SHERIFFDOM OF NORTH STRATHCLYDE AT CAMPBELTOWN

[2024] FAI 36

CAM-B45-23

DETERMINATION

BY

SHERIFF EUAN CAMERON

UNDER THE INQUIRIES INTO FATAL ACCIDENTS AND SUDDEN DEATHS ETC (SCOTLAND) ACT 2016

into the death of

WILLIAM MCLEAN

Campbeltown, 30 September 2024

Determination

The sheriff, having considered the information presented at the inquiry, determines in terms of the Inquiries into Fatal Accidents and Sudden Deaths etc. (Scotland) Act 2016, (hereinafter referred to as "the 2016 Act"):

In terms of section 26(2)(a) of the 2016 Act (when and where the death occurred)

The late William McLean, born 21 November 1966, died at 1435 on 10 September 2022 within the Queen Elizabeth University Hospital, Govan Road, Glasgow.

In terms of section 26(2)(b) of the 2016 Act (when and where any accident resulting in the death occurred)

The accident resulting in the death took place between 1610 and 1855 on 1 September 2022 at Killellan Park Farm, Campbeltown.

In terms of section 26(2)(c) of the 2016 Act (the cause of causes of death)

The cause of death of said William McLean was a traumatic brain injury sustained by the deceased after he fell through the roof of a shed onto a concrete floor below.

In terms of section 26(2)(d) of the 2016 Act (the cause or causes of any accident resulting in the death).

The cause of the accident which result in Mr McLean's death was that, for reasons unknown, he placed his body weight onto a fragile roof surface which was incapable of supporting his weight. This caused the fragile roof surface to give way, resulting in Mr McLean falling to his death. It is not known what caused Mr McLean to place his body weight on the surface.

In terms of section 26(2)(e) (any precautions which (i) could reasonably have been taken and (ii) had they been taken, might realistically have resulted in death, or any accident resulting in death, being avoided.

A precaution which could reasonably have been taken which might realistically have resulted in the death, or the accident resulting in the death, being avoided was the use of two crawl boards to move about the fragile roof surface.

In terms of section 26(2)(f) of the 2016 Act (any defects in any system of working which contributed to the death or the accident resulting in death)

A defect in the system of working which contributed to the death or the accident resulting in death was the failure to implement a safe system of work, which would include adequate precautionary measures to negate or minimise the risk of the deceased falling through the fragile roof surface he was working on.

In terms of section 26(2)(g) of the 2016 Act (any other facts which are relevant to the circumstances of the death)

There are no other facts which are relevant to the circumstances of the death of said William McLean.

Recommendations

In terms of section 26(1((b) of the 2016 Act (recommendations (if any) as to (a) the taking of reasonable precautions, (b) the making of improvements to any system of

working, (c) the introduction of a system of working, (d) the taking of any other steps which might realistically prevent other deaths in similar circumstances

There are no recommendations.

NOTE

Introduction

[1] This was a mandatory Fatal Accident Inquiry in terms of section 2(3) of the Fatal Accidents and Sudden Deaths etc (Scotland) Act 2016 ("the 2016 Act). William McLean died as a result of an accident which occurred while he was acting in the course of his employment.

Proceedings and Parties.

[2] Notice of the inquiry was given by the procurator fiscal on 1 November 2023. A preliminary hearing was held at Campbeltown Sheriff Court on 4 January 2024. The inquiry proceeded by way of Webex at Campbeltown Sheriff Court on 1 March 2024, 21 May 2024 and 22 May 2024. The Crown was represented by Jennifer Guy, Procurator Fiscal Depute. No other parties were represented.

[3] The majority of the evidence at the inquiry was presented by way of a detailed and comprehensive notice to admit lodged by the Crown. This Determination does not reproduce the entirety of the evidence contained in the notice to admit but the content of the evidence contained within is summarised below from paragraph 6 onwards. In addition to the evidence contained within the notice to admit, the Crown led evidence

from Mrs Hazel Dobb, a Principal Inspector with the Health and Safety Executive, in relation to the types of measures which can be taken by those working at heights to minimise the risk of falls.

The Legal Framework

[4] The purpose of an inquiry such as this is set out in section 1(3) of the 2016 Act as being to establish the circumstances of the death and to consider what steps (if any) might be taken to prevent other deaths in similar circumstances. In terms of section 26 of the 2016 Act the inquiry must determine the following matters:

(a) When and where the death occurred;

(b) When and where any accident resulting in the death occurred;

(c) The cause or causes of the death;

(d) The cause or causes of any accident resulting in the death;

(e) Any precautions which could reasonably have been taken and had they been taken might realistically have resulted in the death or any accident resulting in the death being avoided;

(f) Any defects in any system of working which contributed to the death; and

(g) Any other relevant factors to the circumstances of the death.

It is open to the sheriff to make recommendations in relation to matters set out in subsection 4 of section 26 the 2016 Act.

[5] The inquiry is not intended to establish liability. It is an exercise in fact finding, not fault finding. It is an inquisitorial process. It is not open to me to engage in speculation.

Summary

[6] William McLean was born on 21 November 1966.

[7] At the time of his death, Mr McLean was a self-employed farmer who lived and worked on his family-owned farm at Kilblaan near Campbeltown with his wife, Paula McLean and his adult son, Jamie Kilblaan Farm was owned by a business partnership known as "Kilblaan Farm". The partnership comprised Mr McLean, Paula McLean and Jamie McLean. The partnership did not employ any staff.

[8] Prior to 1 September 2022, 'Kilblaan Farm' purchased the farm known as Killellan Park Farm on the outskirts of Campbeltown. Killellan Park Farm was purchased by 'Kilblaan Farm' for use in its farming business.

[9] The farm buildings at Killellan Park Farm include a farmhouse and a number of outbuildings including a milking shed.

[10] The roof of the milking shed at Killellan Park Farm consists of a number of large corrugated asbestos sheets fastened by bolts to underlying purlin support beams. The sheets are of fragile construction and are not capable of supporting the weight of an adult male. The distance between the roof of the shed and the concrete floor inside the shed is roughly 20 metres.

[11] By late August 2022, a substantial amount of foliage was growing between the asbestos sheets on the roof of the milking shed.

[12] Shortly prior to 1 September 2022, Mr McLean inspected the roof of the shed with his son Jamie. There was no damage visible at that point but the roof was densely overgrown with foliage.

[13] Mr McLean was experienced in carrying out repair work on the roofs of farm buildings. Nevertheless, aside from relying on a technique known to as "walking the purlins" when moving over the surface of farm roofs he did not usually take any specific safety measures.

[14] The technique of "walking the purlins" involves a person using it avoiding placing their weight on any part of a fragile roof surface which does not have a purlin support beams underneath it. Instead, they identify the positioning of the underlying support beam by looking for the lines of bolts which fasten the roof sheets to the beam. Thereafter, they navigate their way across the roof surface by walking across the lines of purlin bolts.

[15] Prior to 1 September 2022, Mr McLean set up scaffolding at Killellan Park Farm to facilitate access to the roof of the milking shed.

[16] On the morning of 1 September 2022, Mr McLean left Kiblaan Farm and travelled to Killellan Park Farm to carry out renovation and repair work.

[17] At around 16:00 that day, Paula McLean arrived at Killellan Park Farm.

[18] When Paula McLean arrived at the farm, Mr McLean was on the roof of the milking shed clearing foliage from between the asbestos sheets.

[19] On Paula McLean's request, Mr McLean descended from the roof via the scaffolding and joined her in the farmhouse.

[20] Mr McLean told Paula McLean that the foliage on the roof was thicker than he had anticipated and that he had required to use a chainsaw to cut through it. Mr McLean appeared tired.

[21] Paula McLean left Killellan Park Farm at around 16:10. Before leaving, she told Mr McLean not to return to the roof and to wait until another worker was available to assist him.

[22] When Paula McLean left the farm, Mr McLean was still within the farmhouse. He did not say what he intended to do next.

[23] At some point between 16:10 and 18:15, Mr McLean returned to work on the milking shed roof and placed his body weight on a section of asbestos sheeting which was not capable of supporting his weight. The roof gave way and Mr McLean fell through onto the concrete floor below.

[24] At around 18:15, Jamie McLean was returning home from the village of Peninver when he observed his father's car parked at Killellan Park Farm. He stopped to see if he could assist him.

[25] After searching for his father for some time, Jamie McLean found Mr McLean lying unconscious on his back on the floor of the milking shed. There was a hole in the asbestos roof sheeting immediately above where Mr McLean was lying. There were broken pieces of asbestos sheeting and a chainsaw on the floor near to where Mr McLean was lying. Jamie McLean phoned for an ambulance.

[26] The Scottish Ambulance Service received Jamie McLean's call for assistance at 1855. An ambulance crew comprising paramedic James Stevenson and ambulance technician John Glen arrived at the farm at 19:08, accompanied by police officers.

[27] When the ambulance crew arrived at the milking shed at Killellan Park Farm, Mr McLean was unconscious, breathing heavily and bleeding from a wound at the back of his head. The ambulance crew summoned the assistance of The Emergency Medical Retrieval Service ("EMRS") based at the Queen Elizabeth University Hospital ("QEUH") in Glasgow.

[28] The ERMS, comprising a Consultant in Emergency Medicine, Specialist Registrar and two paramedics arrived by helicopter at Killellan Park Farm at 19:48. At that point, Mr McLean remained unconscious. In light of his condition, Mr McLean was intubated and prepared for transfer to the QEUH.

[29] The EMRS helicopter carrying Mr McLean departed the farm at 20:48 and arrived at the QEUH at 21:25. On arrival, Mr McLean remained unconscious and was found to have sustained a number of injuries to his head and body which were consistent with a fall from a significant height. In particular, he was found to have sustained multiple fractures to his skull and swelling and bleeding to his brain.

[30] Mr McLean was transferred to the QEUH Neurology Intensive Therapy Unit at 01:00 on 2 September 2022. Between 2 September 2022 and 10 September 2022, there was no improvement in his condition and a decision was made to withdraw his life support. Life support was withdrawn at 14:30 on 10 September 2022 and Mr McLean died shortly thereafter. His family were by his side when he passed away.

[31] Mr McLean's life was pronounced extinct by Dr Linda Stewart at 14:35 on 10 September 2022. A death certificate was issued on 15 September 2022. Mr. McLean's cause of death was certified as:

(a) Traumatic brain injury

(b) Fall

[32] On 14 September 2022, two roofers, Graham McPhail and Gavin Semple, attended at Killellan Park Farm to repair the hole which had been created when Mr McLean fell through the roof. They used a Mobile Elevated Work Platform ("MEWP") with a "man-basket" attached to gain access to the roof.

[33] The hole which Mr McPhail and Mr Semple repaired was located a matter of inches away from the nearest purlin support beam and was approximately one metre square in size.

[34] On 14 September 2022, a single plywood crawl board was found on the roof of the milking shed. Although police officers reported Mr McLean's death to the Crown Office and Procurator Fiscal Service ("COPFS"), no report was made to the Health and Safety Executive. This was because they did not consider that Mr McLean had been 'at work' when he suffered the accident which resulted in his death.

[35] The Health and Safety Executive were first alerted to Mr McLean's death by COPFS in November 2022. Although the Health and Safety Executive considered that Mr McLean's death had resulted from an accident at work, it declined to investigate the matter further.

Evidence from Mrs Hazel Dobb

[36] The Crown led evidence from Mrs Hazel Dobb, a Principal Inspector of Health and Safety with the Health and Safety Executive. I found Mrs Dobb to be an impressive witness with an in-depth knowledge of health and safety matters relating to working at height on fragile roofs.

[37] Mrs Dobb confirmed that she had been a health and safety inspector with the Health and Safety Executive from 2000 until 2017 before being promoted to her current role. During her career, she had been involved in investigating numerous deaths resulting from falls through fragile roofs and had extensive experience in dealing with such matters.

[38] Mrs Dobb explained that she had not been involved in any investigation into the death of Mr McLean. Instead, she had been asked by the Crown to review the witness statements and photographs submitted by the police and other Health and Safety Executive employees in relation to the case and provide her opinion on the case.

[39] Mrs Dobb explained that the Health and Safety at Work etc. Act 1974 and the Work at Height Regulations 2005 applied to the work being undertaken by Mr McLean when he fell through the roof. As such, he was legally obliged to "…conduct activities as part of his undertaking in such a way that he didn't place himself and/or others at risk…". This included "taking reasonably practicable precautions to prevent any falls from or through the roof he was working on".

[40] Mrs Dobb explained that determining what amounts to a reasonably practicable precaution involves a balancing exercise between factors such as cost, time and the level

of risk involved. If a precaution was likely to be prohibitively costly in relation to the level of risk involved then it was unlikely to be reasonably practicable.

[41] Mrs Dobb confirmed that there is guidance available on the Health and Safety Executive website which provides examples of the types of precautions which could be utilised by a person or persons working on a fragile roof surface. One such example included the use of a Mobile Elevated Work Platform (MEWP) with a "man-basket" attached. Others included the placing of nets under the roof or the use of a harness attached to anchor points at or near to where a person was working.

[42] Mrs Dobb accepted that it might be difficult for a self-employed person such as Mr McLean to access a MEWP or fund the purchase of nets to hang inside a building.

[43] She also expressed uncertainty over whether the farm buildings at Killellan Park Farm had anchor points suitable for the use of an anchor system. All that being so, she conceded that there were a number of precautionary steps which would not have been reasonably practicable in this case.

[44] On the other hand, Mrs Dobb was of the opinion that there were reasonably practicable precautions which Mr McLean could have used to minimise the risk of a fall through the fragile surface of the milking shed roof. The example which she provided was the use of two or more crawl boards to move about the roof surface. She explained that crawl boards are large rectangular pieces of plywood or plastic which are placed overall parallel purlin beams and enable their user to spread his or her weight over the surface of the roof. The use or more than one crawl board would obviate the need for a worker to place his or her body weight directly onto a fragile roof surface as they moved

around roof. Instead, the user could move around safely by continuously standing on one crawl board as they moved the other.

[45] Mrs Dobb indicated that such a system of working would have been relatively inexpensive and straightforward for Mr McLean to implement and might have led to the accident which resulted in his death being avoided.

[46] Mrs Dobb was absolutely clear that any system of working at heights which involved "walking the purlins" would be fundamentally defective and unsafe. She observed:

> "The practice of walking the purlins is a practice which is now considered very outdated and isn't a practice that the Health and Safety Executive would accept under any circumstances. The issue with it is that it is akin to walking a tightrope as if you lose your balance you are immediately onto the fragile surface and the risk of falling through is significant".

Crown submissions

[47] Ms Guy lodged written submissions on the part of the Crown, the terms of which are largely reflected in the conclusions I have reached in relation paragraphs in relation to the sections 26(2)(a)-(g) of the Act. In relation to section 26(2)(e), she endorsed the evidence of Mrs Dobb and contended that a reasonable precaution which Mr McLean could have taken would have been the use of two crawl boards to move over the surface of the roof. In relation to section 26(2)(f) her submissions were twofold. First, she contended that the absence of adequate safety measures in the system of working being used by Mr McLean at the time of his death rendered it deficient. Second, she invited to

me to infer that it was more likely than not that the absence of adequate safety measures in Mr McLean's system of working was a factor which contributed to his death.

Discussion and conclusions

[48] Having considered the evidence I am satisfied on the balance of probabilities that the deceased deliberately or inadvertently placed his body weight directly onto a section of the fragile roof surface of the milking shed which was not supported by an underlying beam. The reasons for Mr McLean doing so are unknown but as a consequence of this action, the fragile roof surface gave way and he fell some distance onto the concrete floor of the shed. He sustained catastrophic head injuries which resulted in his death.

[49] As Mrs Dobb explained, the Health and Safety Executive has issued detailed guidance in relation to the measures which should be taken by those working at height on fragile surfaces to minimise the risk of falls.

[50] The evidence in this case suggests that Mr McLean was not using any of the protective measures referred to by Mrs Dobb in her evidence at the time of his tragic accident. To the contrary, the evidence supports the inference that the protective measures deployed by Mr McLean did not extend beyond the use of a solitary crawl board and the perilous practice of "walking the purlins".

[51] The use of a solitary crawl board would not have afforded protection to Mr McLean as it would have necessitated him stepping onto the fragile surface to the move the board if he wanted to move to another section of the roof. For the reasons

provided by Mrs Dobb, the practice of "walking the purlins" poses significant risk to those who engage with it and significantly increases the risk of a person falling through a fragile surface.

[52] Although the precise circumstances which led to Mr McLean placing his weight on the fragile surface are unclear, it is difficult to avoid the conclusion that there were reasonable precautions which he could have taken which might realistically have resulted in the accident which caused his death being avoided.

[53] In considering this aspect of the inquiry, it is important to bear in mind the precise wording of section 26(2)(e) of the Act. What is required is not a finding as to a reasonable precaution whereby the death or the accident resulting in death "would" have been avoided, but whereby the death or accident resulting in the death "might" have been avoided. What is envisaged is not a "probability" but a real and lively possibility that the death or accident might have been avoided by the reasonable precaution (*Carmichael, Sudden Deaths and Fatal Accident Inquiries, 3rd edition, para 5-75*).

[54] In all the circumstances, I consider that a reasonable precaution which Mr McLean could have taken would have been the use of two crawl boards to move over the surface of the roof. Such a precaution would not have been prohibitively expensive or time consuming to implement and would have obviated the need for Mr McLean ever to put his body weight directly on to the fragile roof surface. In my judgment, this would have been a reasonable precaution for Mr McLean to take and there is a real and lively possibility that his accident might have been avoided had he done so. Although the precise nature of the system of working being used by

Mr McLean at the time of the accident is unclear, what is clear is that it did not extend beyond the use of a solitary crawl board and the practice of "walking the purlins". Insofar as such minimal "safety" measures afforded little if any protection to Mr McLean, I consider that the deceased's system of working could properly be described as defective. The question thereafter arises as to whether the defects which I have identified in the system of working contributed to the accident.

[55] Any system of working on a fragile roof which does not extend beyond the use of a single crawl board and involves the practice of "walking the purlins" renders it inevitable that the person using it will apply his or her body weight directly to the surface and run the risk of falling through that surface to his or her death. Mr McLean's accident occurred as a result of him coming into direct contact with a fragile roof surface. In the all the circumstances of this case, I have reached the conclusion on the balance of probabilities that the absence of proper protective measures in Mr McLean's system of working was at very least a contributing factor in the accident resulted in his death.

[56] There are no other facts which are relevant to the circumstances of the death of said William McLean.

[57] I wish to conclude by expressing my condolences to the loved ones of William McLean for his tragic loss.