickfords’ tunnel roof.

[74] As I indicated at paragraphs [4] and [5] above, this is a fact finding, not a fault finding Inquiry and I have outlined the facts which inform my determination. If, as I have found, Mr Smyth was on the roof openly and under the instruction of Allied, there are obligations on an organisation instructing work to be carried out at height. These obligations include that persons who work on roofs must be competent to do so. Those obligations may be complied with by, for example, engaging reputable building contractors capable of preparing their own risk assessments and method statements. I should be careful not to stray into a different forum. Suffice to say that all parties were agreed that Patrick Peter Smyth was engaged as a self-employed handyman (Joint Minute, paras 3 and 4).

[75] In terms of the Work at Height Regulations 2005/735, Regulation 5:

“Every employer shall ensure that no person engages in any activity, including organisation, planning and supervision, in relation to work at height or work equipment for use in such work unless he is competent to do so or, if being trained, is being supervised by a competent person.”

In terms of Regulation 3(2) the requirements imposed by the regulations extend to an employee or, (Regulation 3(2)(b)), “any other person under his control, to the extent of his control”.

[76] Accordingly, it has been necessary for me to determine whether, on balance of probabilities, Mr Smyth had accessed the roof on his own initiative or if he was complying with an instruction to do so. I would have been unable to complete the duties incumbent upon the sheriff at a Fatal Accident Inquiry without forming a view on that contentious issue. All parties were agreed on that.

[77] I was invited by Mr Conway to infer that an attempt had been made to remove evidence or at least interfere with it. That is not a matter on which I require to express an opinion. While the ladders used by Patrick Peter Smyth were taken down immediately after the accident, I do not require to consider if this was instructed as an immediate response to the incident (to avoid someone else taking access to the roof) or for a sinister motive. Shortly afterwards the ladders were returned to the exact position where they had been, as could be seen on the CCTV footage. The fact finding function of the Inquiry was not affected.

[78] On a more general note, this was another needless death by a fall from height where no regard had been paid to health and safety legislation especially where, as here, roof cleaning work, which had commenced in August 2009 without incident, engenders complacency until an accident occurs.

[79] I conclude by reiterating my condolences to the family of Patrick Peter Smyth. His family were present throughout the evidential stage of the hearing. Some of the evidence must have been difficult to hear. Mr Smyth appears to have been a hard working individual who was well liked and trusted by those who knew him.

.....Sheriff