SHERIFFDOM OF GLASGOW AND STRATHKELVIN AT GLASGOW

2011 FAI 26

B450/10
PF Ref: GL/GB/GL05059570

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

DETERMINATION by JOHN NEIL McCORMICK, Esquire, Sheriff of Glasgow and Strathkelvin following an Inquiry held at Glasgow into the death of KENNETH McLEAN

GLASGOW, 27th May 2011.

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, **FIND AND DETERMINES**:

(1) In terms of Section 6(1)(a) of the said Act, Kenneth McLean, aged 53, who resided latterly at 145 Whitehill Street, Glasgow died on 13 October 2005 at 09:48 hours within the Western Infirmary, Glasgow.

(2) In terms of Section 6(1)(b) of the said Act, the cause of death was neck and chest injuries due to a fall from a height of nine metres or thereby from a general access scaffold erected at 40 Crathie Drive, Partick, Glasgow. The cause of death was the installation, to the exterior face of the scaffold, of a hop up containing two metal battens, (a two board hop up) without a tie bar. The absence of a tie bar meant that the boards were insecure and liable to splay. Two wheelbarrows of render had been taken to the fifth level of the scaffold at 40 Crathie Drive via a hoist. Kenneth McLean successfully removed the first wheelbarrow at that level. When attempting to remove the second wheelbarrow Kenneth McLean placed his weight on the insecure exterior hop up board which, in the absence of a tie bar, moved causing him to fall to ground level along with the exterior hop up board.

(3) In terms of Section 6(1)(c) of the said Act, the reasonable precaution whereby his death might have been avoided would have been for PBL to eliminate the gap between the hoist and scaffold by either extending the scaffold platform or using a different type of hoist.

(4) In terms of Section 6(1)(d) of the said Act, the defects in the system of working which contributed to his death were:-

1 Failure by PBL Construction Limited (PBL) to employ scaffolders qualified and competent in the erection and alteration of Kwikstage Scaffold.

2 Failure by PBL to appoint a Site Manager experienced in, or able to delegate appropriately, a weekly inspection of scaffold.

3 Failure by PBL to instruct, and enforce the instruction, that only authorised scaffolders erect or alter scaffold.

4 Failure by PBL to insist upon the delivery of properly formulated risk assessments from sub-contractors including Talepine Limited, trading as Quickseal Specialist Contractors and to access them on receipt.

5 Failure by PBL to induct employees of sub-contractors.

6 Failure by PBL to communicate to such contractors (and enforce) an instruction that the fifth level platform was not to be used to access the hoist.

7 Failure by Talepine Limited, the employers of Kenneth McLean, to (a) draft a risk assessment making provision for the delivery of materials to height, (b) check that the scaffold had been erected correctly, (c) check that appropriate arrangements were in place for the alteration of the scaffold as required by their employees and (d) check that Kenneth McLean had been inducted at the site.

(5) In terms of Section 6(1)(e) of the said Act, that there were and are no other facts which are relevant to the circumstances of his death.

NOTE:

[1] A duty on a sheriff presiding at a Fatal Accident Inquiry is set out in Section 6 of the 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 Kenneth McLean 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.

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

[3] A Fatal Accident Inquiry is not a fault finding Inquiry. The standard of proof of the circumstances of the death is on the 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 in the Crown.

[4] This Fatal Accident Inquiry was convened in relation to the death of Kenneth McLean, aged 53, who resided at 145 Whitehill Street, Glasgow which occurred on 13 October 2005. Before summarising the evidence, it is appropriate to make some preliminary observations.

[5] Mr McLean died on 13 October 2005. The Fatal Accident Inquiry took place on 7-11 June 2010, 28 and 30 September, 15-19 November, 22-26 November 2010, 5 January and 17 March 2011. The time between the circumstances of the death and the Inquiry causes its own difficulties.

[6] In many respects recollections of what may or may not have been discussed at routine meetings, site visits etc. prior to the accident are not reliable. Had the Inquiry taken place shortly after the death, evidence would have been more reliable.

[7] In addition, there has been, to a degree at least, an attempt to re-write some of the events leading up to the death. For example, I do not consider it a coincidence that the scaffolders, John Park and Robert Simpson, both gave evidence to the Inquiry that they were not responsible for the erection of the scaffold. John Park and Robert Simpson were employed as scaffolders by PBL Construction Limited. They travelled between sites erecting and altering scaffold as required. At the Inquiry, they were unable to name other scaffolders employed by PBL and had not seen other scaffolders employed by PBL. Ultimately, they had to accept that what they had told the Health and Safety Executive shortly after the accident was accurate, namely, that they had in fact been responsible for the erection and the alteration of the scaffold throughout. Overall, they wished to distance themselves from the responsibility for the state of the scaffold.

[8] In relation to the scaffold, the following Note of Evidence exemplifies the litany of problems with the scaffold so as to explain my determinations under Section 6 in respect of the death of Kenneth McLean.

[9] John Park and Robert Simpson were experienced scaffolders but not in Kwikstage Scaffold, the scaffold which was being used at this site. They had not been trained in its use and the Site Managers (also referred to as Site Agents) were similarly unqualified. The mere fact that Mr Park and Mr Simpson had experience of erecting Kwikstage Scaffold meant nothing if their experience was erecting it incompetently.

[10] The main difficulty with the evidence stems from the fact that there are no eyewitnesses to the accident.

[11] Accordingly, much of the evidence was intended to give a flavour of the operation of the site at 40 Crathie Drive.

[12] At the conclusion one is left with the general impression of a company, PBL Construction Limited, having insufficient scaffolders, neither of whom was qualified to erect Kwikstage Scaffold despite their experience, with Site Managers not qualified to notice this deficiency and or to conduct weekly inspections of scaffold.

Background

[13] PBL Construction Limited, 137 Shawbridge Street, Glasgow were the principal contractor engaged by Partick Housing Association, 10 Mansefield Street, Glasgow to construct a block of four storey residential flats at 40 Crathie Drive, Partick, Glasgow. The external render works were sub-contracted to Talepine Limited trading as Quickseal Specialist Contractors, Cambridge House, 27 Cambridge Park, Wanstead, London.

[14] PBL Construction Limited is in liquidation. Talepine Limited is in administration.

[15] A hired general access scaffold was erected by PBL Construction Limited at 40 Crathie Drive, Glasgow to facilitate construction operations. The scaffold had six levels and was erected to the front, gable and rear elevations. A goods hoist was erected adjacent to the fifth scaffold bay of the front elevation of the exterior scaffold.

Parties to the Inquiry

[16] Parties at the Inquiry were the Crown; Mr Varney, Solicitor for the Insurers of PBL Construction Limited; Mr Forsyth, Solicitor for Talepine Limited and Mrs Hughes, Advocate, for the family of the deceased.

Witnesses to the Inquiry - First Witness – Mrs Elizabeth McLean

[17] The first witness to give evidence on Monday, 7 June 2010 was Mrs Elizabeth McLean, the widow of the deceased. She described her husband as a time-served slater.

[18] Although Kenneth McLean was a time-served Slater, he had latterly worked with his brother Brian McLean and his son-in-law Stephen Mackay as part of a team of roughcasters.

[19] The accident occurred on Thursday, 13 October 2005. In the days before the accident, Kenneth McLean had not been working. Elizabeth McLean and her husband had enjoyed her birthday celebrations on 12 October with the acquisition of a new engagement ring.

[20] She described her husband as a very placid individual. Kenneth McLean would, however, complain bitterly at the condition of scaffold on various sites which she described as the bane of his life.

[21] Previously he had suffered two accidents caused by deficient scaffold. In Elizabeth McLean's opinion these experiences caused her husband to take particular care.

[22] Elizabeth McLean outlined the effect which her husband's death had on the family in both emotional and financial terms.

Witness 2 – Alexander Brian McLean

[23] Alexander Brian McLean, known as Brian McLean, is 60 years of age. At the time of his evidence, 7 June 2010, Mr McLean was unemployed. He is a roughcaster to trade.

[24] Brian McLean had worked with his brother for about eight years prior to the accident in 2005. Kenneth McLean had been a Roofer/Slater to trade but he had picked up roughcasting from Brian McLean over the years they worked together.

[25] Brian worked with Kenneth McLean in a squad known as a "2 and 1" squad. This is a squad of two tradesmen and a labourer.

[26] Brian McLean was the unofficial manager or foreman of the three man squad. Brian McLean, Kenneth McLean and Stephen Mackay had been employed by Talepine Limited trading as Quickseal Specialist Contractors Limited. The squad reported to a travelling foreman,

Graham Nisbet also employed by Talepine Limited. Brian McLean, Kenneth McLean and Stephen Mackay commenced work at the Crathie Drive, Partick, Glasgow site on 29 September 2005.

[27] Much of Mr McLean's evidence related to the nature of the site at Crathie Drive. I do not propose to outline his evidence in that regard as it is dealt with elsewhere.

[28] Similarly, I do not propose to outline Mr McLean's evidence in relation to the importance of properly fitted "hop-ups". This is primarily for three reasons. Firstly, Brian McLean is not a scaffolder. Accordingly, his opinion in relation to the erection and maintenance of scaffold is an opinion personal to him on the basis of his experience at other sites. Secondly, the necessity to have properly erected scaffold is self-evident and not disputed. Finally, those aspects of the erection of scaffold which may have been found wanting, are dealt with by me elsewhere.

[29] The main contractor at the site in Crathie Drive was PBL Construction Limited (PBL).

[30] At the time of the accident the PBL Site Foreman was John Kearns. Brian and Kenneth McLean and Stephen Mackay had a meeting with the PBL Site Foreman John Kearns and Graham Nisbet, the Travelling Foreman of Talepine Limited. This meeting took place on or about 29 September 2005.

[31] At that meeting Brian McLean, Kenneth McLean and Stephen Mackay were authorised to use the on site hoist to take the render, once mixed, to height. The Site Foreman, John Kearns, had explained that the use of the hoist would be shared by other trades such as bricklayers and joiners.

[32] When asked whether it was John Kearns or Graham Nesbit who told Mr McLean to work in that way, the response of Brian McLean was "both of them really because it is just normal." Both Mr Kearns and Mr Nesbit were aware that wheelbarrows would be used to transport the render. Mr McLean explained that whilst he might work using buckets of render, the transport of large volumes of render was best achieved using wheelbarrows.

[33] Scaffold is erected from the ground. The height of the scaffold is in large measure dictated by the height of the building, the top level being at gutter height for safety reasons. The top level of scaffold abutting the building in Crathie Drive was six levels high. The height of the fifth level was reduced compared to the height of the levels below. This was to fit in with the requirement that the top level corresponds to the gutter height of the building roof. Put shortly, the fifth level had reduced headroom. In addition, landing gates, which were present on other levels, were not present on the fifth level. They could not be accommodated because of the reduced headroom.

[34] Despite the absence of landing gates on the fifth level, the understanding by Mr Brian McLean (of the instructions given to him by John Kearns and Graham Nesbit) was to the effect that materials could be off loaded using the hoist at any level, including the fifth level. More particularly, Mr McLean was never instructed not to take access to the hoist at the fifth level.

[35] In the event that scaffold required to be altered, Brian McLean explained that he had been told to approach the Site Foreman, John Kearns. John Kearns was not permanently on this site. Accordingly, in the absence of John Kearns, Mr McLean would speak to a ganger on site, a Robert Binnie.

[36] Before commencing work Brian McLean did not have an induction meeting with John Kearns. Mr McLean was given a toolbox talk by his Travelling Foreman, Graham Nesbit.

[37] In Mr McLean's experience an induction meeting should have covered all aspects of safety on the site.

[38] Mr McLean was not made aware of any site rules, work methods or risk assessments.

[39] During his time on site, Mr McLean had a range of concerns in relation to the scaffold including what he considered to be the incorrect use of hop-ups to the side of scaffold which faced the external walls of the building. Mr McLean explained that certain trades required hop-ups to be located at differing distances from the external walls. Bricklayers require the hop-ups to be very close to the wall. On the other hand, roughcasters need a gap between the scaffold hop-up and the wall so that render can be applied.

[40] When hop-ups needed to be altered, Mr McLean would speak to John Kearns. As far as Mr McLean recollected, however, it could take three or four days for scaffolders to attend for the purposes of altering the scaffold. Mr McLean recalled scaffolders asking him why he had not moved the hop-ups himself, as the bricklayers had done. Mr McLean had refused partly because he did not require to relocate double hop-ups. He required single hop-ups which would allow space between the scaffold and the building sufficient for him to apply the render. In addition, Mr McLean understood that bricklayers required access to double hop-ups, one level at a time. This contrasted with the requirements of roughcasters who require a space between a single hop-up and the building on two or three levels at a time. This is because render can be applied to large areas of the building.

[41] The significance of this evidence, however, is that trades, other than scaffolders, were being allowed to alter the scaffold.

[42] Mr McLean described in some detail concerns which he had in relation to the construction of scaffold at the apex area. He had advised both John Kearns and Graham Nesbit that the structure was unsafe. Eventually, Mr McLean just used the structure, shaky though it was.

[43] The significance of this passage of evidence was that it exemplified a casual approach by both John Kearns and Graham Nesbit to site safety. Although not a qualified scaffolder, Mr McLean had sufficient experience to express his concern at the safety of the scaffold at the apex area at the Crathie Drive site.

[44] In relation to the hoist, this was operated by Stephen Mackay. He was not given instruction as to how to use the hoist but had used similar equipment elsewhere.

[45] After mixing the material at ground level, the labourer, Stephen Mackay, would put the render into one or two wheelbarrows and place these on to the hoist where the material would be raised to the required height.

[46] Mr McLean thought that, at the fifth level, there was a handrail fitted in place of landing gates. He could remember only one handrail. He could not recollect a toe board in place. A toe board at the fifth level hoist area would have prevented wheelbarrows being taken off the hoist at that level. A toe board can be removed comparatively easily.

[47] On this site, hop-ups were used to the outer edge of the scaffold as a means of gaining access from the scaffold to the hoist. Brian McLean, Kenneth McLean and Stephen Mackay had not been on site prior to the morning of the accident (on Thursday 13 October 2005) since Friday 7 October 2005. In the intervening period scaffold, including at the fifth level, had been altered to provide for the installation of a feature window.

[48] After the accident Brian McLean produced a manuscript statement summarising events from 29 September to the day of the accident.

[49] The manuscript statement narrates a number of concerns which Brian McLean had in relation to debris on the scaffold, the quality of the erection of the scaffold, the lack of scaffolders to remedy defects or alter the scaffold. Within the manuscript note there is also reference to Brian McLean being left a joiner's wooden stool with three short battens, on which Brian McLean was to take access to the highest point on the site. He then notes tellingly "shaky does not come into it" referring to this means of access to the apex area.

[50] On page 8 of the manuscript statement Brian McLean makes reference to fixing one or two missing double hop-ups and battens "for our own safety".

[51] On 13 October 2005 Brian McLean recollected arriving on site between 8.00 am and 8.15 am. He was met by John Kearns.

[52] The application of the render would be from the top of the building downwards. The work was to commence at the rear of the building. It was intended to use wheelbarrows to transport the render from the hoist, round the scaffold at the appropriate level, to the rear of the building.

[53] The first job to be attended to was the mixing of the materials. This was done by Stephen Mackay at ground level. Brian McLean had work to do preparing the area for the render. Kenneth McLean intended to join Brian McLean to the rear elevation once the material was mixed.

[54] Kenneth McLean met the hoist platform transporting the wheelbarrows to the fifth level.

[55] Brian McLean took access to the fifth level by taking the internal stairwell of the building to the fourth level and thereafter walking on the scaffold to a ladder which he climbed to the fifth level.

[56] Kenneth McLean came up to the fifth level after Brian McLean. Kenneth McLean had removed one wheelbarrow from the hoist. He had also removed tools from the hoist which he deposited on the scaffold. Brian McLean offered to remove the second wheelbarrow from the hoist but Kenneth McLean asked him to take the first wheelbarrow round to the area to be rendered and he (Kenneth McLean) would remove the second wheelbarrow from the hoist.

[57] Brian McLean recalled a comment by Kenneth McLean to the effect that the scaffold was still “a fucking joke”.

[58] Brian McLean returned to the rear elevation of the building with the first wheelbarrow. After a few minutes he decided to walk back to the front elevation to see what was keeping his brother and to uplift the bucket of tools.

[59] When he got round the second wheelbarrow was still on the hoist. There was no sign of his brother. Brian McLean leant on a handrail. He saw Stephen Mackay running with a mobile phone to his head. He saw his brother Kenneth McLean lying on the ground. Brian McLean went down the scaffold immediately. A passer-by and John Kearns attempted to resuscitate Mr McLean.

[60] In summary, Mr McLean was not an eye witness to the accident.

[61] He had not received an induction meeting. He had not been shown the Method Statement nor his employer’s health and safety policy. Brian McLean had not seen the risk assessment for the site.

Witness (3) – John Kearns

[62] Mr Kearns is currently employed as a Project Manager.

[63] Mr Kearns had been employed as a Site Manager for Pollokshaws Builders Limited (PBL) from 11 September 2001. His role included health and safety on site and the keeping of records relating to health and safety, organising labour and ensuring that the building is erected to specification.

[64] Mr Kearns left PBL in March 2006.

[65] Mr Kearns was appointed Site Manager to the Crathie Drive development three or four weeks prior to the accident. He remained responsible for another site at Hill Street, Glasgow. The Crathie Drive development was behind schedule.

[66] When Mr Kearns was absent from the Crathie Drive site, a general labourer, Robert Binnie, was left in charge.

[67] In relation to the alterations to scaffold, scaffolders were not on site permanently. Scaffolders were employed by PBL to work at various locations. They had to be ordered to site.

[68] Mr Kearns admitted that he had asked labourers to alter hop-ups.

[69] In relation to the suggestion that Brian McLean may have been asked to alter hop-ups, Mr Kearns was equivocal.

[70] Where scaffold required to be altered urgently, Mr Kearns would contact his Managing Director, Alan McWhirter, in an effort to obtain scaffolders quickly.

[71] Mr Kearns was aware of his obligation to inspect scaffold weekly and to keep records of inspections on site.

[72] On arrival to site, Mr Kearns had not found any records prepared by the previous Site Manager, Lawson McLean.

[73] Mr Kearns was referred to a scaffold inspection record dated 26 September 2005. Here the description of the scaffold inspected is "front/rear/gable". The result of inspection reads "Clean down scaffold and replace handrails and toe boards all levels". There is also a short check list where the author is invited to tick relevant boxes to indicate that scaffold does <u>not</u> have the faults listed on the form. This section of the form was not completed.

[74] The scaffold inspection record on 3 October 2005 related to the "front, gable, rear" and narrated "Fill in front elevation top left two bays. Erect two bays top gable for casters. Fit handrails, hops internally."

[75] Within the same Production there is a reference to an inspection on 10 October 2005. This inspection related only to "front and rear". The result of inspection reads "Alter scaffold for sunspace window. Change two board hop-ups to singles rear for casters".

[76] Again the remainder of the form is not completed. These records are signed by Mr Kearns.

[77] Mr Kearns conceded that, standing the imprecise nature of his remarks, there may have been a significant amount of work which needed to be done to the scaffold.

[78] Mr Kearns was referred to the "Genuine Kwikstage User Guide". On page 2 of the User Guide it is narrated in bold that "only trained, competent operatives should erect, dismantle or adapt Kwikstage scaffolds at all times…Interserve recommend that as a minimum the guidelines for working practices for scaffolders working at heights contained in document SG4, produced by the National Access and Scaffold Confederation (NASC) are applied to all scaffold activities." Mr Kearns conceded that at the time of the accident he was not aware of these guidelines.

[79] Mr Kearns had noticed that unauthorised alterations to the scaffold were being carried out including handrails that were missing, toe boards and in some cases hop-ups.

[80] He did not consider that such unauthorised alterations were significant at that time.

[81] Mr Kearns did not consider that the use of hop-ups for the purposes of gaining access to the hoist platform was an unsafe practice.

[82] Mr Kearns was referred to the Genuine Kwikstage User Guide, page 53 where it commences "Platform Brackets are available in three widths to form cantilever extensions to platforms on the inside of a Kwikstage scaffold" (my emphasis). Again "these components can only be used in locations where there is not a risk of people falling". Mr Kearns conceded that, prior to the accident on 13 October 2005, he was not aware of this guidance.

[83] In relation to the scaffold, Mr Kearns remembered an issue where the hoist platform had been catching on a tie bar.

[84] Mr Kearns was not aware, prior to the accident, that rope had been used to lash a two board hop-up to scaffold. He first became aware that this had been done when assisting an inspector, Mr John Shelton, from the Health and Safety executive, after the accident. He said that if he had noticed the rope previously, he would have recorded it and had it changed by scaffolders.

[85] In relation to the hoist, Mr Kearns had not given Brian McLean, Kenneth McLean or Stephen Mackay training in the operation of the hoist.

[86] Mr Kearns said that he would have inspected the hoist weekly. The inspection would have been a visual inspection. Mr Kearns was shown a "Hoist & Access Services" weekly inspection checklist relating to a Wickham U D M Hoist and a daily inspection checklist. He had not seen such documents previously. Mr Kearns was not a trained hoist erector or inspector.

[87] Mr Kearns described the fifth level of the scaffold as a "bastard lift" because it had reduced headroom and no landing gate.

[88] Mr Kearns thought that it might be possible to avoid using the hoist at the fifth level by removing the wheelbarrows from the hoist at a different level and passing the wheelbarrow from one level to the next. Alternatively, the wheelbarrows could have been emptied (at levels four or six) by bucket and passed to the fifth level.

[89] Similarly, Mr Kearns claimed not to be aware that material was being offloaded on the fifth level until the accident on 13 October. He accepted, however, that it could have happened.

[90] Mr Kearns had been responsible for the compilation of the health and safety plan for the Crathie Drive site. He was referred to the document in some detail including the objective to eliminate all accidents which occur within the project.

[91] The Plan provided for regularly convened sub-contractors meetings to ensure compliance with the Health & Safety Plan; to identify risks and have risk assessments carried out; to provide that new operatives on site are updated on health and safety requirements. There is reference to a Safety Induction Course which includes the topic of scaffold.

[92] Mr Kearns said that he had seen the Quickseal Specialist Contractors Method Statement relating to Crathie Drive. This had been given to Mr Kearns by Graham Nesbit three days before the roughcasters commenced work on 29 September 2005. The document is silent about how materials are to be transported to height. Within the document there is a general assessment of risk prepared by David Poole of Quickseal. There is no reference to level 5 within the assessment. Mr Kearns said that although he had received the Quickseal Method Statement he did not discuss health and safety issues with Mr Nesbit and Mr Nesbit had not discussed PBL's Health and Safety Plan with him. The documents were exchanged but that was the extent of it.

[93] As far as Mr Kearns was concerned, there was no pre-start meeting with Mr Nesbit as such. There had been a meeting prior to Quickseal commencing work but this was not an official meeting.

[94] In relation to the day on which the Quickseal employees attended to commence work, Mr Kearns was vague. He believed that Mr Graham Nesbit had also attended. When the question

was asked "Did you have a discussion with Graham Nesbit about how the material was going to be taken to height?" the response was "I probably would have, yes".

[95] During his evidence the words "probably would have" were not uncommon. I questioned Mr Kearns as to whether he was making assumptions or could not remember. He could not remember if there was a plan in place in relation to taking the materials to the fifth level nor whether he had told Mr Nesbit that the fifth level was inaccessible (for the purposes of taking the goods from the hoist).

[96] In relation to the scaffold at the gable end, Mr Kearns instructed the scaffolders to attend to those alterations. In relation to the change from two-board hop-ups to one-board hop-ups, Mr Kearns had instructed Mr Robert Binnie, a General Labourer, to attend to that. Mr Binnie is not a qualified scaffolder.

[97] No training was provided to Quickseal employees in the operation of the hoist.

[98] Mr Kearns obtained a copy of the Wickham UDM Hoist Operating Instructions because when Mr Kearns took over responsibility for the site, there were no operating instructions on site. That said, Mr Kearns, did not recollect whether a copy of the Operating Instructions were given to Quickseal or to the employees of Quickseal.

[99] Initially Mr Kearns thought that he had given the employees of Quickseal an induction before they started work but admitted that he could be wrong. He was referred to the Site Induction Register to confirm that the persons named on the form had received induction on the Site Safety Rules. The names of Kenneth McLean, Brian McLean and Stephen Mackay do not appear on the register.

[100] Mr Kearns accepted that it was possible that the fifth level was being used as an access to the hoist platform. Mr Kearns said that he could not recall seeing missing handrails or guardrails at the fifth level.

[101] Mr Kearns admitted that he was aware of unauthorised scaffold alterations. He could not recollect exactly where or how many, but was aware that there had been some.

[102] The day of the accident was Thursday, 13 October 2005. On the days before the accident, a window had been installed which necessitated alteration to the scaffold.

[103] After the scaffold had been altered and the window installed, Mr Kearns had inspected the window and the scaffold from inside the window. He had not gone on to the scaffold on the fifth floor. He conceded it was possible that, when looking out of the window to the fifth level bay of the scaffold, it would be possible that a missing rail had gone unnoticed by him.

[104] Mr Kearns was taken in evidence to a number of the photographs lodged as productions which showed that, as at 13 October, there were a number of defects in the construction of the scaffold.

[105] On the day of the accident, 13 October 2005, Mr Kearns was occupied by other business on site. He was aware that Quickseal employees were working that day. Mr Kearns was in the building under construction talking to labourers when he heard a bang. He noticed Mr McLean lying in the protected area of the hoist (an area at the bottom of the hoist fenced off to prevent persons walking underneath the hoist when it is in operation). A batten was lying partly against the mast of the hoist and between the legs of Kenneth McLean. Mr Kearns removed the batten and placed it in a skip nearby. Mr Kearns and a third party tried to assist Mr McLean until an ambulance arrived.

[106] Mr Kearns was referred to a seventeen page manuscript note of the condition of the scaffold as at 19 October 2005. Mr Kearns was present when the note was prepared. Mr Kearns conceded that the note outlines defects some of which may have persisted over a period of time.

[107] Mr Kearns was of the opinion that a roughcaster would be both capable and permitted to change a double hop-up to a single hop-up at the inner face of the scaffold. Mr Kearns had no safety concerns regarding the use of hop-ups to the exterior of the scaffold. He described it as the "only system" that he knew because of the setting-out distance needed for the hoist at the base of the scaffold.

Witness (4) – John Park

[108] John Park is 45 years old. He is a time served scaffolder and has completed the appropriate Construction and Industry Training Board (CITB) course.

[109] Mr Park's training had been in tube and fit scaffold. Mr Park said that he had received some training in Kwikstage scaffold when at college.

[110] Mr Park had various criticisms of Kwikstage scaffold when compared to tube and fit scaffold.

[111] It does not do justice to Mr Park's evidence to say that he was aware that Kwikstage produced a User Guide. As far as Mr Park was concerned, "quite a lot of companies have got them (User Guides)". He does not consider that he needs to refer to a User Guide because he said he was trained in Kwikstage scaffold many years ago.

[112] Mr Park was taken through many aspects of the erection of scaffold. I do not propose to reiterate that evidence. The essence of it can be summed up as follows. Mr Park gave the impression in oral evidence of competence in the erection of scaffold but such impression was not borne out by reference to the erection of the scaffold at Crathie Drive. Mr Park saw no difficulty installing hop-up brackets to the exterior of the scaffold. The instruction in the User Guide is that such cantilever extensions should only be made on the inside of the scaffold ("Genuine Kwikstage User Guide", page 53). A cantilever platform is another name for a hop up bracket. According to Mr Park "nobody reads manuals".

[113] John Park worked with Robert Simpson, Steven Thomson and Jason Park. Robert Simpson was an advanced scaffolder. Steven Thomson and Jason Park were labourers.

[114] There was no obvious leader or manager among them.

[115] The squad reported initially to Lawson McLean and latterly to John Kearns. Lawson McLean had been the Site Manager before John Kearns.

[116] Mr Park did not receive induction training for the Crathie Drive site.

[117] Mr Park criticised PBL in relation to a number of health and safety issues including his concern that workers altered scaffold which they should not have done and had no qualifications to do. According to Mr Park, this never stopped happening.

[118] Mr Park was initially at pains to point out that he had not been involved in erecting the hop ups to the exterior of the building. This was until he was exhibited a copy of his statement to the Health and Safety Executive which said that he, or his squad, had indeed installed the hop ups to the exterior of the scaffold.

[119] Mr Park advised that, whilst scaffolders should be the only people who alter scaffold, on some sites the practice varies whereby hop up brackets can be moved by untrained workers. Best practice, however, dictates that only a qualified scaffolder should modify scaffold.

[120] There had been a problem at Crathie Drive with other trades making unauthorised alterations to the scaffold. Mr Park said that he had noticed unauthorised alterations to the scaffold throughout its structure.

[121] Mr Park would be called to site to remedy unauthorised alterations. He did not know what, if anything, was done to discourage or prevent other workers making unauthorised alterations to the scaffold.

[122] Throughout the job at Crathie Drive, each of the Site Managers must have been aware of the unauthorised alterations because it was his obligation to inspect the scaffold and Mr Park was contacted either by the Site Agent or by the Head Office and given instructions to remedy the defects found.

[123] Mr Park described major defects on the scaffold.

[124] Mr Park agreed that the absence of scaffolders permanently on site might encourage other workers to make alterations rather than to delay work.

[125] Mr Park recalled a large window being installed to the front of the building at Crathie Drive. Scaffold required to be altered to allow the installation of the window.

[126] Mr Park concluded, from inspecting the site documentation, that the last time he had been on site prior to the accident was 10 October 2005, when the scaffold had been altered by his team to allow for the installation of a window feature.

[127] The alteration to the scaffold was to allow the installation of a window. After that task had been completed, scaffolders should have been called back to restore the area for other trades to work.

[128] In relation to level 5, Mr Park denied having altered a mid-rail at the bay adjacent to the hoist. He denied having altered hop-up brackets to the outer part of the scaffold on the fifth level. As far as he was concerned, the scaffold was altered on level 5 only by reducing the number of boards on the scaffold from five to three.

[129] Mr Park was referred to a photograph being a view from inside the window on the fifth level taken shortly after the accident on 13 October 2005. Mr Park said that it showed a hop up bracket with one board on it, no tie bar and no bottom guardrail. With no tie bar on the bracket, the boards are insecure. There is nothing to prevent a board from falling off or, if there are two boards, those boards from splaying and falling off.

[130] At that location there should also be two handrails, one at waist height and the other at about knee height. It would appear that the lower guardrail was missing from the photograph. Although Mr Park could not recall if the guardrail had been present on 10 October 2005 when he was last on site, he considered that he would have noticed if it had been missing.

[131] As far as Mr Park and the records of PBL were concerned, it would appear to him that the last authorised alteration to the scaffold was on Monday, 10 October 2005 when Mr Park had been on site between 8.00 pm and 4.00 pm.

[132] Mr Park was next on site on the day of the accident, 13 October 2005 after the accident between 2.00 pm and 3.30 pm.

[133] When asked how many ties were needed to secure the scaffold to the building, Mr Park was candid in saying that he determined the number of ties through his experience. He did not have regard to guidance or documentation. Mr Park was not aware whether a health and safety folder was kept in the Site Office. He had never seen it. Mr Park did not recall having sight of the Method Statement for scaffold erection at 40 Crathie Drive, Glasgow. Mr Park was not aware of the standard of construction BS 5973. In relation to a handover certificate in respect of the scaffold, Mr Park initially said that he could not recall issuing a handover certificate. He would rely on the main contractor giving him a handover certificate to complete. Mr Park explained that a "scaff tag" is a ticket attached to scaffold to let others know that the scaffold is safe and it is inspected weekly. Although Mr Park was aware of such a system, PBL did not employ that system.

[134] Mr Park could "vaguely" recall being called to work on the scaffold because of complaints made by roughcasters about defects to the gable end of the scaffold.

[135] Mr Park conceded that he was aware that workers on site were moving parts of the scaffold. He conceded that he may have told the roughcasters that they could move hop ups. On further pressing, he indicated that he meant the hop ups to the interior of the scaffold (facing the building) not the exterior hop ups.

[136] As far as Mr Park was concerned, the number and type of unauthorised alterations had become dangerous. However, it was not his concern as he was not the Site Agent.

[137] In his statement to the Health and Safety Executive dated 4 November 2005, Mr Park had said that there had been guardrails on the outside of the lift at level 5.

Witness (5) – Robert Simpson

[138] Robert Simpson is 49 years of age. He is a qualified scaffolder. Like Mr Park, Mr Simpson would prefer tube and fit scaffold.

[139] Mr Simpson recollected a substantial alteration to the scaffold at the front of the building on 10 October 2005 so as to allow a window to be fitted. This alteration previously concerned the fourth, fifth and sixth lifts (levels).

[140] Mr Simpson also recollected altering hop ups for bricklayers but not for roughcasters.

[141] Mr Simpson recollected removing a one board hop up and replacing it with two boards tied with rope.

[142] Mr Simpson recollected having to remedy alterations made by other trades on site. This included replacing missing handrails and boards removed from hop ups. These alterations were dangerous. The remedial work had been done on the instructions of the Site Manager. The Site Manager was initially Lawson McLean and subsequently John Kearns.

[143] As far as Mr Simpson was aware, workers would have been told not to alter the scaffold on site at their induction meeting.

[144] On 10 October 2005 Mr Simpson was not concerned with the exterior face of the scaffold as he was altering the scaffold to allow a window to be installed to the inside face of the scaffold.

[145] Mr Simpson was shown a photograph taken after the accident showing a two board hop up bracket at level 5 but with only one board in place. In addition there is no tie bar. This means that the boards would have been insecure.

[145] Mr Simpson's evidence was that, had the hop up been in that condition on 10 October 2005, he would have either removed the single board from the double hop up bracket or obtained a second board together with a tie bar. Either action would have made the hop up secure.

[146] Similarly, if a mid-rail was missing on 10 October, he would have replaced the mid-rail.

[147] Mr Simpson thought that there were other scaffolders working for PBL though he had not seen them.

[148] After the accident, Mr Simpson had returned to the site. At that point he had noticed gaps in the handrails, boards missing, materials left on scaffold such as bricks and debris.

[149] If level 5 was not to be used for off-loading materials, there should have been a toe board installed. Again, if one had been missing on 10 October, it was Mr Simpson's position that he would have replaced it.

[150] On occasions Mr Simpson had attended the Crathie Drive site only to discover that there was insufficient scaffold to do what needed to be done. He would then contact either the Site Manager or Head Office to order further material. Although he could not recollect doing so, it was quite possible that he had taken scaffold from one part of the scaffold and relocated it to another.

[151] Mr Simpson was referred to the statement which he had given to a Health and Safety Inspector. In the statement Mr Simpson is recorded as having said that he was involved at the commencement of the Crathie Drive site and could recall erecting the scaffold.

[152] Mr Simpson then conceded that he may have been involved with the initial erection of the scaffold.

[153] Mr Simpson described health and safety on site as "a bit lax". For example, he had seen people on site without helmets. A stairwell was dark and Mr Simpson had asked Mr Kearns to instal a light on a couple of occasions but without success.

[154] There had been no induction meeting specific to Crathie Drive. He had never seen the Health and Safety Folder, Risk Assessments or Method Statements. As far as Mr Simpson was concerned, it would be for John Park to complete a handover certificate in relation to the scaffold.

[155] Mr Simpson conceded that photographs taken after the accident disclosed that, on level 5, mid-rails, boards and toe boards were missing. His position was that if the scaffold had been in that condition on 10 October, he would have repaired it. Accordingly, by implication, between him leaving site on 10 October and the photographs being taken after the accident, the scaffold must have been altered in these respects.

[156] Mr Simpson recollected saying to the Site Manager that scaffold was being altered by workers on site. He was not aware if anything was done to improve the situation.

[157] In relation to fixing cantilever platforms to the outside of the scaffold, Mr Simpson described this as very unusual because of safety concerns.

[158] Mr Simpson recollected installing two-board hop ups to the exterior of the scaffold when the hoist was being installed. This is because the hoist had to be installed further away from the scaffold than a one board hop up would allow.

Witness (6) – Lawson McLean

[159] Lawson McLean is 65 years of age. He trained as a joiner but was promoted to Site Agent and Contracts Manager. A Site Agent would generally have responsibility for one site. A Contracts Manager would be in charge of more than one site.

[160] Mr McLean had been employed as Contracts Manager with PBL from 2001 until 2005. Mr McLean left the employment of PBL in August 2005.

[161] Prior to leaving PBL Mr McLean had no training in health and safety. Mr McLean had no training in erecting or inspecting scaffold.

[162] Mr McLean explained that he had been asked to be the Site Manager at Crathie Drive by a Mr Alan McWhirter the Managing Director of PBL. Mr McLean took responsibility for the site in May 2005.

[163] Mr McLean's time was split initially between the Crathie Drive site and a development in Stewarton. He moved to Crathie Drive full-time during the second half of June 2005.

[164] Mr McLean recollected that the scaffold on the Crathie Drive site had been hired. The type of scaffold hired was Kwikstage scaffold. Mr McLean had no training in Kwikstage scaffold.

[165] Mr McLean trusted the scaffolders to erect the scaffold correctly. As far as Mr McLean was concerned, the scaffold was erected some time in July 2005. Mr McLean believed that John Park and the scaffolders were trained in the erection of Kwikstage scaffold and were qualified to certify the scaffold as safe for use.

[166] Mr McLean conceded that access to the hoist platform may have been used for off-loading materials at the fifth floor but, in his time on site, he did not see this and considered that there would be no reason for tradesmen to off-load materials at the fifth floor. This is because, by the time he left employment with PBL, the roof work was just completed and most of the material for the roof would have been hoisted by a crane.

[167] Mr McLean could not recall checking the scaffold after it had been erected. He did not recall receiving a handover certificate in relation to the scaffold. A handover certificate comes from the scaffold contractor. It is given either to the Site Manager or to the Head Office. There should always be a handover certificate.

[168] When asked why there were no written records of weekly scaffold inspections on site when Mr McLean was the Site Manager, he was candid in saying that there was either no appropriate paperwork on site or it was never completed. He conceded that it was possible that no weekly scaffold inspections had taken place. This, he said, was because John Park, the scaffolder, was on site regularly.

[169] Mr McLean was aware that a hoist had been hired for the site but he was not responsible for its requisition. Upon erection the installer provided a "handover certificate" to the effect that the hoist is safe to operate.

[170] Mr McLean recalled a Health and Safety Consultant, a Mr James McIntyre of Macsafe Health & Safety Limited inspecting the site. Mr McLean was referred to a Site Safety, Health and Welfare Report dated 29 June 2005 signed by Mr McIntyre and Mr McLean. In

particular, two matters are of note. Mr McIntyre notes: "induction records must be brought up to date. Inductions must be carried out prior to work being carried out" and "There are various scaffold problems which must be addressed. Jim McIntyre will address those problems". As far as Mr McLean could recall, Mr McIntyre had spoken to Mr Alan McWhirter about the problems with the scaffold. Mr McLean could not recall specifically what the problems with the scaffold had been.

[171] In relation to the hoist, Mr McLean could not recall whether he or anyone else carried out weekly inspections of the hoist or completed paperwork in relation to the inspection of the hoist.

[172] Mr McLean expected the scaffolders both to alter the scaffold and to inspect those changes once they were made

[173] In relation to Mr McIntyre of Macsafe, he had returned to the site for a further inspection. He remained concerned about the scaffold. Mr McLean could not recall the precise details of the concerns.

[174] When it was suggested that Mr Park had indicated in his evidence that Mr McLean should have inspected the scaffold, Mr McLean replied that he did not have a certificate for checking scaffold and was not a scaffolder. Accordingly, Mr McLean could not understand why Mr Park would think that it was Mr McLean's responsibility to inspect the scaffold. As far as Mr McLean was concerned, a qualified scaffolder should carry out a scaffold inspection.

[175] . Mr McLean left the employment of PBL in August 2005. He did not have a handover meeting with his successor. Neither Mr John Kearns nor Alan McWhirter contacted Mr McLean about any aspect of site after he (Mr McLean) had left.

Witness (7) – Stephen MacKay

[176] Stephen MacKay, aged 30, worked with Kenneth and Brian McLean as a labourer. Kenneth McLean was the father-in-law of Stephen MacKay. His job was to prepare the material, send it up to Kenneth and Brian McLean; prepare the tools and tidy the site after work. Stephen MacKay was an employee of Talepine Limited trading as Quickseal Specialist Contractors. Mr MacKay described in detail the use of the hoist to carry both wheelbarrows and buckets of material to height. Other tradesmen shared the use of the hoist.

[177] Mr MacKay recollected moving boards. He did not consider this to be altering the scaffold as it did not alter the structure of the scaffold. The purpose of moving a board was to allow

Kenneth or Brian McLean closer access to the building for the purposes of applying the roughcast. After that work was complete, the board would be replaced.

[178] Mr MacKay estimated that he would spend the vast majority of his working day at ground level rather than on the scaffold.

[179] On the week of the accident, Mr MacKay recollected arriving on site on the Monday. However, no work could be done that day because scaffold was being altered to allow a window to be installed. The weather did not permit Kenneth McLean, Brian McLean or Stephen MacKay to carry out any work on site on Tuesday and Wednesday of that week.

[180] On Thursday, 13 October, Mr MacKay recollected arriving on site. He was told that Kenneth McLean and Brian McLean intended to start work on the back of the building. Mr MacKay was instructed to mix the material and send it up in wheelbarrows using the hoist. Mr MacKay prepared the material at ground level.

[181] Mr MacKay could not recollect whether Kenneth and Brian McLean had gone straight up the scaffold on arrival at the site. Mr MacKay was busy preparing the material at ground level.

[182] After preparing the material Mr MacKay walked from the preparation area down the street to the hoist. Mr MacKay put both wheelbarrows on to the hoist. He did so by walking backwards on to the hoist with the wheelbarrows. This was to facilitate the removal of the wheelbarrows by either Kenneth or Brian McLean at the fifth level.

[183] Mr MacKay recollected that the fifth level where Mr Kenneth McLean was standing had reduced headroom. Mr MacKay recollected that there was a top rail, at waist height, at the fifth floor landing bay. He could not recollect whether there was a mid-rail (at knee height) but did not think so.

[184] Mr MacKay was referred to his statement which had been written by Mr MacKay shortly after the accident. Within the statement Mr MacKay wrote:

> "Kenny noticed a handrail approximately 3-4 feet from the lift he was on blocking access to the hoist. There was no cage door on this lift, only this handrail. The cage door had obviously been took(sic) off when scaffold was amended for glazier and never put back on. The handrail became an obstacle for Kenny to manoeuvre around. He had to duck under this rail in order to get access to the hoist. He took of (*sic*) the first wheelbarrow, then the tools. I went back to mix the cement. I was then going up

> the scaffold to take the rail off for Kenny to get access. The next thing I hear is a bang."

[185] Mr MacKay could recollect Kenneth McLean taking off the first wheelbarrow. Mr MacKay considered that if his statement suggested that Mr MacKay might go up the scaffold to take the rail off, that was a possibility.

[186] Mr MacKay heard a crash. He turned round. He saw that his father-in-law had fallen into the hoist enclosure at the ground level. There was a scaffold batten and a hard hat lying in the enclosure beside him.

[187] Mr MacKay ran to his van, obtained a mobile phone and telephoned for an ambulance.

[188] Brian McLean came down from the scaffold. Stephen MacKay recollected John Kearns administering first aid. An ambulance arrived and took Kenneth McLean to hospital.

[189] Mr MacKay was of the opinion that if a mid-rail had been present at the fifth level which had been removed by Kenneth McLean, he (Stephen MacKay) would have either recollected the mid-rail or Kenneth McLean removing it. He doubted if Kenneth McLean would have removed a mid-rail if there was a safety issue.

[190] Mr MacKay had not seen the Health and Safety Policy General Statement of Quickseal Specialist Contractors, before the accident.

[191] There had been no Site Induction at the Crathie Drive site.

[192] Mr MacKay did recollect a tool box talk by his employers, Quickseal Specialist Contractors. Part of this covered health and safety issues. The talk had been given by Graham Nesbit.

[193] Mr MacKay was referred to a register of tool box talks. It would appear, on the face of the document, that Mr MacKay received a tool box talk on a Method Statement. Mr MacKay accepted that as the document mentioned the Method Statement, he may have seen the Method Statement previously although the Method Statement makes no provision for taking material to the fifth level.

Witness (8) – Mr Kevin Arthur

[195] Kevin Arthur is 39 years of age. He has been a self-employed bricklayer for 20 years. Mr Arthur stated work at Crathie Drive during about August 2005. He had taken over from an earlier team which had commenced the construction. Mr Arthur stopped work at Crathie Drive about a week before the accident.

[196] The significance of his evidence was that, one week before the accident, he could recollect only a top rail being present at the lift access area on the fifth level. There was no mid-rail.

[198] Mr Arthur had not been given instruction as to how to use the hoist but he had used similar hoists previously on other sites.

[199] Mr Arthur recollected the hoist hitting the two-board hop ups as it travelled up the hoist. In his opinion, this was because either the scaffold or the hoist were off plumb.

[200] Mr Arthur had used plywood sheeting to bridge the gap between the hoist and the platform at the third level.

[201] As far as Mr Arthur was concerned, John Kearns, the Site Manager, would have been aware of this practice. In addition, Mr Arthur recollected raising the problem of the gap between the scaffold and the hoist with Mr Kearns. Mr Arthur realised that it was unsafe to use the plywood sheeting in this manner but nothing had been done to remedy the gap between the scaffold and the hoist.

[202] In relation to the fifth level, Mr Arthur recollected the hoist hitting the scaffold. Again this was raised with Mr Kearns.

[203] Mr Arthur was not given any instruction about the fifth level. In particular, he was never told not to unload at the fifth level. Mr Arthur required to offload at the fifth level because, as a bricklayer, he worked from the ground up using the scaffold as a platform to lay bricks and the hoist as a method to obtain bricks and materials.

[204] Mr Arthur was clear that there could not have been a mid-rail in place at the fifth level. If a mid-rail had been in place, the wheelbarrows could not have been offloaded from the hoist at the fifth level.

[205] The fifth level was reduced in height. Mr Arthur estimated that the height was about five feet whereas normally the height would have been about six feet.

[206] Accordingly, Mr Arthur was bent over crouching into the hoist. He would open the gate and put a piece of plywood to bridge the gap between the hoist and the scaffold. He would then pull out the wheelbarrow. The top rail caused a difficulty at the fifth level because you had to "hang over it" to get into the hoist.

[207] When asked on how many occasions Mr Arthur took the wheelbarrow from the hoist at the fifth level in this manner, he replied that it would be up to twenty times a day for approximately four days at that level. Mr Arthur not only assumed that Mr Kearns had seen this process taking place but

also recollected Mr Kearns attending the scaffold to check on the progress of Mr Arthur's work. Accordingly, Mr Kearns would have seen this method.

[208] The work at the fifth level finished at the end of September 2005. The work continued on the sixth level with Mr Arthur leaving site about one week before the accident.

Witness (9) – Robert Alexander Binnie

[209] Robert Alexander Binnie is 39. He was employed as a Ganger/Labourer with PBL Construction Limited for three years between 2002 and 2005. A usual working day would have been stocktaking for one hour and thereafter working as a general labourer on site. Mr Binnie reported initially to Lawson McLean, the Site Manager and thereafter to John Kearns.

[210] Mr Binnie described the scaffold as "never complete" (19 November 2010, page 100) this was because parts of the scaffold were being removed and not replaced.

[211] Mr Binnie remembered the hoist being installed. He and another person on site were given instruction as to the operation of the hoist by the installers.

[212] Mr Binnie recollected the fifth level of the scaffold having no handrails. That was why he had refused to go on to the fifth level. In particular, Mr Binnie recollected Mr Lawson McLean asking Mr Binnie to off-load insulation material for the inside walls at the fifth level. Mr Binnie refused because of the unsafe condition of the scaffold at that time.

[213] Mr Binnie recollected that subsequently handrails were installed on the fifth level but he still refused to go on to the fifth level. Mr Binnie could recollect only one rail to half height being installed on the fifth level.

[214] Although Mr Binnie was aware that only scaffolders should alter the scaffold, he had installed handrails round the back of the building because there were none there at all.

[215] Mr Binnie also moved hop up boards. In particular, he had moved hop up brackets from the exterior of the scaffold to be used elsewhere.

[216] Mr Binnie said that he had regular arguments with other workers for altering scaffold when they were unqualified to do so. He reported these difficulties to the Site Manager, Lawson McLean.

[217] During the week of the accident, Mr Binnie was on holiday.

Witness (10) – Andrew McQuarrie

[218] Mr McQuarrie is 60 years of age. He has been the Director of Hoist & Access Services since 1996. His company supplied a Wickham UDM hoist to PBL Construction Ltd at their site in Crathie Drive in 2005. In terms of the handover certificate dated 22 June 2005, the most recent test and examination of the hoist had been conducted on 13 May 2005. The certificate was given by Hoist & Access Services Limited to PBL Construction after installation. The handover certificate was signed by John Wilson, a Director of the Company and countersigned by Mr McQuarrie as Operations Director.

[219] Mr McQuarrie confirmed that people using the equipment should have been inducted in its use.

[220] Mr McQuarrie was referred to weekly and daily inspection checklists prepared by Hoist & Access Services Limited. These are supplied to the hirer where the hirer is trained to carry out inspection of the hoist.

Witness (11) – Graham John Nesbit

[221] Graham John Nesbit is 47. He has been a plasterer by trade since 1982. Mr Nesbit was working with Talepine Limited trading as Quickseal Specialist Contractors, at the time of the accident on 13 October 2005. Prior to October 2005, Mr Nesbit did not have training in Health & Safety. Mr Nesbit was a travelling foreman for Quickseal.

[222] In relation to Health & Safety, Mr Nesbit would conduct a tool box talk with the workers on site. He would highlight areas of health and safety.

[223] Quickseal was a roughcasting company. The application of roughcast at the Crathie Drive site was slightly different than the usual application. As there is nothing to suggest that the unusual nature of the application of the roughcast of itself contributed to the accident, I do not propose to go into detail.

[224] Mr Nesbit was first advised of the job at Crathie Drive by his boss, Mr David Poole. Mr Poole had given Mr Nesbit a Health & Safety Plan for the site. It was assumed that the site induction would be conducted by the contractor on site who should arrange for the workers to read through the Health & Safety Plan and sign it off.

[225] Mr Nesbit liaised with John Kearns the Site Manager of PBL. He handed to Mr Kearns the Health & Safety Plan the first time they met. This meeting was at the Crathie Drive site a few days

before Quickseal commenced work on site on 29 September 2005. On receipt of the plan, Mr Kearns had said that he would read it through, check it and if there were any problems, Mr Kearns would contact David Poole at Quickseal. Mr Kearns did not raise any issue with the content of the document with Mr Nesbit.

[226] At the meeting Mr Nesbit did not ask for, nor was he given, documentation from PBL by Mr Kearns. Put shortly, there was no discussion about Risk Assessment or Method Statements whether at the instance of Quickseal or PBL.

[227] Mr Nesbit had assumed that Mr Kearns would deal with matters such as Risk Assessment, Method Statements and the Health & Safety Policy of workers on the site.

[228] Mr Nesbit was referred to the Method Statement for Quickseal Specialist Contractors. The Method Statement did not give instruction for the transportation of materials. The Method Statement had been prepared by David Poole. Mr Nesbit accepted that the Method Statement could have been expanded to indicate whether materials were to be transported in wheelbarrows or in buckets and to instruct workers as to how to take the material to height. In addition, the Method Statement made no mention of a hoist.

[229] Mr Nesbit was also referred to a Risk Assessment dated 14 September 2005. The author appears to have been David Poole. There is nothing in the Risk Assessment relating specifically to difficulties with the fifth level.

[230] As far as Mr Nesbit was concerned, Kenneth McLean, Brian McLean and Stephen MacKay were told not to alter the scaffold and, if there were problems with the scaffold, to speak to Mr Nesbit or to the Site Manager.

[231] Quickseal would provide employees with "little flyer cards, Health & Safety cards" reminding employees not to alter scaffold.

[232] In relation to the content of the Health & Safety Policy document as a whole, this had not been given to Kenneth McLean, Brian McLean or Stephen MacKay by Mr Nesbit. Mr Nesbit had been instructed to deliver the document to John Kearns and to ensure that Kenneth McLean, Brian McLean and Stephen MacKay were given a tool box talk.

[233] When Quickseal employees started on site, this was the second time that Mr Nesbit had met with Mr Kearns. There was no discussion regarding Risk Assessment, Method Statement or Health & Safety Policy between Mr Nesbit and Mr Kearns.

[234] Although Mr Nesbit had thought that the Main Contractor would give the Quickseal employees an induction meeting, he did not check that this had been done. Mr Nesbit found out that there had been no induction meeting only after the accident had occurred.

[235] Mr Nesbit would not attend a pre-start meeting with the Main Contractor. This was dealt with by David Poole. A pre-start meeting would normally be held between management personnel of the Main Contractor with the sub-contractor. Mr Nesbit was not aware whether a pre-start meeting had taken place in relation to Crathie Drive.

[236] Mr Nesbit recollected Mr Kearns saying that all of the roughcasters would be entitled to use the hoist. In practice Stephen MacKay would be the one operating the hoist on behalf of Quickseal. No special training had been arranged for Mr MacKay. Mr Nesbit assumed that he would be familiar with such hoists from previous experience.

[237] Mr Nesbit recollected speaking with Mr Kearns asking for the scaffolders to attend to alter the scaffold. Mr Nesbit thought that the scaffolders attended two or three days after such conversations.

[238] Mr Nesbit had not authorised his roughcasters to alter the scaffold themselves nor was he aware that Mr Kearns had done so. Mr Nesbit did recall that he had advised roughcasters not to alter the scaffold on any site.

[239] In relation to the fifth level specifically, Mr Nesbit was not aware of any issue with that particular level. He was not advised of an issue by John Kearns or by the roughcasters. As far as Mr Nesbit was concerned, he was not aware of a problem taking material off the hoist platform at the fifth level. Accordingly, Mr Nesbit did not give directions or instructions to Kenneth McLean, Brian McLean or Stephen MacKay in relation to the fifth level.

[240] Prior to commencement on site, Quickseal would not arrange for a scaffold inspection. Mr Nesbit is not a Scaffold Inspector. Similarly, he did not carry out inspection of the hoist.

[241] Mr Nesbit had not been instructed to check the Scaffold Handover Certificate.

[242] Mr Nesbit recollected being contacted by his roughcasters in relation to scaffold alterations, on two occasions. The first one was in relation to the gable end and the second issue was to do with the rear of the building. On each occasion, Mr Nesbit contacted Mr Kearns.

[243] Mr Nesbit recollected speaking to David Poole and suggesting that the roughcasters should be taken off site until the difficulty with the scaffold was resolved. However, there was nowhere

else for the roughcasters to go. Brian McLean had said to Mr Nesbit that he felt the scaffold was unsafe. Mr Nesbit said that he should not go on to the scaffold.

Witness led by Mrs Hughes, Advocate, on behalf of the relatives of the deceased: James Campbell McIntyre

[244] James Campbell McIntyre, born 21 August 1969, is Managing Director of Health & Safety Consultancy and Training Company, Macsafe Health & Safety Limited.

[245] Mr McIntyre had been appointed as a Health & Safety Adviser to PBL Construction Limited during about 2004 after discussions with one of the Directors of PBL Construction Limited, Alan McWhirter.

[246] Mr McIntyre resigned as a Safety Adviser in August 2005.

[247] Mr McIntyre agreed to conduct monthly site inspections. This meant that Mr McIntyre inspected the building sites of PBL Limited with the Site Manager. Mr McIntyre would be accompanied by the Site Manager when inspecting the site, identifying hazards that needed to be attended to and preparing a report a copy of which would be given to the Site Manager and a copy sent to Mr McWhirter.

[248] Mr McIntyre recalled attending the Crathie Drive site in August 2005. He arrived unannounced for the inspection. He noticed that there was various parts of the scaffold which were not in place. Parts of the scaffold were missing. He was concerned that there could be a fatal accident if a worker slipped, or tripped or fell. He advised the Site Manager to take all workers off the scaffold. The Site Manager at that time was Lawson McLean. Mr McIntyre telephoned Alan McWhirter to have the problems resolved.

[249] It was agreed with Mr McWhirter that Mr McIntyre would return at 8.00 am the following day when the scaffolders would attend to remedy defects. Mr McIntyre attended the following day. Mr McIntyre waited from 8.00 am until 8.30 am when the Site Manager, Lawson McLean, advised Mr McIntyre that Alan McWhirter, the Managing Director of PBL, had told him that the scaffolders were too busy elsewhere, to attend the site at Crathie Drive. Mr McIntyre left the site. He returned to his office and sent a letter resigning his appointment.

[250] Mr McIntyre was referred to the Site Safety, Health & Welfare Report, prepared by him on 29 June 2005.

[251] Mr McIntyre was referred to the words in the report "There are various scaffold problems which must be addressed. Jim McIntyre will address the problems." Mr McIntyre could not specifically recall what the specific problems had been. Mr McIntyre would have spoken either with the Site Manager or with the Contracts Manager to resolve the problem.

Witness (12) – James Gordon Hooker

[252] James Gordon Hooker, aged 55, is employed by Thyssen Krupp Palmers, Edinburgh as a Quality, Health, Safety and Environment (QHSE) adviser. Until the spring of 2010 Mr Hooker had been employed as a Regional QHSE adviser for Interserve Industrial Services Limited for 10 years.

[253] Interserve was the supplier of scaffold to the site in Crathie Drive.

[254] Mr Hooker described Kwikstage Scaffold and its popularity in Scotland.

[255] I do not propose to outline his evidence in detail. Suffice to say that Mr Hooker would expect that a scaffolder would have, as a minimum, completed a 2½ day system specific course run either by Interserve or by the Construction Industry Training Board.

[256] Interserve would both supply scaffold or supply and erect scaffold.

[257] The contract for Crathie Drive was for the supply of scaffold.

[258] Mr Hooker recollected visiting the site on 19 October 2005. He was present when detailed notes were taken of the problems with the scaffold. In the opinion of Mr Hooker, such problems must have occurred progressively over a period of time.

[259] Mr Hooker was referred to the Genuine Quicksave User Guide. In particular, Mr Hooker agreed with the recommendation at page fifty three that platform brackets should not be erected to the exterior of the scaffold as had been the situation at Crathie Drive.

Witness (13) Adrian Mark Tinson

[260] Adrian Mark Tinson is 40 years of age and is a Health & Safety Inspector employed by the Health & Safety Executive based in Glasgow. He attended the site on 13 October 2005. Mr Tinson took photographs before the scaffold was altered to make it safe. He expressed a number of concerns in relation to the gaps throughout the scaffold and, in particular, the area around the hoist on the fifth level of the scaffold. Mr Tinson issued a Prohibition Notice to PBL Construction Limited prohibiting any construction work being carried out at the site. Stacked loose slates and other material were, with the agreement of Mr Kearns and the scaffolders, moved to eliminate the

risk that they might fall overnight. Thereafter, the site was secured until Mr Tinson returned along with Mr Shelton (the next witness) the following day.

[261] Mr Tinson had noticed a number of problems with missing guardrails, toe boards and the like on the scaffold. These problems are highlighted in greater depth in the Report prepared by John Shelton.

Witness (14) - John Shelton and discussion

[262] Mr Shelton is one of Her Majesty's Health & Safety Inspectors currently working in the Construction Unit of the Glasgow Office. He has worked for the Health & Safety Executive for 31 years.

[263] Although Mr Shelton's evidence was spread over a number of days, I do not propose to rehearse it here. Part of his evidence involved an outline of the sources of evidence causing him to come to the conclusions which he reached in his Report. For the purposes of this exercise, it is sufficient for me to say that Mr Shelton spoke to the terms of the Report marked "Prosecution Report" dated 12 October 2006. It is a substantial Report divided into parts.

[264] Those parts of the Report which were referred to during the Inquiry paint a picture of the scaffold, the erection of which was dangerously substandard in places. Mr Shelton highlighted the fact that Mr Kenneth McLean, and others, were not inducted at the site. Neither of the scaffolders had been trained sufficiently to be familiar with the specific requirements for the safe erection of Kwikstage Scaffold. John Kearns, the Site Manager, was not familiar with the Kwikstage User Guide and Mr Shelton highlighted, for example, that the scaffolders were not aware of the requirements for tying patterns (the frequency and positioning of rigid fixings between the scaffold and the building). Similarly, Mr Kearns had made no formal checks of the tying ratio for the scaffold. Mr Shelton's Report also deals with the hoist. As the contract progressed, some sub-contractors, who had not received formal instruction routinely operated the hoist. No formal procedures were in place by PBL to inspect the hoist.

[265] These and the other examples cited by Mr Shelton summarise the poor standard by which this site was operated and supervised. The Report is damming in its terms.

[266] For the purposes of this Inquiry, however, Mr Shelton highlights in particular that platform brackets should not be used as an extension to the exterior of the scaffold. Had John Park and Robert Simpson been given appropriate training in the erection of Kwikstage Scaffold (or had they

consulted the Kwikstage User Guide), such information would have been known to them. Similarly, if the Site Managers had been properly instructed so as to carry out effective weekly checks, they would not have permitted the use of platform brackets to the exterior of the scaffold.

[267] Mr Shelton highlights the manufacturer's guidance that tie bars are essential for two and three board platform brackets. A failure to fit tie bars could be fatal.

[268] Mr Shelton writes at pages 32/33 of his Report:

> "Accidents have occurred where tie bars have been omitted and persons have placed their weight upon the decking between the brackets resulting in the outer most board being displaced from the brackets because of migration of the board both along the bracket and the brackets spreading outwards. In this situation the board would detach from the bracket and collapse causing the person to fall. There would be no warning of this."

[269] Again, at page 36, in relation to the causation of the accident, Mr Shelton writes:

> "Because of the lack of tie bar it is likely with the brackets being loose that the outer board dropped off the outer ends of the angles when Kenneth McLean's (*sic*) stepped on to it. The looseness of the brackets and their ability to spread or splay outwards thus leading to poor support of the board would be a major contributory factor to the reason for the board displacing. If a tie bar had been fitted and had displaced along with the board then it is likely that the tie bar would have landed in the hoist bay along with the deceased and the steel scaffold board. It can also be concluded that if the tie bar had been in position then the outer most board would not have moved off the platform brackets in the first instance."

[270] From the evidence before me, I agree with these comments by Mr Shelton.

[271] Having heard the evidence, there is an important conclusion which Mr Shelton draws but with which I do not agree.

[272] At page 37 of his Report Mr Shelton says:

> "Evidence suggests that guardrails (upper guard rail and mid-rail) and a toe board were likely to have been *in situ* at this area [fifth level platform] prior to the roughcasters attending site that morning [13 October]."

[273] After the accident the upper guardrail between the scaffold and the platform on the fifth level remained in place. The implication is that, in order to remove the wheelbarrows of

render from the hoist, Mr McLean removed (a) the mid-rail so that he could lean under or over the upper guardrail to take hold of the handles of the wheelbarrow, and (b) the toe board from the platform (so that the wheelbarrow could be removed without obstacle).

[274] I do not agree with this conclusion. The conclusion appears to be based on the proposition that "The scaffolders and site manager believe that the guardrails and toe boards were in place along the front elevation and John Kearns went to the area to check on the fitment of the window and recollects no problems with the guardrails at this part of the platform."

[275] It is evident that the recollections, even at the time, of the scaffolders and Mr Kearns were selective. The problems at the fifth level and elsewhere on the scaffold at 40 Crathie Drive were so numerous that reliance simply cannot be placed on the scaffolders or Mr Kearns as a source of evidence that the guardrail and toe board were in place at the hoist area on the fifth level.

[276] The day before the accident the attention of Mr Kearns was directed to checking the fitment of the window feature, not the scaffold. Furthermore, he checked the fitment of the window from inside the building. He did not go on to the scaffold for the purpose of checking the window.

[278] Similarly, both in relation to the Mr Kearns and the scaffolders, there is no reason to believe that, had they inspected the scaffold, they paid greater attention to this area than any other area on level five. Had they inspected level five at all, they would have seen that toe boards and guardrails were missing elsewhere on that level.

[279] The dangers on level five would have been obvious over a substantial period of time. Yet those dangers were not rectified. That being so, it seems to me that no reliance can be placed on the information given to Mr Shelton by Mr Kearns and the scaffolders that before the accident a lower guardrail and toe board had been in place at the platform area in level five on the day of the accident.

[280] At the Inquiry, Mr Kearns was of the opinion that no one was allowed to offload goods from the hoist at the level five platform. The evidence which I heard indicated that such a practice had been ongoing since at least September 2005 with the tacit approval of Mr Kearns.

[281] Similarly, conflicting evidence was heard in relation to the alteration of the scaffold. Mr Kearns initially suggested that only scaffolders should alter the scaffold. It became apparent that certain alterations by certain trades were tolerated. However, even the extent to which scaffold could be altered by those trades was ill defined.

[282] I suspect that a blind eye was turned to such scaffold alterations partly because of the time it would take to have scaffolders (themselves unqualified in Kwikstage scaffold) return to make the alterations. Accordingly, pragmatism dictated that sub-contractors altered the scaffold as they saw fit. Such practice must have been known to Mr Kearns.

[283] I now return to the specific conclusion of Mr Shelton that the mid rail and toe board were likely to have been in situ prior to the roughcasters attending the site on the morning of the accident. The only evidence for this is the close proximity of a guardrail and a toe board lying on the fifth level near the scene of the accident. However, to suggest that these were removed by Mr McLean that morning is speculation. It relies on information imparted from the roughcasters and Mr Kearns. That information is in my opinion neither credible nor reliable. It conflicts with the evidence of Mr Brian McLean and Mr Stephen MacKay. More probably the guardrail and toe board would have been removed some days or weeks earlier on the basis of the evidence of Mr Kevin Arthur.

[284] There is ample evidence to suggest that the fifth level was being used routinely as an access point for the removal of goods from the hoist. The installation of a guardrail and toe board would have prevented or impeded the removal of goods from the hoist.

[285] If, on the morning of the accident, Kenneth McLean removed a toe board and one guard rail, it seems illogical not to have removed both guard rails. The removal of both guard rails would have considerably eased the process of removing the wheelbarrows from the hoist. The evidence that one of the guard rails remained in place after the accident supports in my view the proposition that Mr McLean found the fifth level hoist access area to have had the toe board and one guard rail already removed. He was not to know that in addition to these items having been removed, a tie bar which would have held the steel boards or battens in place, was also missing.

[286] It was suggested that the tie bar may have been knocked out of position (whether by the hoist or otherwise) and had fallen along with Mr McLean. A tie bar was found at ground level. I refer the evidence of Mr Shelton in this regard. Put shortly, he was of the view that it would be unusual for a tie bar to come loose in such circumstances. Moreover, if a tie bar had fallen with Mr McLean, Mr Shelton thought that the tie bar would have been found in close proximity to Mr McLean, his hard hat and the batten, namely, in the hoist cage area at ground level. Instead, a tie bar was found at ground level some distance from Mr Kenneth McLean, leading Mr Shelton to the opinion that no tie bar was in place at the fifth level at the time of the accident.

[287] Turning back to the missing guard rail, I note from the evidence of Kevin Arthur that he recollected leaning over a guard rail to remove a wheelbarrow from the hoist on to the scaffold at the fifth level. Mr Arthur described this procedure occurring twenty times a day over a four day period at the end of September 2005. If that is correct, it would imply that the evidence of Stephen McKay in relation to the condition of the scaffold on 13 October 2005 is to be preferred over that of Mr Kearns and the scaffolders.

[288] On 10, 11 and 12 October 2005, the only persons working at the fifth level would have been (1) the scaffolders on site on 10 October to alter the scaffold for the window to be installed and (2) the window installers.

[289] The scaffolders should have left the fifth level safe. It was clearly not left in that condition despite them saying that if they had noticed any problems, those problems would have been remedied. There were toe boards and guard rails missing on other levels as well as level five, despite the evidence of the scaffolders that such problems would have been made safe.

[290] The Scaffold Inspection Records show a lack of understanding of what was required by an inspection and what should have been noted. The records omit the shear number of defects which existed on site.

[291] The competency of Mr Kearns should have been noticed by his employer which should have suitably trained Mr Kearns in the inspection of scaffold. Moreover the scaffolders, John Park and Robert Simpson, were qualified and experienced scaffolders but not competent in the erection and alteration of Kwikstage scaffold.

[292] In this regard, I am mindful of the evidence of Mr Thomas McIntyre, the Health & Safety Consultant. In August 2005, Mr McIntyre inspected the site. He was so concerned at the condition of the scaffold that he asked Mr Kearns to order all workers off the scaffold.

[293] Mr Alan McWhirter, Managing Director of PBL Construction Limited, was advised of this difficulty. Mr McIntyre attended the following morning as he had been told that scaffolders would be on site to remedy the defects. Scaffolders were not on site. Mr McIntyre was advised that they were needed elsewhere.

[294] Mr McIntyre returned to his office to resign his appointment. That speaks volumes.

[295] Mr McWhirter was, I was informed, advised not to provide a detailed precognition to the family for the purposes of formal citation. It would be inappropriate for me to come to any conclusion as to his responsibility in this sorry saga of ineptitude. If, however, the account given

by Mr McIntyre – which was not challenged in evidence - is accurate, Mr McWhirter should be ashamed of himself.

[296] Mr Kearns had neither inspected the hoist nor maintained any records relating to the hoist.

[297] One of the concerning aspects of this Inquiry is the paucity of records. Records which should have been compiled during the period when Lawson McLean was the Site Manager, were never traced, if ever they existed.

[298] It would appear that Mr Kearns inherited a poorly run site. He may have instructed some improvements to working practices and to the scaffold but these were, in the scale of things, comparatively minor. His time was split between this and other sites. When Mr Kearns was off site, he delegated responsibility for site management to Robert Binnie, a labourer.

[299] In conclusion, this is an accident which was entirely avoidable. If proper consideration and instruction had been given so that work could be undertaken by tradesmen at the fifth level, the accident might have been avoided. This is because arrangements would have been made to facilitate the transfer of materials to the fifth level (whether by extending the scaffold platform, replacing the hoist or otherwise).

[300] If sub-contractors, such as Kenneth McLean, had been given an induction meeting before commencing work, he would have received definitive instructions (a) that he should not use the fifth level (b) that he should not offload materials at the fifth level and (c) he should not alter scaffold. It is not disputed that an induction meeting was not given to Mr McLean by PBL.

[301] Quickseal, Mr McLean's employers, had thought that an induction meeting would be given to Mr McLean as a matter of routine. They did not check. They were aware of their employees' concerns in respect of the scaffold but did not question PBL to any real extent in respect of the scaffold erection and alteration.

[302] If the difficulties in taking materials to the fifth level had been identified by Mr Kearns and Quickseal in advance of the work commencing, and any method devised to overcome those difficulties had been communicated to Mr Kenneth McLean, the accident might not have occurred. However, the overall condition of the scaffold was unsafe to such a degree that, on balance of probabilities, on the morning of 13 October 2005 Mr McLean did what he had done previously and what he had seen others do, namely, take access to the hoist at the fifth level. On this occasion, a tie bar was missing. The first wheelbarrow was removed in a manner which did not displace the

steel batten. When manoeuvring to remove the second wheelbarrow, Mr Kenneth McLean placed his weight on the outer most steel batten which splayed causing both it and Mr McLean to fall.

[303] Regrettably this is one more example of Health & Safety legislation being ignored on site by those who are either unqualified or unwilling to take the necessary action so as to protect employees and other workers on site from accidents which are entirely preventable.

[304] Unauthorised alterations to the scaffold were rife. They should have been forbidden and those found doing so disciplined. Scaffolders employed by PBL Construction Limited were not experienced in the correct erection of Kwikstage scaffold. Accordingly, whilst they may have been experienced scaffolders, the impression remains that they were experienced in the incorrect erection of Kwikstage scaffold. The site managers were not qualified to check the experience of the scaffolders nor whether they were erecting the scaffold correctly. That said, commonsense and a basic familiarity with the erection of scaffold, should have alerted the site managers to the absence of essential safety measures such as missing toe boards, guardrails and the like.

[305] Before concluding, there is one further matter upon which I wish to comment. I was invited by Mrs Hughes, counsel for the family, to find in terms of section 6(1)(c), that a reasonable precaution whereby the death and accident resulting in the death might have been avoided was the insertion of a tie bar in the hop up platform at level five, bay five.

[306] Technically speaking that proposition is correct. However, I have declined to make such a finding on the basis that it may imply legitimacy in the use of such cantilever platforms to the exterior face of the scaffold, subject to a tie bar being in place. That would be contrary to the instructions given within the Kwikstage User Guide.

[307] The number and extent of the failures to properly manage and maintain this site - many of which may not have contributed directly the to demise of Kenneth McLean, though the issues I have detailed in my determination did - will be cold comfort to Mrs Elizabeth McLean and her family to whom the court sends its condolences.

…….

Sheriff