SHERIFFDOM OF GRAMPIAN, HIGHLAND AND ISLANDS AT ABERDEEN.

Under the Fatal Accidents and Sudden Deaths Inquiry (Scotland) Act 1976.

2010 FAI 49

DETERMINATION

By

Sheriff Douglas J. Cusine

Into the death of

MICHAEL LINDLEY SCOTT.

ABERDEEN, 9th November, 2010.

The sheriff, having resumed consideration, determines under the Fatal Accidents and Sudden Deaths Inquiry (Scotland) Act 1976 ("the Act") as follows:-

(a) that in terms of s. 6(1)(a) of the Act, Michael Lindley Scott born 31 May 1988 was pronounced dead at Aberdeen Royal Infirmary on 13 December 2006. The death followed upon an accident which occurred at or about midday on 13 December 2006 at premises known as the Old Mill, York Place, Aberdeen, ("the premises"). At the time of his death Mr Scott was employed as an apprentice plumber by Steven Anderson trading as A.P.H. Services.

(b) the cause of death was traumatic asphyxia whereby his chest and neck were compressed by a considerable weight of medium density fibreboard (MDF).

(c) there were no reasonable precautions which could have been taken by Steven Anderson whereby the death the accident which resulted in the death might have been avoided.

(d) there were no defects in the system of working which contributed to the death or the accident resulting in the death.

(e) there are no other facts which are relevant to the circumstances of the death.

I was not addressed on the question of expenses, but I shall put the matter out for any consideration of that issue and appoint parties to be heard thereon, if so advised, on 19th November 2010 at 11.00am.

NOTE.

In this matter, the Crown was represented by Mr Bowman, procurator-fiscal, and the employer by Mr Donaldson, solicitor. A considerable amount was agreed and is contained in the Joint Minute.

The background.

Michael Scott was an apprentice plumber employed by Steven Anderson, and was registered as such with the Scottish and Northern Ireland Plumbing Employers Federation. He had his own training officer at the Federation. As part of his training, Michael attended Aberdeen College on Mondays and Tuesdays. During the first week of the course at the College, Michael was given instruction on manual handling, further aspects of which were covered later in the course. That instruction related to manual handling within the plumbing industry, including the handling of pipes and other plumbing equipment. It did not include manual handling of timber, large boards, or similar products, and, specifically, not MDF, which is used by plumbers, but only occasionally.

Michael was a conscientious apprentice and he was popular with his employer and his fellow employees. He enjoyed his work and was willing to assist both his employer and others in the vicinity.

Not long before the accident, Steven Anderson had acquired the use of the premises which he was in the course of converting. The premises were on three floors. The ground floor was to be for storing tools and other material for the plumbing trade, while the first floor would be an office and kitchen.

The conversion was being done by Steven Anderson and some of his employees, and at the time of the accident, some of this conversion work had begun. In late November or early December 2006, Steven Anderson ordered a quantity of MDF from Plaza Interiors Ltd who are suppliers of MDF. There were 68 sheets, which were delivered to the premises in two batches, the first of 48 sheets and the second of 20. Each sheet measured 3050 x 1220 x 12mm and weighed 28.1kg, (28lbs.) There was no discussion between Plaza and Steven Anderson about how the MDF should be stored at the premises. The delivery lorry was unable to park directly outside the premises, and so each sheet of MDF had to be carried from the lorry into the premises. Michael Scott assisted in this, each sheet being carried in by two people.

By 13 December, the second batch of 20 sheets (weighing 562 kg) had been placed in the ground floor corridor, lying on their long edge at an angle to the

wall of approx. 78 degrees, with the innermost sheet approx. 25cm, (10 ins) from the left hand wall.

The day of the accident.

Michael Scott attended college part-time on Mondays and Tuesdays, but he left early on Monday 11 and had not attended on Tuesday 12 December, because he had not been well. His mother advised Steven Anderson of this during the afternoon of 12 December. Mr Anderson sent her an e-mail saying that if Michael was fit, he should attend at the premises on Wednesday 13. Michael left work on that day at 7.30am.

It is not known when he arrived at the premises, but when he did so, Steven Anderson was not there as he and his brother were attending a business meeting. None of the other employees was there either. Between 8.53am and 9.31am, e-mails were exchanged by Michael and Steven Anderson. Mr Anderson did not want Michael to be standing outside the premises, as he had been unwell, and he suggested to Michael that he get something to do from a company next door who had in the past, allowed Michael to valet cars. Michael advised Steven Anderson that there was no one at the place next door, and so Steven Anderson advised Michael to get a key for the premises from a company called Aitkens and added "just go in and tidy the upstairs etc," to which Michael replied "OK." At that time, Michael was alone in the building.

Michael did tidy the upstairs part of the premises, but there was no evidence that he had started to tidy up the ground floor. There were unanswered telephone calls from Michael to his mother, and to Steven Anderson and one from Steven Anderson to Michael. These calls were made between 11.04 and 11.09am.

The accident.

At about midday, Steven Anderson arrived at the premises. He found Michael pinned against the right wall of the ground floor corridor by the 20 sheets of MDF. Michael was facing the MDF, his hands and mobile 'phone resting on top of the sheets, between his hands. An ambulance was summoned, and Steven Anderson called for assistance from Ross Paterson from the company next door. They attempted to free Michael, but they were unable to move all 20 sheets at the one time, but managed to lift them 3 or 4 at a time. After the sheets had been removed, Michael slid to the ground with his back to the floor, the position in which he was found by the ambulance personnel. They attempted to resuscitate him, but without success. It was noted that he had extensive bruising to his upper chest and neck with indentation marks across his neck at the base of his windpipe. Michael was taken to Aberdeen Royal Infirmary where he was pronounced dead at 12.52 on 13 December 2006.

It is impossible to determine from the evidence how the accident took place.

As Michael was alone in the building, it seems that he had decided to move at least one of the boards himself, but for what reason and how he attempted to do this, one cannot say.

The immediate aftermath.

Photographs of the scene were taken by a police photographer and also by Health and Safety Inspectors. On 15 December, a Health and Safety Inspector attended the premises and carried out a "floor roughness test" to ascertain the potential slipperiness of the floor. That was assessed as medium.

The storage of MDF.

It is accepted that MDF is a slippery product. It is also accepted that the MDF sheets were stored in such a way that they could not have fallen over by themselves. It would be easier to move the sheets from the top than the bottom.

Crown Production No.1 is a book of photographs which were taken by a police photographer on 13 December 2006, after Michael had been taken to the hospital. They show among other things, how the MDF had been stored once the sheets had been removed by Steven Anderson and Ross Paterson. They do not depict how the sheets had been stored prior to the accident. Crown Production No.2 is another book of photographs. These were taken on 15 December by two HSE Inspectors. Photographs 1 and 2 depict the approximate position of the 20 sheets of MDF after delivery from Plaza. Photographs 3 and 4 show an HSE Inspector supporting a sheet of MDF at approximately waist height.

Crown Production No.3 is an HSE Information Sheet, Woodworking Sheet No. 2 (Revised) entitled "Safe stacking of sawn timber and board materials" and Crown Production No.4 is "Woodnig News," issue 21, dated December 2001 entitled "Danger from Stacking Board Materials." This document is the newsletter of the Woodworking National Interest Group.

The introduction to Crown Production No.3 says that it "contains practical guidance on the safe stacking and storage of sawn timber and board materials," and that it had been produced after consultation with the woodworking industry. "It is aimed at all premises where timber or board material is stacked and stored, not just woodworking premises." Under the heading "Stacking timber and board material," it states at bullet point 3 "Ideally, store boards…flat…." and at bullet point 4, "Never stack boards on edge without adequate support as they can tip out of control from a vertical position." If the boards cannot be stored flat, it is recommended that they be stored in something which looks like a large toast rack.

Crown Production No.4 highlights two then recent prosecutions, but the facts

these cases were radically different from the present case.

One of the HSE Inspectors, Douglas Conner, accepted that the sheets of MDF, if stored in the way shown in photographs 1 and 2 in Crown Production No.2 would not move of their own accord, and that it was unlikely that an attempt to move one board would dislodge the others. He also accepted that he had seen MDF and similar material stored in the way shown in these photographs as a temporary measure. He suggested that MDF boards could carry a warning about the dangers of their not being stored flat. He also suggested that if an apprentice is to be left on his or her own, the employer should spell out what the apprentice should or should not do.

David Wood, who was called as a witness by the employer, is the founder of and a director of Plansafe, a company formed in 1995. It gives health and safety advice to the construction, engineering and manufacturing industries. Mr Wood was an HSE Inspector for 15 years, has been employed in occupational health and safety for 30 years and is a Chartered Member of the Institution of Occupational Health and Safety. He visited the premises on 23 July 2009, took photographs and prepared report in connection with the criminal proceedings then pending. That is the Employer's Production No.1.

He visited joiners' premises where extensive quantities of MDF are used and took photographs of a sheet of MDF lying against a wall in the approximate position of the MDF in photograph 1 in Crown Production No. 2. The joiner's piece of MDF was shorter in length but the same width. Mr Wood then used a spring balance to measure the amount of force needed to move the board 2 inches and that was 2.75 kg.

On his visit to the premises where the accident occurred, he noted the layout of the ground floor, in particular, the corridor, and the access to and layout of the upper floors. The access to the first floor was up a steep staircase with narrow treads, not uncommon in an older building. In his opinion, storage of MDF in the way done at the premises was common and even on building sites, it was rare to find MDF, plasterboard and plywood stored other than on the long edge. There was nothing unusual about the angle at which the MDF was lying against the wall at the premises and it coincided with the HSE recommendation in relation to the angle at which ladders should be placed against the vertical. He accepted that it would have been possible for the MDF to be taken to the first floor where it could have been stored flat, but that would have meant negotiating the stair which, in his view, posed "a considerable risk," and so it was sensible to store the sheets where and how they were. Crown Production No.3, he opined, related to commercial storage, not to the situation of Steven Anderson. In his view, the instructions which Steven Anderson gave to Michael Scott in the e-mail about cleaning were understandable. He did not subscribe to the view that employers have a duty to think for their employees, but conceded that if another person had been present, the accident might not have happened.

Submissions by the Crown.

I was invited to recommend that suppliers of MDF should give a warning printed or stamped on each sheet advising that MDF be stored flat. The Crown prayed in aid Crown Productions No. 3 and 4 which highlight the type of accidents which can take place if boards are not stored properly. Such a warning, it was suggested, would be reasonably cheap and practical.

Submission for the employer.

I was invited not to make the recommendation above referred to, because there was no evidence to show that Steven Anderson had done something, or had failed to do something, whereby the accident could have been prevented. It was impossible to say how the accident had occurred. The cases referred to in Crown Production No.4 were cases of boards sliding away from their original position, or boards of different sizes being stored and an employee trying to get access to a particular board behind others. Neither scenario applied in the present case. In considering the possibility of storing the sheets flat, one had to examine the way in which that would be achieved, i.e. taking them up the stairs above referred to.

Decision.

I have decided not to make the recommendation suggested by the Crown, which was based on the opinion of Mr Conner, the HSE Inspector. There are a number of reasons for that.

The first and most cogent is that, in terms of the Act, any recommendation about reasonable precautions can only be made if I am satisfied that the accident might have been avoided had this warning on the sheets been there. As it is not possible to say, on the basis of the evidence, how the accident took place, it would not be sensible or appropriate for me to say that a warning might have prevented it.

Secondly, there are already warnings in place, but these relate to the commercial storage of wood, etc. Before making such a recommendation of general applicability, it would be necessary to have some further evidence about the practicality and cost-implications. The recommendation, if made, would, sensibly, have to relate not only to MDF, but other material such as plasterboard and plywood. Other things such as doors and windows which might present similar hazards could not be excluded. A wide-ranging investigation would be needed to identify all such material and that is not the function of an FAI.

Thirdly it is not uncommon, for someone to visit a DIY store to purchase MDF, plywood, or plasterboard. If the person did not have assistance in moving the material from a position in which it was stored in accordance with the HSE guidelines (Crown Production No.3,) say, to the floor and then on to a trolley, an accident might occur, injuring the customer, or others. The warning might be in place, but the implications of having enough staff to assist all customers

with awkward and/or heavy items would have to be considered. What effect would the warning have on the subsequent transport by the customer of his or her purchase to its destination?

Fourthly, Michael had been involved in transporting the MDF sheets from the point of delivery to the corridor in the premises and would know how heavy the sheets were and that they could not be lifted by one person alone.

Final Comments.

1. Both the Crown and Mr Donaldson expressed their condolences to the family of Michael Scott on his tragic death as I did, and do once again. Michael's parents sat through the proceedings and I understand that other relatives and friends did also. They are to be commended for giving Michael's parents their support through what could only have been a fairly harrowing experience. Their composure throughout was commendable.

2. It was suggested by Mr Conner, the HSE Inspector that if an apprentice is left on his or her own, the employer should set out clearly the parameters of any instructions given to the apprentice. That comment was made in relation to the text message which said, "…just go in and tidy the upstairs etc." I do not accept that view. It is unrealistic in that it suggests that the employer should detail all of the things which the apprentice should not do. I also smacks of a view that the employer has a duty to think for the employee and absolve an employee of the responsibility of thinking for himself or herself. In any event, a conscientious employee, as Michael was, might find it insulting if his employer asked him, say, to get a drill form the van, but went on to say "Do not start the van, do not bring a saw, etc." That in my view is taking health and safety too far, and makes no concession to the application of common sense.

3. The purpose of an FAI is not to ascertain whether a crime has been committed, or to establish a claim for damages. As the Act says, the purpose is to determine among other things where and when the death took place, and the causes. It can also result in identification, where appropriate, of any reasonable precautions which could have been taken to avoid the accident, and any defect in any system of working which contributed to the death, and anything else which may be relevant to the circumstances of the death. In this case, it has not been possible to ascertain from the evidence how the accident happened, and that may be unfortunate for the family. That said, it would not be proper to indulge in speculation.

4. The Act provides in s.1(1)(a) that an FAI shall be conducted where it appears that a death has resulted from an accident in the course of employment, but in s. 1(2), it says, "other than a death in a case where criminal proceedings have been concluded against any person in respect of the death or any accident from which the death resulted, and the Lord Advocate is satisfied that the circumstances of the death have been sufficiently established in the course of such proceedings." Criminal

proceedings were taken against the employer, but it was held that there was insufficient evidence in law to allow the case to go to the jury. Before that stage was reached, the Crown must have had available to it all of the necessary evidence to determine where and when the death and the accident relating to the death took place and the cause or causes of the death and any accident resulting in the death. It is not obvious to me that any new information was brought out in the Inquiry which was conducted in front of me.