

SHERIFFDOM OF GRAMPIAN, HIGHLAND AND ISLANDS AT INVERNESS

[2022] FAI 35

INV-B122-22

DETERMINATION

BY

SHERIFF GARY AITKEN

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

into the death of

**PAWEL KOCIK**

**INVERNESS, 13 September 2022**

**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 Pawel Kocik, born 20 June 1983, died at around 12.00 hours on 17 May 2017 at Kishorn Quarry, near Lochcarron, while in the course of his employment.

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

The accident which resulted in Mr Kocik's death occurred at some time after 09.30 hours and before 11.35 hours on 17 May 2017 at Kishorn Quarry, near Lochcarron.

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

Mr Kocik's death was due to chest and abdominal injuries, sustained as consequence of being struck by an excavator boom and dipper arm resulting in a fall while working on a quarry stone crusher machine.

**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 resulting in the death of Mr Kocik was inadvertent contact by the excavator operator with the left-hand control joystick of the excavator at a time when the safety control lever was not engaged, resulting in the unintentional movement of the boom and dipper arm which then struck Mr Kocik.

**In terms of section 26(2)(e) of the 2016 Act (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)**

The following precautions 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: namely (a) a discussion between Mr Morgan and Mr Kocik about the task in hand before Mr Kocik entered the feed hopper might have prevented the need for Mr Morgan to communicate with Mr Kocik during the task and the accident would have been avoided; (b) had Mr Morgan engaged the safety control lever when Mr Kocik was working in proximity to the boom when inserting the wedge and, in particular, had

he done so prior to opening the cab door and attempting to communicate with Mr Kocik then the accident would have been avoided and (c) had the sides of the hopper been modified so they were fixed in place, with no folding mechanism as per their current design then the accident would have been avoided.

**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)**

The system of work employed to raise the feed hopper sides was defective in that it lacked an instruction or step that required an excavator operator to engage the safety control lever when at rest or when others were in proximity of the boom.

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

At the time of Mr Kocik's death, and for some considerable time before, the risk from the inadvertent operation of operator controls in excavators was widely recognised in the construction industry but not so recognised in the quarrying and extractive industry.

Industry training did not expressly include or record the correct use of the safety control lever in excavators on the approach or persons or when the machine was at rest.

The operator's manual for the excavator in question did not specify that the safety control lever should be used when a person is within the danger zone of the excavator and when the machine is at rest. It is possible for the safety control lever to be interlinked to an external warning red beacon so that those working in close proximity to the excavator can see when the safety control lever has been activated, the excavator controls are disabled and it is safe to approach the machine.

It is possible to modify crushers of the type involved in this fatal accident so that the feed hopper sides do not require to be lowered and raised to allow road transportation.

### **Recommendations**

**In terms of sections 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)**

It is recommended that the Health and Safety Executive consider issuing a Safety Bulletin Alert to the quarrying and extractive industry to further raise awareness of the correct use of the safety control lever fitted to excavators, especially when using excavators in lifting operations.

It is further recommended that the Product Safety Team of the Health and Safety Executive consider raising with the manufacturers of excavators the issue of how the use of the safety control lever is addressed in operator manuals for excavators.

### **NOTE**

#### **Legal Framework**

[1] This inquiry was held in terms of section 1 of the 2016 Act and was governed by the Act of Sederunt (Fatal Accident Inquiry Rules) 2017 (hereinafter referred to as “the 2017 Rules”). This fatal accident inquiry was presented by the Crown as a mandatory

inquiry in terms of section 2 of the 2016 Act as Mr Kocik died as a result of an accident in the course of his employment or occupation.

[2] The purpose of this inquiry is set out in section 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. It is not intended to establish liability, either criminal or civil. The inquiry is an exercise in fact finding, not fault finding. It is not open to me to engage in speculation. The inquiry is an inquisitorial process. The Crown, in the form of the Procurator Fiscal, represents the public interest.

[3] In terms of section 26 of the 2016 Act the inquiry must determine certain matters, namely where and when the death occurred, when any accident resulting in the death occurred, the cause or causes of the death, the cause or causes of any accident resulting in the death, any precautions which could reasonably have been taken and might realistically have avoided the death or any accident resulting in the death, any defects in any system of working which contributed to the death, and any other factors relevant 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 1 of the 2016 Act.

### **Introduction**

[4] This inquiry was held into the death of Pawel Kocik. He was a 34 year old man who was employed as a quarry operative. He died on 17 May 2017 when he was fatally injured while working on a mobile rock crushing machine at Kishorn Quarry, near Lochcarron.

[5] Preliminary hearings were held at Inverness Justice Centre by Webex on 1 July 2022 and 22 July 2022. It was clear that much of the evidence was not likely to be disputed and the Crown undertook to prepare a joint minute of agreement.

[6] The inquiry proceeded at Inverness Justice Centre by Webex on 28 July 2022 and 5 August 2022. A hearing on submissions proceeded at Tain Sheriff Court by Webex on 29 August 2022. Ms Swan, Procurator Fiscal Depute, represented the Crown.

Mr Donaldson, solicitor, represented Mr Kocik's employer, Leiths (Scotland) Limited (hereinafter referred to as 'Leiths'). No other parties were represented. Parties lodged a substantial joint minute of agreement. I accepted the facts set out in the joint minute of agreement. The findings in fact listed at paras [11] to [60] below are derived from the joint minute of agreement and the evidence of Mr Morgan and Mr Tetley.

[7] The Crown lodged an inventory of documentary productions as follows:

1. Training file – J Morgan
2. Training file – P Kocik
3. Guidance on lifting operations in Construction when using Excavators
4. Report by Peter Dodd, HSE Specialist Inspector – Mechanical Engineering
5. Edited book of photographs taken on 17 May 2017
6. Post mortem report
7. Toxicology report
8. Photographs taken by M Tetley
9. Extract from Excavator Operator Manual
10. Health and Safety Laboratory Research Report 1000

11. Mineral Products Qualification Council Plant Operator Competency Assessment Record – J Morgan
12. Quarry induction sheet – J Morgan
13. List of Tool Box Talks
14. Tool Box Talks copy signatures
15. Excavator service and inspection sheets
16. Crusher service sheets
17. Copy extract Lokotrak 100/100 R Instruction Manual
18. Operational Risk Assessment ORA109KN
19. Method Statement and Risk Assessment
20. Risk Assessment ORA 27 KN Primary Crusher at the Quarry Face
21. Safe System of Work SSOW 01
22. Quarry induction sheet – P Kocik
23. Report of Thorough Examination of Lifting Equipment
24. Daily Check Sheets
25. Risk assessment for mobile crusher set up at Northlasts Quarry
26. Guidance on Reducing Unintended movement of Plant and Managing Exposure to Consequential Risks
27. Copy e-mail dated 7 December 2017
28. Copy e-mail dated 1 December 2017
29. Copy e-mail dated 5 June 2017
30. Copy RIDDOR report

31. Notice of Contravention letter
32. Copy Indictment
33. Typed Police statement – Paul Niemi
34. Typed HSE statement – Paul Niemi
35. Typed HSE statement – David Bremner
36. Typed Police statement – Donald Alexander Gillies
37. Typed HSE statement – Donald Alexander Gillies
38. Typed HSE statement – Ronald Chalmers
39. Typed Police statement – Kevin Richard Sargent
40. Typed Police statement – Stuart Williamson
41. Typed Police statement – Joseph Morgan
42. Typed HSE statement – Joseph Morgan
43. Typed Police statement – Simon Andrew MacLellan
44. Typed Police statement – Stanley Jackson
45. Typed Police statement – Dr Lorna MacGregor
46. Report by M Tetley, HM Specialist Inspector of Quarries
47. Letter dated 30 June 2022
48. Handwritten statement – Paul Niemi
49. Handwritten statement – Donald Alexander Gillies
50. Handwritten statement – Kevin Richard Sargent
51. Handwritten statement – Stuart Williamson
52. Handwritten statement – Joseph Morgan



53. Handwritten statement – Simon Andrew MacLellan
  54. Handwritten statement – Stanley Jackson
  55. Handwritten statement – Dr Lorna MacGregor
  56. Book of Photographs
  57. Book of Photographs
  58. Book of Photographs
- [8] The Crown lodged a list of witnesses as follows:
1. Paul Niemi, c/o Leiths (Scotland) Limited, 1 Rigifa, Cove, Aberdeen
  2. David Bremner, c/o Leiths (Scotland) Limited, 1 Rigifa, Cove, Aberdeen
  3. Donald Alexander Gillies, c/o Leiths (Scotland) Limited, 1 Rigifa, Cove, Aberdeen
  4. Robert Chalmers, c/o Leiths (Scotland) Limited, 1 Rigifa, Cove, Aberdeen
  5. Kevin Richard Sargent, c/o Leiths (Scotland) Limited, 1 Rigifa, Cove, Aberdeen
  6. Stuart Williamson, c/o Leiths (Scotland) Limited, 1 Rigifa, Cove, Aberdeen
  7. Joseph Daniel Morgan, c/o Leiths (Scotland) Limited, 1 Rigifa, Cove, Aberdeen
  8. Simon Andrew MacLellan, c/o Scottish Ambulance Service, Lochcarron
  9. Stanley David Jackson, c/o Scottish Ambulance Service, Lochcarron
  10. Dr Lorna MacGregor, c/o Ferguson Medical Centre, Lochcarron
  11. Dr Ian Strath, c/o Ferguson Medical Centre, Lochcarron

12. Dr Abethan Anparasan, Speciality Registrar, Raigmore Hospital,  
Inverness
13. Dr Mark Ashton, FRCPath, Consultant Pathologist, Raigmore Hospital,  
Inverness
14. Shonacgh Laoing, Detective Constable, Police Service of Scotland, Portree
15. Peter Dodd, HM Specialist Inspector of Health and Safety, Belford House,  
59 Belford Road, Edinburgh
16. Norman Johannes Schouten, HM Inspector of Health and Safety,  
Longman House, 28 Longman Road, Inverness
17. Mike Tetley, HM Inspector of Quarries, Energy Division, Health and  
Safety Executive, 2.2 Redgrave Court, Merton Road, Bootle

I heard oral evidence from Joseph Daniel Morgan and Mike Tetley.

[9] Leiths lodged an inventory of documentary productions as follows:

1. e-mail dated 30 March 2013
2. Wheeled Loading Shovel MPQC Assessment – Joseph Morgan
3. Multiple Health and Safety Assessment – Joseph Morgan

**The facts**

[10] Pawel Kocik (hereinafter referred to as “Mr Kocik”), born 20 June 1983, was at the time of his death employed by Leiths as a quarry operative assigned to a mobile crushing team. He had worked for Leiths for approximately one year. He was a Polish

national who had resided in Scotland for ten years along with his wife. The couple have one daughter who was six years old at the time of his death.

[11] Kishorn Quarry, near Lochcarron is owned by Leiths Group. The company operate fourteen quarries, located throughout Scotland.

[12] Mr Kocik arrived at Kishorn Quarry on the morning of 17 May 2017 and was working in the course of his employment as part of Leiths' mobile crushing team when at some time after 09.30 hours he began to assist witness Joseph Daniel Morgan (hereinafter referred to as "Mr Morgan"), another member of the mobile crushing team, with the setup of a Nordberg Lokotrack LT100 mobile primary crusher (hereinafter referred to as "the crusher") and, in particular, with the fixing in place of the rear and side panels of the feed hopper of the crusher.

[13] The rear and side panels of the feed hopper of the crusher had been lowered to allow transportation of the crusher to Kishorn Quarry and required to be raised and fixed into place for operation. Mr Morgan was using a Volvo Excavator EC380EL, Plant No EXC29 (hereinafter referred to as "the excavator") with a chain suspended from the lifting eye on the quick hitch of the dipper arm of the excavator as a lifting appliance to raise the said panels.

[14] Mr Kocik was standing within the feed hopper of the crusher when he was struck on the body by the quick hitch attached to the dipper arm of the excavator operated by Mr Morgan causing him to be crushed against the nearside feeder panel of said crusher. He then stumbled further within the feed hopper, landing on the cross

brace support beam for the crusher which was stored on the floor of the feed hopper for transportation.

[15] The emergency services were summoned. Initially, Mr Kocik was conscious. His colleagues noted a serious injury to his shoulder and arm which was described as "deformed" and bleeding. Witness Donald Alexander Gillies, the Quarry Supervisor and a qualified First Aider, was summoned to the crusher to assist. Mr Kocik asked his colleagues to help to move his arm to a different position as he was unable to move it freely himself. This request was relayed to the ambulance control room by phone and permission was given to allow him to move into a position that he felt comfortable in. Whilst doing this, Mr Kocik collapsed, and the colour began to drain from his face. He was placed on his back and cardiopulmonary resuscitation was carried out for approximately ten to fifteen minutes until the ambulance arrived.

[16] The ambulance arrived about 11.35 hours and the ambulance personnel attached defibrillator pads to Mr Kocik and attempted resuscitation, inserting a cannula without success. Shortly thereafter witnesses Dr Lorna Macgregor and Dr Ian Strath attended and attempted further life support along with paramedics from Helimed, the helicopter ambulance. Mr Kocik could not be resuscitated, and Dr Strath pronounced him dead at approximately 12.00 hours on 17 May 2017.

[17] On 22 May 2017 witness Dr Abethan Anparasan, Speciality Registrar, under the supervision of witness Dr Mark Ashton, Consultant Pathologist and Dr Natasha Inglis, Consultant Pathologist, undertook a post mortem examination of the body of Mr Kocik. They found multiple injuries, predominantly to the left side of the chest and abdomen

and primarily involving the chest wall, heart, lungs, spleen, abdominal wall and left kidney. There was no evidence of any natural disease which may have contributed to the fall and toxicological investigations revealed no trace of alcohol or drugs. The cause of death of Mr Kocik was certified as I (a) Chest and abdominal injuries, due to (or as a consequence of) I(b) Fall while working on a quarry stone crusher machine. Crown production number 6 - Post Mortem Report and Crown production number 7 - Toxicology Report are the reports of said examinations. The injuries noted at post mortem are entirely consistent with Mr Kocik being struck by the quick hitch of the excavator. Dr Inglis' report refers to a "fall" because that is how she and her colleagues abbreviated the information available to them at the time of their examination.

[18] Kishorn Quarry is one of a number of smaller or lower output quarries operated by Leiths which do not justify either fixed rock crushing plant or mobile rock crushing plant being permanently on site. Crushing operations at these quarries are carried out on a campaign basis around the various sites by a mobile crushing team. A blast is fired at a particular quarry creating large pieces of rock. The mobile crushing team is brought in to crush the rock and create stockpiles which are then worked off. Thus, the mobile crushing team and their equipment moves from quarry to quarry. A typical mobile crushing team will consist of an excavator (with operator), a jaw crusher (in this case the incident Nordberg Lokotrack LT100 mobile primary crusher), a cone crusher, screening plant, and one or more loading shovels with operators. The excavator is used at the base of the blasted rock and feeds the jaw crusher, this in turn feeds the cone crusher which then feeds the screening equipment. The jaw crusher uses an impact motion to crush the

rock into smaller sizes, the smaller material is processed through a cone crusher and screens and then on to the conveyor belt which take the material up allowing it to fall in to pre designated areas where the loading shovel can then remove this material to a stockpile area within the quarry.

[19] Typically, the mobile crushing team will be transported into a site either before or following a blasting exercise by low loader under a special notification to the police due to the size and weight of the equipment being transported. The mobile crushing team will be given the blast area of the quarry and will set up their equipment in such a way to allow them to process the rock into smaller sizes.

[20] Upon arrival the mobile crushing team will be given a site induction. During the site induction provided by witness Donald Alexander Gillies to both Mr Morgan and Mr Kocik, the need for risk assessments for mechanical work was discussed in general terms but none were exchanged or specifically discussed nor was any other documentation such as method statements or safe systems of work discussed. The mobile crushing team have generic risk assessment templates. These documents will reviewed by the quarry management team in conjunction with mobile crushing team to make them site specific. In anticipation for this activity witness Paul Niemi, area quarry manager, Leiths, had begun to review the method statement and risk assessment for crushing and screening works, contained in Crown production 19. Said Donald Gillies states that no mechanical activity, including the setting up of the crusher should have occurred without a task specific risk assessment being in place and signed off by the site management.

[21] If any repairs to the plant are required a plant fitter will be allocated to carry out this task prior to the plant being set up for operation. Each plant fitter is trained in task specific risk assessment and is required to carry out this function for each of the tasks carried out.

[22] Each plant operator is responsible for the set up and operation of his plant; the excavator operator is responsible for the set up and the operation of the jaw crusher. The shovel operators are responsible for the set up and operation of the cone crusher and screening plant.

[23] On this occasion Mr Morgan was the excavator operator and witness Stuart Williamson and Mr Kocik were the loading shovel operators. Alan Garson was the plant fitter.

[24] The crusher is a Nordberg Lokotrack LT100 mobile primary crusher. It was manufactured in 1997. It was one of two such crushers owned by Leiths. The function of the crusher is to take boulder sized blasted rock and crush it down into smaller pieces of rock. It does so by passing the boulder sized rocks from a feed hopper through a crushing chamber where they were crushed between two crusher jaws before being discharged from the machine on a belt conveyor. The crusher is self-propelled and mounted on tracks which enable it to be driven between positions when on site. To move a greater distance, i.e., between quarries, a low loader is used. Height restrictions on public roads meant that prior to and at the time of the fatal accident the feeder side panels of the crusher were lowered for transportation.

[25] Once on site at a quarry, the rear and side panels of the feed hopper of the crusher were raised and fixed into position. This was done in a set order. The rear panel was raised first, followed by a side panel which was secured by fixing a metal wedge through the side and rear panel. A securing pin or bolt was then fitted once the wedge was in place.

[26] Mr Morgan is employed by Leiths as a plant operator. He had worked on and off for Leiths throughout his 18 year career as a plant operator. He had been back working for Leiths, as a plant contractor, for around 3 years at the time of the fatal accident.

[27] Mr Morgan arrived on site at Kishorn Quarry on 16 May 2017 along with the excavator. He was given a site induction by said Donald Alexander Gillies, the Quarry Supervisor, and then undertook some preparatory works with the excavator. Mr Kocik and witness Stuart Williamson arrived on site on the morning of 17 May 2017 and also received a site induction from Donald Gillies. The crusher, two mobile screening units and a secondary mobile cone crushing unit also arrived on site that morning. Crown production number 12 is the Quarry Induction Sheet for Mr Morgan and Crown production number 22 is the Quarry Induction Sheet for Mr Kocik.

[28] At around 9.30 am on 17 May 2017 said Stuart Williamson asked Mr Kocik to track one of the mobile screener units down to the processing area of the quarry. Having completed that task Mr Kocik walked back to the concrete pad adjacent to the quarry office and welfare facilities, where the crusher and excavator were situated. At that time, Mr Morgan was engaged in the task of preparing the crusher for operation. He had secured the rear or back panel of the feeder hopper.



[29] Mr Morgan had just returned to the cab of the excavator after attaching the lifting chain to the lifting eye of the nearside panel of the feeder and he then lifted the near side panel into position. When Mr Kocik arrived he gestured to Mr Morgan to stop and indicated that he would go up into the feed hopper. Mr Kocik then placed the wedge through the side panel and back panel.

[30] Once the wedge had been inserted Mr Morgan shouted to Mr Kocik to "Put the pin in". Mr Kocik raised his arms and made a gesture while looking around giving Mr Morgan the impression that the pin could not be found or that his instruction could not be heard. At this time a mobile cone crusher situated adjacent the crusher was operating and the engine of the same was generating additional background noise.

[31] Mr Morgan then opened the cab door of the excavator. This door is situated to the left hand side of the excavator and he leaned out of the door slightly in order to ensure that Mr Kocik was able to hear him. In doing so, Mr Morgan inadvertently caught the left hand joystick in the excavator with the left side of his abdomen or his overalls. The left hand joystick controls the slew (rotation) of the excavator and this action caused the boom and dipper arm of the machine to move to the left. It was this movement which caused the quick hitch attached to the dipper arm to strike Mr Kocik. Mr Morgan saw the quick hitch strike Mr Kocik on his arm and chest and he immediately pushed the controls away to clear the dipper arm from him. It was then that Mr Kocik stumbled from view into the feed hopper.

[32] Mr Morgan switched the excavator off, got out of it and shouted to Mr Kocik, asking if he was okay. He heard Mr Kocik moan and say "No". He then climbed onto

the access platform on the offside of the crusher from where he could see Mr Kocik lying over the feeder cross brace support beam which was on the feed hopper floor.

Mr Morgan then ran to the quarry office (approximately 30 or so metres away) to summon help and inform the site management that a serious accident had occurred.

[33] The crusher was examined as part of the investigation into the death of Mr Kocik. No defects or significant deficiencies were identified with it. Access arrangements, handrails, steps and working platforms were fit for purpose and maintained for general use. Crown production number 16 - Crusher Service Sheets is the service record for the crusher.

[34] Crown Production number 17 is a copy of an extract from the Instruction Manual for the crusher. This extract was provided to The Health and Safety Executive by Leiths on 24 May 2017. References to assembly of the crusher after transport are found in Parts 2.8 and 6.2. Part 2.8 - Transportation states:

“Only use appropriate transportation and lifting equipment with adequate capacity. Provide a supervisor to direct lifting operations...Carefully assemble all of the parts previously disassembled.”

In Part 6.2 - Transportation from Site to Site under measures before transport, there is a requirement to turn down the additional side walls of the feeder and to remove the feeder beam and place it inside the feeder.

[35] At the time of Mr Kocik's death, Leiths had a number of risk assessments and safe systems of work relating to mobile crushing operations. Reference to the setting up of the crusher after transportation is found in Crown production number 21 - Safe System of Work (SSOW 01) Excavator operator/Tracked crusher where at item 17 it

states "Erection of feeder hopper sides to be a two man operation". Said Safe System of Work SSOW 01 is referenced in another document, Crown production number 20 - Risk Assessment Record ref: ORA 27 KN Primary Crusher at the Quarry Face at item 11, under control measures. Crown Production number 19 - Method Statements and Risk Assessments deals with the unloading plant from a low loader and the moving of tracked mobile screen and crushers using remote control but does not deal with the setup of the mobile crusher once it has been removed from the low loader.

[36] Mr Kocik had received recognised training for his primary role as a wheeled loading shovel operator and had attended a number of toolbox talks and safety alerts including 14 since joining Leiths. No record was found of him receiving specific training in relation to the setting up of the mobile primary crusher. His Leiths training file was produced as Crown production number 2.

[37] The Minerals Products Qualification Council (hereinafter referred to as "MPQC") was established in 1983 to help develop and maintain industry training and needs in the extractive sector. It is a Not for Profit membership organisation whose members are derived from the quarrying, mineral products, mining, construction and related manufacturing sectors. MPQC is formed of two Divisions; MP Awards and MP Skills. These divisions operate independently of each other and are governed and regulated by a range of Government Bodies and Independent Regulators. MP Awards is a dedicated sector specific Awarding Organisation that develops qualifications for the quarrying, mineral products, mining and related manufacturing industries. It works in collaboration with the Health and Safety Executive (hereinafter referred to as "HSE"),

professional institutes and trade associations to ensure there is access to relevant qualifications, accreditation services and industry schemes to support the sector's drive towards a fully competent workforce. MP Skills provides industry training and assessment. Mr Morgan's MPQC Plant Operator Competency Assessment Record was produced as Crown production number 11.

[38] In relation to his training on processing plant, Mr Morgan achieved an MPQC Assessed Operator for Mobile Crushers, & Screeners Certificate with the assessment dated 16 July 2016. Recorded on his certificate for Mobile Crushers was Factors Not Assessed (FNA) –code 8, relating to loading and unloading from a low loader. It would therefore appear that the crusher was in situ and the assessment did not include the setting up of the crusher. His Leiths training file was produced as Crown production number 1.

[39] Crown production 13 is a list of Tool Box talks arranged by Leiths and attended by Mr Kocik and Mr Morgan in the years 2015 to 2017. Crown production number 14 is a copy of the signature sheets for said toolbox talks.

[40] Crown Production number 27 is a copy of an email from witness David Bremner, Group Health and Safety Director, Leiths confirming that Mr Morgan received a toolbox talk instruction on the Guidance on Lifting Operations in Construction when Using Excavators (Crown production number 3) at Leiths' Edston Quarry in March 2013. Details of the content of said toolbox talk are not known.

[41] Leiths pled guilty by way of a contravention of the Health and Safety at Work etc. Act 1974, Sections 2(1), 2(2)(a) and (c) and 33(1)(a) in respect of the setup of the

crusher at Kishorn Quarry on 17 May 2022 at Inverness Sheriff Court on 26 October 2021. Said offence related to a failure to ensure, so far as was reasonably practicable, the health, safety and welfare of its employees, and in particular, the provision and maintenance of plant and systems of work that were so far as was reasonably practicable, safe and without risk to health, and the provision of such information, instruction, training and supervision as was necessary to ensure so far as was reasonably practicable, the health and safety at work of your employees, in that (a) there was a failure to make a suitable and sufficient assessment of the risks to the health and safety of employees to which they were exposed whilst carrying out the task of setting up the crusher for use (b) there was a failure to provide employees with such information, instruction and training as was necessary to ensure, so far as was reasonably practicable, the health and safety at work of employees engaged in the task of setting up the crusher for use, such that the said employees carried out said set up without sufficient information and instruction as to the safe method by which the said task ought to have been carried out; and (c) there was a failure to provide appropriate equipment to said employees to enable them to safely attach and detach the hooks of the chain sling to the rear panel, side panels and cross brace beam of the hopper of the crusher and to insert wedges and pins without thereby being exposed to the risk of falling from height.

Crown production number 32 is a copy of said Indictment. The Crown accepted when presenting the case on 26 October 2021 that there was not a causal link between any of the contraventions listed on the indictment and the death of Mr Kocik.

[42] The excavator was examined as part of the investigation into the death of Mr Kocik and no relevant or significant defects or deficiencies were found. The excavator and attachments were suitable for the tasks being undertaken. In addition, Leiths had employed best practice (beyond the legal standard) in the provision of fall protection and hand railing around the machine. The excavator was suitable for lifting operations and had an in date thorough examination certificate. It was being serviced and maintained in accordance with the manufacturer's recommendations. The functional integrity of the machine controls were checked and these proved to be functioning correctly, in particular the safety control lever correctly isolated both the joystick controls and the machine track motors. Crown production number 15 is the Excavator Service and Inspection Sheets for the excavator. Crown production number 23 is a report of Thorough In Service Examination of Lifting Equipment dated 8 March 2017 in relation to the excavator and Crown production number 24 is the Daily Check Sheets for the excavator. Crown production number 9 Excavator Operator Manual is a true and accurate extract of the manufacturer's manual for the excavator.

[43] Witness Peter Dodd is one of His Majesty's Inspectors of Health and Safety. He has been employed as such since 1996 and more particularly, he is a Specialist Inspector in Mechanical Engineering. Whilst working for the Health and Safety Executive he has undertaken a number of inspections and investigations that have involved mobile plant including excavators. His professional qualifications are detailed in Crown production number 4 report by Peter Dodd, HSE Specialist Mechanical Engineer which is referred to for its terms. He is as a specialist in the field of mechanical engineering.

[44] At the request of witness Mike Tetley, another of His Majesty's Inspectors of Health and Safety said Peter Dodd was asked to carry out an inspection to establish

- the functional integrity of the controls of an excavator that had been used and its suitability for lifting.
- the suitability of the arrangements to gain access to the feed hopper from the crusher access platform
- the suitability of the feed hopper to be used as a means of access and a working place for the setting up of the feed hopper sides, fitting of the cross-brace beam and the suitability of these as a safe system of work for the setting up of the crusher for use.

He visited Kishorn Quarry on 18 May 2017 and Leiths premises at Rigifa, Cove, Aberdeen on 15 June 2017 where facilities were provided for him to gain access to the rear and sides of the crusher.

[45] In relation to said inspection, said Peter Dodd subsequently compiled Crown production number 4 - report by Peter Dodd, HSE Specialist Mechanical Engineer which he entitled "The investigation of a fatal accident at Kishorn Quarry during the assembly of the feed hopper of a mobile crushing plant" and which is dated 8 January 2018.

[46] The said examination revealed that the excavator was driven and operated from a seated position in an enclosed operators cab situated at the front nearside corner of the upper structure. The upper structure was mounted on a tracked undercarriage on which it was able to rotate 360 degrees. The excavator had a hydraulically operated main boom consisting of two sections, the boom and dipper arm, which were linked end

to end. On the end of the dipper arm was a quick hitch for fitting a bucket or other attachment onto the excavator consisting of two sections, the boom and dipper arm, which were linked end to end. On the end of the dipper arm was a quick hitch for fitting a bucket or other attachment onto the excavator, in this case, a two leg chain sling. The movement of the boom and dipper arm and the rotation of the upper structure were accomplished by the operator using two joysticks, one situated to either side of their seat. The joysticks were biased so that they returned to a central off position when the operator released them. Located below the nearside joystick adjacent to the door of the cab was the control lockout lever which had to be lowered from its horizontal position to allow access in and out of the cab. The control lockout lever was interlocked with the excavator's hydraulic systems to prevent inadvertent movement when the operator was entering or exiting the cab.

[47] Said Peter Dodds supervised a number of tests with the excavator's engine running to establish whether the two joystick controls and the control lockout lever were operating as intended. He observed the following:

- With the safety-locking lever in either position there was no movement of the excavator, boom or dipper arm when the joysticks were in their central off position.
- With the safety-locking lever in the lowered position, when the operator moved the joysticks the excavator did not respond.



- With the safety-locking lever in the raised horizontal position the operator repeated the test whereupon the excavator responded to the movement of the joysticks.
- After positioning the chain sling so it was hanging vertically with its hook a short distance from the ground and the safety-locking lever in the raised horizontal position the operator momentarily knocked the nearside joystick to the left and released it. The upper structure of the excavator rotated to the left a distance of 800mm. The test was repeated a number of times with similar results.

[48] In relation to the crusher, each of the hinged sections of the rear and side walls of the feed hopper incorporated integral lifting eyes to which lifting equipment could be attached to enable them to be raised and lowered by mechanical means. At the time of inspection at Kishorn Quarry the rear and nearside wall of the feed hopper were in their raised positions. A wedge was fitted through each of the two hinges on the rear wall and a further wedge was fitted into the corner where the rear and nearside walls met. Each wedge was fitted with a short length of chain. Only the wedge in the nearside hinge of the rear wall was attached to the mobile crushing plant by means of its chain. Each wedge had a series of holes drilled through it to secure it when fitted; both wedges on the rear hinges appeared to have pins inserted through the holes, the wedge in the corner did not. The cross brace beam which was intended to span the front of the feed hopper and which would have been fitted when the rear and both side walls had been

raised and secured was lying on the floor of the feed hopper. A single leg of the two leg chain sling was connected to the front lifting eye on the nearside wall of the feed hopper.

[49] The examination established that:

- The excavator was functioning as intended for this type of mobile plant and was not itself the cause of the fatal accident occurring. (An error message which was observed on start-up of the excavator did not affect the safe operation of the excavator and was something that would normally wait to be cleared until a subsequent service).
- The control lockout lever was provided to meet the requirement of BS ISO 10968 (the relevant safety standard for Earth Moving Machinery -Operators controls) which stated that:

“The controls shall be so arranged or deactivated or guarded that they cannot be activated unintentionally – in particular when the operator is getting into or out of the operator’s station according to the manufacturer’s instructions”.

As Mr Morgan was not intending to get out of the cab he had not violated the safety function provided by the control lockout lever.

- The inadvertent operation of operator controls in excavators is widely recognised in the construction industry. It was the subject of research conducted on behalf of the Health and Safety Executive in 2014 which identified that
  - inadvertent operation of operator controls in excavators was a significant and regularly occurring issue that led to a number of fatal and serious accidents

- the inadvertent operation could be as a result of the actions of the operator and that getting into/out of the cab and loose clothing accidentally moving control levers were the most frequently mentioned accidental actions by operators.

Said Research is contained in Crown production number 10 - Health and Safety Laboratory Research Report 1000.

- The prevention of the inadvertent operation of the controls whilst leaning out of the cab would require a behavioural response by Mr Morgan firstly recognising that it could occur in these circumstances and secondly the actions which he needed to take to prevent it.
- The excavator was suitable for undertaking lifting operations and had been subject to a thorough examination and was safe to undertake such operations.
- The use of the excavator resulted in the movement of the main boom in close proximity to the feed hopper. This movement created both an impact hazard and depending on its position in relation to the feed hopper, a crushing hazard between it and the walls.
- It was foreseeable that a person working inside the feed hopper whilst the excavator was being used to raise the walls of the feed hopper would be exposed to these hazards because they would be in close proximity to the main boom as it moved. It was equally foreseeable that a collision between the main boom and a person would result in serious or fatal injuries.

- A safe system of work to lift the hinged sections of the walls of the feed hopper and lift and fit the cross brace beam which eliminated the need for a person to work in the feed hopper was not in place.
- A person working in the feed hopper was exposed to the hazard of falling from height when they accessed the feed hopper, when any of the three hinged walls of the feed hopper was in their lowered position because of the resulting low height which they could fall over, and, because of the opening in the floor of the feed hopper below which was the crushing chamber and which involved a drop of 2 metres.
- It would have been reasonably practicable to undertake all the work associated with raising the walls from a safe place outside the feed hopper such as the work platform of a mobile elevating work platform.

[50] Paul Niemi, Area Quarry Manager, Leiths stated that whilst waiting for the ambulance to arrive on 17 May 2017 he noticed that a cone crusher was running about 20 metres south of the crusher where the accident occurred. He walked over and stopped it because (a) it was making a noise and (b) it should not be left running unattended. He further states that the mobile crushing team have a generic risk assessment template. This document is then reviewed by the quarry management team in conjunction with the mobile crushing team to make site specific. This current document for Kishorn Quarry is reference ORA 109KN. This now forms Crown production number 19 - Operations Risk Assessment ORA109K. There is also a Method

statement and Risk Assessment document (Crown production number 19) which is again a generic document and made site specific.

[51] Robert Chalmers, crushing plant operator, Leiths stated that in about October 2016 he had been involved in the preparation for transport of a sister crusher to the incident crusher from the quarry face at North Lasts Quarry to the plant workshop at Cove for repairs. He had received training for the daily operation of the crusher but as he recalls, that did not include the setting up and disassembly of the crusher. He prepared a risk assessment for the task which now forms Crown production number 25. He lowered the feeder sides and removed the spreader bar from transport off site without assistance using an excavator with a two leg chain sling attached to the quick hitch. He positioned the excavator on the excavator platform (a rock pad) which allowed access to the wedges without the use of a ladder. He states that to remove the wedges, you first have to remove a locating bolt which is just dropped through a hole in the wedge. It was his experience that mostly the wedges are loose and do not have to be hammered out. When the crusher returned to the quarry after repair, he once again utilised the platform (rock pad) for reassembly of the feeder sides. The spreader required a second man to steady and guide it in.

[52] Kevin Sargeant, Quarries Operations Manager, Leiths, stated that he was in the site office at Kishorn Quarry on 17 May 2017 when suddenly the door burst open. Mr Morgan came into the office and shouted "You better come quick, there has been a serious accident". Said Kevin Sargent ran behind Mr Morgan towards the crusher that they were working on to see what had happened. Just as he got out the door

Mr Morgan said "with Pav". Between the office and the crusher Mr Morgan also said something about a bolt on the floor which Kevin Sargent did not understand at the time. Later that day he was having a chat with Mr Morgan. He told him what had happened. He told Kevin Sargent that he had shouted to Mr Kocik to tell him that the bolt for the wedge was on the floor. He said that Mr Kocik didn't hear him so he leaned out of the excavator to shout to him to tell him where the bolt was and caught the joystick and realised what happened, he released the lever and shouted to Mr Kocik "Are you alright?" and all he could hear was mumbling and that is when he came to the office.

[53] Stuart Williamson, machine operator, Leiths stated that on 17 May 2017 he arrived at the crusher after the emergency services had arrived. It was suggested that he should go to the canteen and speak and be with Mr Morgan because it would be better if a work colleague sat with him to make him feel comfortable rather than management. He had two cups of coffee and Mr Morgan was physically shaking while he was with him. Said Stuart Williamson worked with Mr Kocik in Sconser in October and November 2016 and again on 27 March 2017. He was of the opinion that Mr Kocik was "a good one". He was always willing to help.

[54] The following produced photographs were particularly relevant to the Inquiry:

- Crown Production number 5 - Edited Book of Photographs taken on 17 May 2017 by witness Norman Johannes Schouten. Photographs 5-8, 10, 18 and 19 show the excavator and crusher in their post-accident positions.

Photograph 9 shows the interior of the cab of the excavator and in particular the red safety control lever and black joystick.

- Crown Production number 8 - Photographs taken by Mike Tetley. These photographs contain images of the crusher and excavator in their post-accident positions, the cab of the excavator and the view therefrom, the side and rear panels of the feeder of the crusher and general views of Kishorn Quarry.
- Crown Production number 56 - Book of Photographs taken on 17 May 2017 by Jodi Busby, Scene of Crime Examiner, Scottish Police Services Authority.

The following photographs are of note:

- Photographs 1-3 General photographs of site showing location of Volvo Excavator and Nordberg crusher.
- Photographs 4-7 General views of the crusher.
- Photograph No 9 View of crusher showing metal panel on left hand side in the “down” position with metal wedge hanging down by a chain.
- Photograph No 10 View showing end (front) panel in the “up” position.
- Photograph No 11 View of crusher showing end and right hand side panels in the “up” position.
- Photograph No 12 Close view showing panel on right hand side in the “up” position
- Photograph No 24 View within crusher showing arm of excavator and mallet in corner of crusher below.
- Photograph No 25 Close view showing arm of excavator.

- Photograph No 26 Close view of mallet within crusher.
- Photograph No 27 General view of Volvo excavator
- Photograph No 30 Further general view of Volvo excavator
- Crown production number 57 - Book of Photographs taken on 17 May 2017 by Jodi Busby, Scene of Crime Examiner, Scottish Police Services Authority.

The following photographs are of note:

- Photograph No 31 View showing cab unit of Volvo excavator.
- Photograph No 32 General view within cab.
- Photograph No 33 Close view showing red lever on left hand side of seat.
- Photographs No's 34 and 35 Views within cab showing instruments.
- Photograph No 36 View taken inside cab looking towards crusher
- Crown production number 58 is a series of photographs showing the changes made by Leiths to said crusher after the death of Pawel Kocik.

[55] The document entitled 'Guidance on Lifting Operations in Construction when Using Excavators' was published by the Construction Plant-hire Association in May 2008. The version in place on 17 May 2017 was the 2<sup>nd</sup> edition published in March 2009. Crown production number 3 is a copy of said Guidance. The document entitled "Guidance on Reducing the Unintended Movement of Plant and Managing Exposure to Consequential risks" was published by the Construction Plant-hire Association in August 2017. Crown production number 26 is a copy of said Guidance.



[56] Immediately following the fatal accident involving Mr Kocik the two Nordberg jaw crushers operated by Leiths were taken out of service. Leiths ultimately decided to redesign and re-engineer the sides of the hopper and they are now fixed in place with no folding mechanism. This has added to the stability of the hopper structure to the extent that the cross beam is no longer required. The changes still allow for transportation of the crushers to site via public roads on a low loader. The changes can be seen in the photographs contained in Crown production number 58.

[57] Leiths also introduced an 'authorisation to proceed' process for all workers visiting quarry sites. They will only receive authorisation to proceed from the site manager once all the appropriate risk assessments and method statements have been completed and approved.

[58] As a further precaution Leiths are in the process of fitting their excavators with an additional red warning beacon to alert other workers as to when the lock out control lever is not engaged. Other workers must remain outside the reach of the excavator boom at all times when the red beacon is flashing. Other workers can only approach once the red beacon has stopped flashing. This will only happen once the operator has applied the lock out control lever and immobilised the machine. The excavator operator will then signal for the other workers to approach.

[59] On 1 December 2017 Brian Sullivan, Plant Scheme Manager at MP Skills sent an e-mail alerting plant trainers and assessors to the "Guidance on Lifting Operations in Construction when using Excavators", the Health and Safety Laboratory Research

Report 1000 and asking them to address and record that the machine isolation must be made on the approach of persons and during periods of resting.

[60] On 30 June 2022 MP Awards wrote a letter to the Health and Safety Investigation Unit at Crown Office. Said letter details the actions taken by MPQC following said email from Brian Sullivan. A random sample of “Competency Checklists” conducted in January and February 2018 identified that assessors were recording the information requested in said email. In addition, A Toolbox Talk “MPQC Excavator 360 Pre-Inspection Toolbox Talk Trainers Notes” was published in September 2018 on the MPQC website.

## **The evidence**

### *Evidence of Joseph Daniel Morgan*

[61] Mr Morgan stated that he was 55 years old, having been born on 2 July 1967. He currently works for Leiths (Scotland) Limited. He stated that he had been a work colleague of Pawel Kocik and had been working with him on the morning of 17 May 2017 at Kishorn quarry, near Lochcarron. At that time, Mr Morgan had been a plant operator for 18 years. He was working on the mobile crushing team. He had worked for Leiths on and off and had been back working for them for about three years at the time of the incident. He gave some detail as to his employment history. He explained that he is employed as an excavator operator. In May 2017, he was also employed as an excavator operator. He worked with the mobile crushing squad. They moved from quarry to quarry. He had never been to Kishorn quarry before. He was referred to

Crown production 56, photograph 5, and confirmed that the machine in the photograph was the mobile rock crushing machine which he and Mr Kocik were working on 17 May 2017.

[62] Mr Morgan described the operation of the crushing machine. He confirmed that it had been manufactured in 1997. It crushes boulders into smaller rocks. The boulders enter through a feed chamber, pass through crushing jaws and on to a conveyor belt.

Looking at the photograph, the feed hopper is on the right-hand side and the discharge conveyor belt is on the left-hand side. He explained that although the crusher can move under its own power on the tracks attached to it, it is moved between sites on a low

loader. Side panels on the feed hopper had to be lowered for transport at that time. The photograph shows the crusher sitting on a concrete pad. It would have been moved to the quarry floor prior to operation. The concrete pad provided good flat ground with

plenty of room to get the machine set up before operation. At the time, Mr Morgan was using an excavator. He is the only regular user of that excavator. He was referred to Crown production 56, photograph 30, and confirmed that the excavator shown in the

photograph is the one that he was using on 17 May 2017. The excavator is also shown in Crown production 57, photograph 31. Mr Morgan explained that it is a tract excavator.

The door visible in photograph 31 is the only access door in and out of the cab. The yellow rails are to aid access. The red lever is the safety control lever. He was referred to the following photograph, photograph 32, and confirmed that it shows the operator seat of the excavator, the two joystick controls and the red safety lever. The right-hand joystick lifts the boom and the jib up and down. The left-hand joystick slews the

excavator left and right and moves it forwards and backwards. He was referred to photograph 33 which shows the safety control lever in greater details. He explained that if the operator wants to climb out of the excavator the safety control lever must be moved into the down position which disables the joysticks. The safety control lever is lifted into a horizontal position while the machine is working.

[63] Mr Morgan explained that he assisted Mr Kocik in getting his job with Leiths. They had worked together for about a year. They were good friends. Mr Kocik was employed to drive a loading shovel. Mr Morgan explained that he used the excavator to feed boulders in to the crushing machine and Mr Kocik used the loading shovel to take the crushed rocks away. He explained that when the mobile crushing machine was in operation it was just the two of them who worked at the machine.

[64] He explained that he had arrived at the site the day before. The mobile crusher had not yet arrived. He was given an induction by one of the quarry staff, Donald Gillies. Mr Kocik arrived the next day. They spent the night in the same hotel and socialised together. That was not unusual.

[65] On 17 May 2017, the mobile crusher and other equipment for the team arrived with the staff to operate it. Mr Kocik and another member of the team were given their site induction. Mr Morgan was starting to raise the sides on the feed hopper of the crusher to get it ready for operation. The team had something to eat together for breakfast. They did not discuss Mr Kocik helping Mr Morgan with the crusher. Mr Morgan did not recall discussing that the evening before with Mr Kocik either.

[66] He stated that he began raising the sides of the feeder hopper. He had done the rear panel. There was a ladder propped up against the back. The chains were connected and he lifted one of the sides with the excavator. He explained that steps take you up on to a platform on the crusher and then it is necessary to walk along the feeder system to put the locking pins into place. He had lifted the left, nearside, panel into place.

Mr Kocik arrived. Mr Morgan stated that he was about to come out of the excavator to put the pins in when Mr Kocik indicated that he would do it. This was by hand communication. He indicated to Mr Morgan that he would do the task that Mr Morgan was about to do. Mr Morgan stated that as Mr Kocik approached, Mr Morgan did not engage the safety control lever on the excavator. The excavator was holding up the side of the feeder hopper. The excavator was at rest until the wedge and the retaining pin were in place.

[67] Mr Morgan was referred to Crown production 8, photograph 4, and confirmed that this showed a view out of the cab of the excavator. He explained that he was leaning forward so that he could see Mr Kocik's whole body. Mr Kocik was standing in the hopper facing Mr Morgan. Mr Kocik had to lean out over the panel to fit the wedge. The wedge is shown in Crown production 8, photograph 8. The triangular piece of metal is the wedge. A pin is then inserted through the wedge to keep it in place. The wedge and the pins were lying on the feeder floor inside the hopper during transport.

[68] Mr Morgan stated that he shouted to Mr Kocik to put the pin in to hold the wedge in place. He communicated this by shouting and by giving hand signals.

Mr Kocik gestured that he could not hear Mr Morgan. Mr Morgan stated that he leaned

out of the excavator door, but as he did so the left-hand joystick was moved and this resulted in the excavator moving and the boom of the excavator hitting Mr Kocik. He saw Mr Kocik stumble down on to the floor of the feeder.

[69] Mr Morgan stated that he had done this task with Mr Kocik before. He thought that Mr Kocik had forgotten to put the pin in on that occasion. That was why he had shouted at him to remind him to do so. He stated that he did not engage the safety control lever when he leaned out of the excavator door.

[70] Mr Morgan was referred to Crown production 56, photograph 4, and confirmed that the steps and gantry of the crusher were visible. The rear panel was raised, the right-hand side was down. He stated that photograph 5 showed the left-hand panel which was the one that he was holding up with the excavator. He went on to confirm that once all three sides had been raised, a crossbeam was placed across the front to stop the pressure of the boulders being fed into the machine bursting the sides. The crossbeam had been transported in the hopper. Once the rear panel, both sides and the crossbeam were in place the crusher would be ready for operation.

[71] Mr Morgan indicated that he had set up the crusher on a large number of occasions. He thought that this was the second time that Mr Kocik had helped him to do so. When Mr Kocik helped the first time that had been at the quarry they had just been at. Mr Morgan had raised the sides and was up a ladder. Mr Kocik handed up tools to tighten the bolts. Mr Morgan accepted that he may have told the police and the Health and Safety Executive that Mr Kocik had helped three times in the past. He was unclear

as to exactly how often it had been. He confirmed that stripping the crushing machine down was simply a reverse of the operation to build it up.

[72] Mr Morgan confirmed that he is an assessed operator by MPQC for crushers and screeners. He confirmed that MPQC do training for the quarry industry. He confirmed that he might have undergone an MPQC assessment on 16 July 2016. He stated that he was not assessed in loading and unloading the crusher from the low loader. He explained that the low loader operator usually takes care of that operation himself.

[73] He did not remember any training from MPQC in relation to setting up the crusher. The last crusher operator before him had showed him how to do it and then he did it the way the previous operator did. That operator was moving on to a different machine when Mr Morgan took over his job. He stated that he had never seen any company documentation in relation to setting up the crusher. At that time, Leiths had two crushers of the same type. He could not remember ever doing a risk assessment for the setting up of the crusher.

[74] Mr Morgan stated that he was qualified to use the excavator and had the appropriate tickets. He stated that at that time when people approached the excavator, he would normally put the control lever down and turn the engine revs down to make it easier to speak to them. He explained that on 17 May 2017 everything happened so quickly and it slipped his mind to use the safety control lever. He accepted that when he spoke to Mike Tetley from the Health and Safety Executive he had been of the view that the safety control lever was to be used when leaving the machine. Since the incident, he now uses it if people are approaching next to the machine. He said it was not common

for him to use the lever at the time of the incident if people approached the machine. He was referred to Crown production 3, Guidance on Lifting Operations in Construction when using Excavators, and stated that he was not familiar with the guidance at the time of the incident but that he is familiar with it now. He stated that as he leaned out of the door the cuff of his sleeve or a pocket of his overalls must have caught the joystick. He immediately moved the joystick back as soon as he realised what had happened.

[75] It was put to Mr Morgan that he had attended a toolbox talk in March 2013 in relation to the guidance but he did not remember that training. He accepted that if there was a record of him being on such training then he must have been. Whatever the content of the training may have been, the use of the safety control lever was not something that he was particularly aware of. Since the incident there are a lot more toolbox talks and core meetings. He said that health and safety was being drummed into the staff more and more just now.

[76] Mr Morgan explained that the two crushers owned and operated by Leiths have now been modified. The newer crushers have hydraulic rams which raise and lower the hopper sides with levers to operate them at a height which means you can stand on the ground. It is now a one person job. He was referred to Crown production 58 and confirmed that the photographs show the crusher in its current, modified condition. The side panels are welded in place and at a height that the crusher can still be moved by low loader.



[77] In concluding his evidence in chief, Mr Morgan stated that Mr Kocik was a really good friend. He will never forget him. If he was able to turn back time the incident would not happen.

[78] In cross-examination Mr Morgan accepted that he and his colleagues travelled between locations in a van provided by Leiths. There is now a folder of risk assessments and protocols in the van. It was not there at the time of the incident. He accepted that he may have told the police that there was a folder in the van but at the time he did not know what was in it.

[79] He stated that toolbox talks were frequently held. The one in relation to using excavators as cranes was just one part of a lot of training. He described his MPQC qualifications. He confirmed that he is qualified to operate both excavators and loading shovels. He advised that the training included looking at the safety and dangers of the respective machine and teaching the operator the safest way to operate the machine. The MPQC assessor also watches while the operator uses the machine. He was referred to Crown production 11, MPQC Plant Operator Competency Assessment Record. He accepted that this related to his assessment in relation to the use of an excavator. He explained that that particular excavator was very similar to the one he was using in May 2017, but was slightly smaller. He did not recall being given a copy of his assessment checklist. He was taken through the terms of the form and accepted that paragraph (g) in the second section relating to start up procedures related to disengaging the hydraulic safety control device. He explained that the hydraulic safety control device was the red safety control lever he had described earlier in his evidence.

He explained that he had been assessed by MPQC at least three times prior to the incident. He did not recall that training ever indicating that he should use the safety control lever when someone approached the machine.

[80] He stated that if he had thought that Mr Kocik did not know how to carry out the job they were doing, he would have told him. Mr Kocik volunteered to help.

Mr Morgan assumed that he knew what he was doing. They had worked together, and stayed together, for approximately 12 months. If he did not know how to do something he would have asked Mr Morgan.

[81] He confirmed that the previous crusher operator, David Shaw, had showed him how to set up the crusher. This was on-the-job training. Mr Morgan understood how to set up and take down the crusher by the time he had started working on it.

[82] At the time of the incident on 17 May 2017 he was waiting for Mr Kocik to put in the wedge and the pin, disconnect the chain and then he would have moved the boom of the excavator clear to lift the other side. While he was waiting for Mr Kocik to do that, the excavator was at rest.

[83] Mr Morgan indicated that he had taken the initiative to set up the crusher. It was a preparatory step that required to be taken before they could start work. Another member of the team, Mr Gaston, was working nearby and could have helped Mr Morgan if Mr Kocik had not. Mr Morgan could not remember taking a multiple choice health and safety questionnaire on the same day as the MPQC assessment and getting 20 out of 20.

[84] In re-examination, Mr Morgan indicated that Mr Gaston had been working on another crusher right next to where Mr Morgan and Mr Kocik were working.

Mr Morgan had been on his own when Mr Kocik arrived and offered to help him.

*Evidence of Michael John Tetley*

[85] Mr Tetley advised that his full name is Michael John Tetley. He is 59 years old.

He is employed by the Health and Safety Executive as a specialist inspector of quarries, based at Bootle. This is within the energy section of the Health and Safety Executive.

He explained that he has spent 31 years as an HSE inspector, always regulating quarries, in various sections of the HSE. The quarries unit has been within the energy division for the last four years. His qualifications for being a specialist inspector of quarries include holding the Statutory Quarry Manager Employment Requirements. He has experience of explosives and has been a member of the Institute of Quarrying for 35 years and is also a member of the Explosives Engineers trade body. He has many years' experience as a regulatory inspector with involvement in accident investigation, the provision of advice to employers, the investigation of complaints etc. Since June 2022, he has been acting as the principal inspector of quarries.

[86] Mr Tetley confirmed that he was the reporting inspector in relation to the death of Pawel Kocik. He confirmed that he had visited the site at Kishorn quarry. He noted statements from various witnesses. He instructed that his colleague, Peter Dodds, specialist inspector in mechanical engineering, should be instructed to provide a report.

[87] Mr Tetley was referred to Crown production 46 and confirmed that this was a report prepared by him. He was taken to paragraph 4 of that report and explained the statutory management regime required in quarries. He was further referred to paragraph 6 of his report detailing the mobile crushers operated by Leiths. He confirmed that photograph 3 contained in paragraph 7 of his report shows the crusher involved in the fatal incident relating to Mr Kocik. He confirmed that paragraphs 8 to 13 of his report describe the raising of the panels on the feed hopper of the mobile crusher. He explained that photograph 4 in his report had been taken by him to show the locking pin through the steel wedge. This photograph shows the rear plate, which he understood had been raised first. He went on to state that photograph 2 in his report shows the rear of the crusher, as seen from the excavator cab. The grid across the front window of the excavator is to protect the window, and occupant, from falling objects.

[88] Mr Tetley went on to describe photograph 5 in his report, which shows the nearside panel which was in the process of being raised during the incident. He described a bracket, which is pivoted on a lower bolt and swings in once raised. It is then wedged in place and the wedge pinned so that it cannot come out during the crusher operation. He stated that photograph 6 shows the wedge, as viewed from the inside of the feed hopper.

[89] Mr Tetley went on to describe the crossbeam, which would be the final element to be put in place when the hopper sides were raised. He estimated that the crossbeam alone weighs around 800kg and is normally transported in the bottom of the feeder hopper.

[90] He stated that photograph 7 shows a general view, with the wedge in place for the right top corner. The closest side is down. A handrail can be seen in the bottom left. This is the access platform to the crushing platform. The access platform is to observe the machine and to provide access for maintenance.

[91] Mr Tetley confirmed that paragraphs 11 and 12 of his report narrate what he understood happened in the course of the incident, as a result of his investigations.

[92] He referred to paragraph 20 and confirmed that the crossbeam had been in the feed hopper for transportation, as per the manufacturers' instructions, necessarily requiring access to the feed hopper to raise or lower the hopper sides prior to and after operation. He reiterated that the crossbeam in particular was a very substantial and robust piece of metal which would necessarily require to be lifted by mechanical means, namely some form of lifting appliance. In the current situation, the lifting appliance was the excavator operated by Mr Morgan.

[93] Mr Tetley was then referred to the analysis section of his report and read out the first paragraph. He confirmed that MPQC is the recognised training and awarding body for the quarry industry. He explained that the organisation had had various names over the years. He indicated that it would not be appropriate for the same body to set standards and also to train and award qualifications. Accordingly, there are "walls" or barriers within the organisation. He stated that MP Awards sets standards and MP Skills is responsible for the training of operators.

[94] Mr Tetley referred to Mr Morgan's training records and noted that he had not been assessed in loading and unloading of the mobile crusher. He confirmed that this

made sense, as assessments were likely to be carried out when the crusher was in position at a quarry, rather than being moved between sites. He accepted that it might very well be the operator of the low loader who was primarily responsible for loading and unloading the crusher from the low loader.

[95] Mr Tetley confirmed that newer crushers than the one involved in the incident generally have hydraulic rams that push the feeder sides in to position. However, they still have a cross brace that needs to be lifted and manually fitted in place.

[96] Mr Tetley confirmed that EPIC was one of the old names for MPQC. That organisation provided accredited training on quarry risk assessment etc. In paragraph 4 of his analysis, he described the in-house training with Leiths. This provided general guidance with nothing directly specific to the manner of the accident. He referred to stand down days, taking a full day out of operations to provide training away from the pressures of operations. This provides more in depth training than a toolbox talk and shows commitment by the employers. He stated that the quarry industry is recognised as a high hazard environment. It is important to remind employees that safety is a core value and also to have a good system of near miss reporting. It is essential to know about near misses in order to avoid "hits". He considered this was a good element of any health and safety management system by an employer. It was his view that Leiths had a commitment to health and safety. He explained that he has dealt with that particular company for a number of years and, indeed, has known some of their employees and managers for close to 30 years. He considered the company to be very committed to health and safety.

[97] Mr Tetley went on to describe toolbox talks, and in particular the toolbox talk provide to Mr Morgan, which he noted was two years prior to the incident. That is relevant because, in his experience, after that passage of time it is difficult for employees to retain safety information. He accepted that this was something of a self-considered arbitrary period on his part.

[98] He was referred to paragraph 13 in relation to the toolbox talk on the use of excavators. He explained that a toolbox talk is not accredited training. It is a refresher of formal training. It is also a phrase that can mean different things to different people. It could be a 20-minute chat or a 2 hour formal presentation. In the course of his investigations, Mr Tetley had been unable to establish the content of the toolbox talk provided to Mr Morgan in relation to excavators. Mr Tetley recommended that it was important not just to record the provision of a toolbox talk, but also the duration, format and what topics had been covered.

[99] The incident occurred four years after the toolbox talks. Staff memory could well have started to drop off.

[100] Mr Tetley accepted that it was fairly rare for people to approach excavators in operation in a quarry setting. Excavators are usually working lifting rocks at the rock face with no one around, unlike the situation in construction work where it is much more common for operators of excavators to have other persons in close proximity, for instance digging a trench. He went on to explain that there are not many lifting operations carried out in aggregate quarries. He thought that most of Leiths' quarries were aggregate quarries, but he had not been to them all.

[101] Mr Tetley was referred back to paragraph 6 of his report and noted that there was nothing in relation to the lifting of the hopper sides specifically. He found no formal record of training in relation to that. He confirmed that he would not consider “cascade” training or “on the job” training as being formal accredited training.

[102] Mr Tetley read out paragraph 7 of his report and confirmed that the incident was not a willful act by Mr Morgan.

[103] In paragraph 8 he referred to the operator’s manual of the excavator, which refers to the operator leaving his seat and activating the safety control lever. Mr Morgan was not leaving his seat, he was leaning out of the side of the door. Mr Tetley considered that the MPQC training in place did not appear to address and record the correct use of the safety control lever. He explained that when the safety control lever is up, with reference to photograph 8 in his report, it is very difficult for the operator to get round it. To do so would have to be a willful act.

[104] He read out paragraphs 10 and 11 of his report, quoting from the operator’s manual. He confirmed in this regard that there is nothing in the manual to say that the control lever should be used when someone approaches the machine. This is certainly a weakness in the manual, in Mr Tetley’s view, although he thought the expression “deficiency” was a bit strong.

[105] In paragraph 12 of his report, Mr Tetley speculated that the HSE publication referred to might have formed the basis of the toolbox talk in 2013. Mr Tetley described slight differences between different manufacturers as to how the safety control lever looked and operated, although the basics were consistent across manufacturers. The



HSE publication specifically addresses catching clothes on the joystick controls of the excavator, very poignant given the circumstances of Mr Kocik's death.

[106] In paragraph 14 of his report, Mr Tetley referred to a report by the HSE laboratory. He explained that the background to the report was that there was a BSE standard and there was a query as to whether there could be improvements in design. The report found that inadvertent contact with machinery controls was frequent. This shows that the issue which arose in the fatal incident involving Mr Kocik is indeed a (...inaudible...) problem which had been recognised and considered.

[107] Mr Tetley was referred to Mr Morgan's assessment record, particularly in relation to the use of the safety control lever and the tick box in the assessment record. Mr Tetley queried exactly what this assessment meant. Accordingly, he made enquiries with MPQC. He made the organisation aware of the HSE laboratory report and reminded them of the HSE publication in relation to construction equipment and the approach of persons to excavators.

[108] Mr Tetley referred to paragraph 18 of his report and a number of suggestions and recommendations made by him, including that a safety bulletin could be issued by HSE to industry to increase awareness. He suggested that there was also scope to improve the detail contained in operator's handbooks, although he accepted that he had only looked at the operator's manual for the Volvo excavator involved in this particular incident. He confirmed that he was taking steps to raise awareness of these issues whenever he got the opportunity to do so. He confirmed that issues in relation to the operator's handbooks could be raised directly with the manufacturers by the machinery

suppliers. This was something which could be facilitated by the product safety team at HSE.

[109] Mr Tetley summarized the training received by Mr Kocik. He noted that he was fully trained in relation to his primary role as a front shovel operator. He had the correct accredited training for using a wheeled loading shovel. Mr Tetley had not identified any specific training in relation to acting as a “slinger” or setting up of the crusher. How to communicate with a lifter, for instance, was simply left to hand signals. Mr Tetley stated that, in his view, no accountability lay with Mr Kocik for the incident.

[110] Mr Tetley went on to consider the items of plant involved in the incident and noted that there were no inherent faults which were significant or contributory. He also noted in passing that Mr Morgan appeared to take a conscientious approach to the equipment he used. He noted that quarries are a very messy environment, yet the cab of the excavator was clean and cared for, reflecting well on Mr Morgan. Mr Tetley was of the view that the operation of raising the side panels of the feed hopper on the mobile crusher could have been done safely with a good risk assessment. He did not consider it necessary, or particularly practical, to suggest that all mobile crushers should be fitted with hydraulically operated side panels. He was aware that following the incident, Leiths were considering upgrading their two oldest mobile crushers to remove the need for the manual lifting of the hopper sides but did not know what steps had actually been taken. He was referred to Crown production 58, photographs of the crusher, and noted that it was clear that the sides and rear panel had been welded in place very securely with the result that the front cross base would no longer be needed.

[111] Mr Tetley stated that on his arrival at the Kishorn quarry he was given a good safety induction. The concrete pad where the operation was carried out was a good place to set up the crusher and certainly better than the quarry floor where the crusher would be operating. He explained that overlapping safety documents are fine so long as they are consistent and not contradictory, even if slightly less than ideal.

[112] He was referred to paragraph 40 of his report and read out the recommendation. He recognised that the setting up of the crusher, as carried out by Mr Kocik and Mr Morgan, was a two-person job so that increased the risks associated by possible communication issues and having someone close to the excavator when it was operating. He suggested that this all came back to the appropriate use of the safety control lever in the excavator.

[113] Mr Tetley noted that the operator of the sister crusher to the one involved in this incident set it up slightly differently. He constructed a rock pad around the exterior so that the operator did not require to be in the feed hopper. It would be possible to do that every time the crusher moves. It is always set up in a quarry where rock is likely to be readily available so that could be a safe system of work.

[114] In paragraph 45, Mr Tetley considered issues of working at height. Climbing in to the hopper on a regular basis was not ideal.

[115] In paragraph 48, he stated that if he had encountered this proactively, he would point the situation out for advice and improvement. He stated that it was not good to let employees think that it is ok to climb over things to gain informal access to plant.

[116] In paragraph 49, he stated that it was not necessary to enter the feed hopper to insert the wedges and pins, but noted at paragraph 50 that it was essential to enter the feed hopper to get access to the crossbeam which was transported within. Mr Tetley confirmed that, in his view, given the noise generated by the various machines which were operating, verbal communication, namely shouting, between Mr Morgan and Mr Kocik would never have been a particularly satisfactory way to communicate during the task.

[117] Mr Tetley then read out the conclusions of his report in relation to Mr Morgan and Mr Kocik. He went on to detail his conclusions in relation to Leiths and, in particular, paragraph 3 where a suitable and sufficient risk assessment should have identified a lifting operation and the relevant guidance for that which would have led to the construction guidance publication and greater emphasis on the correct use of the safety control lever. He did not identify any such written risk assessment in the identification.

[118] Mr Tetley noted, at paragraph 7 of his conclusions, that further guidance was issued three months after Mr Kocik's death. He considered that given the timescale, this guidance was coincidental and was not initiated by the circumstances surrounding Mr Kocik's death. He confirmed that the guidance was lodged as Crown production 26. He pointed out that the photograph on the front of the guidance shows the cuff of clothing catching a control lever on the left when someone is reaching for the lever on the right.

[119] Mr Tetley explained that he regularly speaks to the Institute of Quarrying and he has raised these various issues with them, at technical evenings, at CPD days and at conferences. He provided a list of the events he had attended to the procurator fiscal. However, he thinks that he has actually raised it at more than those but the list is all the events which he has recorded. He uses a PowerPoint presentation on these occasions, which he had added to his report as an appendix.

[120] In cross-examination, Mr Tetley confirmed that the report prepared by his colleague, Peter Dodds, had been prepared at his request. He confirmed that Leiths must have known about the guidance in relation to the use of excavators as they had provided some training on it. He confirmed that if a company was using an excavator for lifting operations, he would expect training to be provide in that regard.

[121] He confirmed that he had noted a statement from Mr Morgan in which Mr Morgan had said that the incident happened very quickly.

[122] Mr Tetley confirmed that he would consider a toolbox talk to be a refresher for formal training, rather than a means of raising fresh training issues. He also confirmed that Mr Morgan had been trained and assessed by MPQC. He accepted that, in addition to assessments in relation to excavators, Mr Morgan had been assessed by MPQC in relation to the use of wheeled loaders. Mr Tetley confirmed that although he had some experience of wheeled loaders as an operator, that was around 30 years ago, and while they were fitted with an emergency stop in those days he could not say with confidence whether they now were fitted with a safety control lever, in the same way as excavators.

[123] He confirmed that both he and Mr Dodds had taken the view that the MPQC training in relation to the use of excavators would concentrate on some detail on the safety control lever. This is a safety critical aspect of the operation of the machine. He confirmed that when he raised these matters with MPQC he was rather surprised by their response.

[124] Mr Tetley was unable to confirm whether or not Leiths' senior management still held certificates to operate machinery, but accepted that they may well do so and observed that a recently departed member of the Leiths' senior management team had previously been an MPQC assessor, although he did not know exactly which assessment the individual had been involved in. He took the view that MPQC seemed to have accepted that there was a lack of consistency at the time of the incident in their training in relation to the safety control lever. In light of the guidance on plant and the HSE lab study, the unintended movement of plant was a recognised issue in industry before Mr Kocik's death.

[125] In reference to his conclusions, Mr Tetley reiterated that he wanted to follow matters up with MPQC. He stated that a primary function of an HSE inspector is to fill gaps if found and to liaise with industry. He found it a relevant line of enquiry with MPQC to seek to have their procedures altered in an effort to prevent such incidents in the future by better training and assessment. In this regard, he was referred to production 28 – an email. He recalled seeing the email before, which was relevant to the current investigation. The issue of machines addressed was very pertinent to the current situation. Mr Tetley confirmed that the contents of the email went a long way to easing

his concerns over the MPQC assessment process. He hoped that the enhanced MPQC training and his awareness raising with industry will provide more knowledge in relation to this issue for the benefit of operators and to prevent a recurrence of this incident. He was aware that Leiths intended to take a number of steps after the incident but did not recall being specifically made aware of proposals to fit red warning beacons to excavators. It was put to him that red beacons had been fitted to excavators in such a way that when the safety control lever is “active” the beacon is red as a visual warning to other employees not to approach the machine. Mr Tetley indicated that he would applaud such a step. He considered this to be an example of best practice going beyond the minimum legal requirements.

[126] There was no re-examination.

### **Crown submissions**

[127] Ms Swan produced written submissions. She invited me to make formal findings in keeping with the information contained in the joint minute of agreement, the productions and the oral evidence in connection with sections 26(2)(a), 26(2)(b), 26(2)(c) and 26(2)(d) of the 2016 Act. I concur with her submissions. Ms Swan made detailed submissions in relation to sections 26(2)(e), 26(2)(f), 26(2)(g) and 26(1)(b) of the 2016 Act, with which I largely concur and will expand on my reasons for doing so below.

[128] Ms Swan expressed her sympathies and those of the Crown to Mr Kocik’s family.

**Submissions of behalf of Leiths (Scotland) Limited**

[129] Mr Donaldson likewise produced written submissions in which he largely adopted the Crown submissions. He invited me to consider reflecting the steps taken by his clients following the fatal accident, namely the addition of a red warning beacon on excavators and the modification of the crusher, both discussed further below, in my findings under section 26(2)(g) of the 2016 Act. I accept those submissions.

[130] Mr Donaldson described Mr Kocik as a hardworking and popular employee who was well thought of and is still very much missed. He took the opportunity to publically express his own and Leiths' sympathies to Mr Kocik's family and friends.

**Discussions and Conclusions**

[131] There is no great dispute as to the circumstances of Mr Kocik's tragic death. He was assisting his colleague, Mr Morgan, to prepare a mobile rock crusher for operation later that day. He was not instructed or requested to do so, but chose to do so as a conscientious worker wishing to assist a friend and colleague. There was a breakdown in communication between them which Mr Morgan tried to resolve by moving within the cab of the excavator he was controlling. In doing so he inadvertently came into contact with one of the control joysticks of the machine, causing the boom arm to move, striking Mr Kocik, as a result of which he stumbled into the feed hopper of the crusher, sustaining injuries which sadly proved fatal, despite prompt medical assistance.

[132] As with all fatal accident inquiries, in reaching my decisions in this inquiry I am able to apply the "wisdom of hindsight". Looking back at events, they can often be seen



with a degree of clarity that is simply not possible as the events are being lived. The statutory purpose of this inquiry, and the findings I am obliged to make, is to use the enhanced vision afforded by hindsight to learn for the future, in the hope of preventing a recurrence of this particular fatal accident.

[133] Looking back, it is now clear that there are a number of ways in which the accident which resulted in Mr Kocik's death might have been avoided.

[134] Firstly, the operation in which Mr Kocik and Mr Morgan were engaged is not in fact necessary. Having given the circumstances of the accident careful consideration, Leiths have now modified both of the two mobile crushers owned by them which required the hopper sides to be lowered for transport so that the sides are now fixed in place yet the machine can still be transported by road. This modification will remove the need in the future for any of Leiths employees to carry out the operation Mr Kocik was engaged in. No doubt other operators of mobile rock crushers may give consideration to similar modifications.

[135] Secondly, had those modifications not been carried out so that the operation was still necessary, a clearer instruction for carrying out the task, with associated training for operators, could and should have ensured that as part of the operations on any occasion that the excavator operator needed to move from his seat, whether to get out of the cab or simply lean out, the safety control lever should have been used to isolate and "lock" the excavator controls. Indeed, the use of the safety control lever any time someone is in close proximity to the excavator while it is idle would seem to be best practice.

[136] Thirdly, had Mr Kocik and Mr Morgan had or taken the opportunity to discuss the task in advance it may have prevented the need for them to communicate with each other during the task itself.

[137] So far as more remote factors are concerned, Mr Tetley's investigations revealed an apparent weakness in the training provided to operators in the quarrying industry by MPQC. It is to the credit of MPQC that when this issue was highlighted it was accepted and remedied. Similarly, Leiths have gone beyond minimum legal requirements in fitting red warning beacons to excavators, interlinked to the safety control lever, to provide a visual warning for anyone approaching an excavator as to the status of the safety control lever.

[138] In highlighting these learning points I must re-emphasise that while they may all appear obvious in the knowledge of how the accident involving Mr Kocik occurred, they were not necessarily so clear to the participants involved at the time. It is not the function of this inquiry to establish fault or blame and my comments should not be seen to be, or taken as, a criticism of MPQC, Leiths and certainly not Mr Morgan or Mr Kocik himself. They are simply an effort to learn something useful and positive from this tragic set of events.

[139] Mr Tetley explained in his evidence the steps he has taken to share the lessons from Mr Kocik's death with the wider quarrying industry. He also helpfully, and properly, suggested two further avenues that could be taken by the HSE to raise awareness. He explained that a Safety Bulletin Alert could be issued and that his colleagues in the Product Safety Team might liaise with the manufactures of excavators

in relation to the working of operator's manuals. I concur with both suggestions and have made recommendations on that basis, although ultimately it is a matter entirely within HSE's discretion whether to follow these recommendations.

[140] I am obliged to Ms Swan and Mr Donaldson for their careful presentation of the evidence in this inquiry and to all the participants for the assistance which their involvement gave to the inquiry. It cannot have been easy for Mr Morgan to relive the circumstances of 17 May 2017 but he did so with candor and described events to the best of his recollection. The death of his friend and colleague clearly still affects him.

[141] I also consider it appropriate to commend Mr Tetley not only for his diligent investigation into the circumstances surrounding the death of Mr Kocik and his clear and helpful evidence to this inquiry, but particularly for the steps he has proactively taken to ensure that the lessons from Mr Kocik's death are learned by those in the quarrying industry.

[142] In closing this Determination, may I join with Ms Swan and Mr Donaldson in expressing my condolences to the family and friends of Mr Kocik. He was a young family man who was clearly very well thought of by his employer and colleagues. His untimely death is no doubt still keenly felt by his family.

**Sheriff Gary Aitken**

**Inverness, 13 September 2022**