SHERIFFDOM OF TAYSIDE CENTRAL AND FIFE AT FALKIRK

[2023] FAI 10

FAL-B386-22

DETERMINATION

BY

SHERIFF SG COLLINS KC

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

into the death of

JOHN PRYDE

Falkirk, 7 February 2023

Determination

The sheriff, having considered the information presented at the inquiry, determines in terms of section 26 of the Inquiries into Fatal Accidents and Sudden Deaths etc. (Scotland) Act 2016 (hereinafter referred to as "the 2016 Act"):

1. In terms of section 26(2)(a) of the 2016 Act (when and where the death occurred): That the late John Pryde, date of birth 31 October 1955, was pronounced dead at 1410 hours on 8 February 2022 at Ward 20, Intensive Care Unit, Ninewells Hospital, Dundee.

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

That the accident resulting in death took place around 1050 hours on 7 February 2022 at an outbuilding to the rear of the domestic dwelling house at [address withheld], Cupar.

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

That the cause of death was craniocerebral injuries due to blunt force trauma.

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

Mr Pryde was a self-employed joiner, who had been contracted to remove and replace a shallow pitched roof of mixed concrete and asbestos sheets on the said outbuilding. An area of the roof collapsed while Mr Pryde was standing or walking on it and he fell around 2.5 metres onto the concrete floor below, striking the back of his head, and sustaining the injuries from which he later died.

5. 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):

It would have been a reasonable precaution for Mr Pryde to have removed the said roof from below, thus avoiding the need for him to stand or walk on it, this precaution being in accordance with publically available guidance contained in the leaflet published by the Health and Safety Executive: *Fragile Roofs – Safe Working Practices* GEI55 (November 2012).

6. 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):

It is not possible on the available evidence to determine whether there were defects in Mr Pryde's system of working or whether his death resulted from an error of judgment on his part in the particular circumstances of the present case.

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

That there are no other facts relevant to the circumstances of the death.

Recommendations

In terms of section 26(1)(b) of the 2016 Act (recommendations (if any) as to (a) the taking of reasonable precautions, (b) the making of improvements to any system of working, (c) the introduction of a system of working, (d) the taking of any other steps, which might realistically prevent other deaths in similar circumstances):

There are no recommendations made. The risks of working on roofs such as that which featured in the present case, and the precautions which can be taken to address these risks, have long been well known, and have already been addressed in the said publically available HSE guidance.

NOTE

Introduction

[1] This inquiry was held into the death of John Pryde. Mr Pryde died on 8 February 2022, following an accident at work the previous day whereby he had fallen through a fragile, mixed asbestos and concrete roof of an outbuilding of the dwelling house at

[address withheld], Cupar. The death of Mr Pryde was reported to police and to the Procurator Fiscal (hereinafter referred to as "the PF"). A preliminary hearing was held on 19 December 2022. The inquiry took place on 6 February 2023. Miss Dickie, PF Depute, represented the Crown. No other parties were present or represented.
Mr Pryde's two daughters attended the inquiry, and were given the opportunity to suggest additional questions to be put to the witnesses, and to comment on the evidence and submissions generally. Apart from one matter they had nothing which they wished to add, but I was grateful to them for their attendance in any event.

[2] The PF had prepared a substantial Notice to Admit. There were no objections to this Notice and I accepted the facts set out in it. It was based on and supported by the following productions, copies of which were available to me: (i) Mr Pryde's death certificate; (ii) a post mortem report by Dr David Saddler dated 24 February and 1 April 2022; (iii) a report by David Charnock, Health and Safety Executive, dated 28 February 2022; (iv) a copy of the HSE guidance leaflet *Fragile Roofs – Safe Working Practices* GEI55 (November 2012); (v) the police witness statements taken from (a) John Cumming, the householder of [address withheld], Cupar, (b) Julie Ronald, Consultant in Emergency Medicine, Ninewells Hospital, and (c) Stephen Waite, Core Trainee in Anaesthetics, Ninewells Hospital.

[3] In these circumstances the need for oral evidence was significantly reduced. I heard from the following two witnesses:

a. John Cumming

b. David Charnock

I am grateful to them both for their clear and helpful evidence. Mr Cumming is to be commended for his efforts to assist Mr Pryde immediately following the accident.

The legal framework

[4] This inquiry was held in terms of section 1 of the 2016 Act. Mr Pryde died in the course of his employment or occupation, and, therefore, the inquiry was a mandatory inquiry held in terms of section 2 of the 2016 Act. The inquiry was governed by the Act of Sederunt (Fatal Accident Inquiry Rules) 2017 (hereinafter "the 2017 Rules") and was an inquisitorial process. The PF represented the public interest.

[5] The purpose of the inquiry was, in terms of section 1(3) of the 2016 Act, to establish the circumstances of the death of Mr Pryde and to consider what steps (if any) might be taken to prevent other deaths in similar circumstances. It was not the purpose of the inquiry to establish civil or criminal liability (see section 1(4) of the 2016 Act). The manner in which evidence is presented to an inquiry is not restricted. Information may be presented to an inquiry in any manner and the court is entitled to reach conclusions based on that information (see Rule 4.1 of the 2017 Rules).

[6] Section 26 of the 2016 Act sets out what must be determined by the inquiry. Section 26 of the 2016 Act is in the following terms:

> "26 The sheriff's determination
>
> (1) As soon as possible after the conclusion of the evidence and submissions in an inquiry, the sheriff must make a determination setting out—
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>> (a) in relation to the death to which the inquiry relates, the sheriff's findings as to the circumstances mentioned in subsection (2), and

(b) such recommendations (if any) as to any of the matters mentioned in subsection (4) as the sheriff considers appropriate.

(2) The circumstances referred to in subsection (1)(a) are—

(a) when and where the death occurred,
(b) when and where any accident resulting in the death occurred,
(c) the cause or causes of the death,
(d) the cause or causes of any accident resulting in the death,
(e) any precautions which—

(i) could reasonably have been taken, and
(ii) had they been taken, might realistically have resulted in the death, or any accident resulting in the death, being avoided,

(f) any defects in any system of working which contributed to the death or any accident resulting in the death,

(g) any other facts which are relevant to the circumstances of the death.

(3) For the purposes of subsection (2)(e) and (f), it does not matter whether it was foreseeable before the death or accident that the death or accident might occur—
(a) if the precautions were not taken, or
(b) as the case may be, as a result of the defects.

(4) The matters referred to in subsection (1)(b) are—

(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.

(5) A recommendation under subsection (1)(b) may (but need not) be addressed to—

(a) a participant in the inquiry,
(b) a body or office-holder appearing to the sheriff to have an interest in the prevention of deaths in similar circumstances.

(6) A determination is not admissible in evidence, and may not be founded on, in any judicial proceedings of any nature.”

Facts

[7] I found the following facts admitted or proved:

a. John Pryde, born 31 October 1955, and aged 66 years, was an experienced joiner, having worked in this occupation most of his life.

b. At the time of his death Mr Pryde was self-employed, with no employees or business partners, trading under the name John Pryde Joinery.

c. Mr Pryde had extensive experience working in the construction industry, including on roofs much larger than that featuring in the present case.

d. Mr Pryde had served an apprenticeship as a joiner but it is unknown whether he had ever received any formal training in relation to working at height or the health and safety aspects thereof.

e. The house at [address withheld], Cupar, is a mid-terraced property accessible only from the front. There is an outbuilding to the rear of the back garden. This outbuilding was previously a cottage but had not been habitable for many years prior to the accident.

f. Like the back garden, the outbuilding is accessible only though the house itself. It is not possible to bring a mobile elevated work platform through the house.

g. The outbuilding is single storey structure with a shallow pitched timber beamed roof. The roof is approximately 2.4 metres high at the front eaves and 2.7 metres high at the rear peak.

h. At the time of the accident the roof was clad with a mixture of asbestos and cement corrugated roof sheets and translucent plastic sheets. These were in the region of 40 years old. Both by their construction and their age the said sheets were fragile and not load bearing.

i. The outbuilding is accessed via a single door to the front, and has a solid concrete floor.

j. The householder of [address withheld] and owner of the outbuilding is John Cumming. He is now 60 years of age, and a retired police officer of 20 years' service.

k. In around 2020 Mr Cumming applied a protective coating by brush to the roof of the outbuilding. He placed ladders and boards on the roof to distribute his weight while working on it.

l. By the end of 2021 Mr Cumming had decided to renovate the outbuilding and render it habitable for use as a studio or gym. In order to so he now wanted to remove and replace the roof.

m. The said roof sheets were attached to wooden roof beams by metal screws, driven in from above. In order to remove the roof sheets it was necessary to cut the screws. It was possible to do this from above, which would necessitate working on the roof, or from below, working from within the outbuilding.

n. Given the presence of asbestos, Mr Cumming was unsure how to remove and dispose of the roof safely. He was recommended to Mr Pryde as someone who would be able to do this work for him.

o. In around December 2021 Mr Cumming contracted with Mr Pryde to remove and replace the roof of the outbuilding. Mr Pryde subsequently attended at [address withheld] on two occasions in order to assess the work, and to take measurements in relation to the purchase of materials.

p. On no occasion did Mr Pryde discuss with Mr Cumming how he proposed to carry out the work, or what if any health or safety measures he proposed to take.

q. At around 0930 hours on 7 February 2022 Mr Pryde attended at the property. He brought timber intended for strengthening the roof construction, and had arranged for delivery of roofing tin later in the week. Mr Cumming assisted Mr Pryde to carry the timber through the house and out to the outbuilding.

r. After discussion with Mr Cumming, Mr Pryde decided to start work that day. He retrieved his tools from his vehicle. Mr Cumming went into the house to make coffee for them both.

s. As Mr Cumming was waiting for the water for the coffee to heat up he opened the curtains in a room to the rear of the house and saw Mr Pryde standing on the roof of the outbuilding, at the back right hand corner, viewed from the house.

t. Mr Pryde had not placed any supports on the roof to strengthen it or distribute his weight when walking on it. He had with him his tools, and an

access ladder was leaning against the wall at the front right hand end of the outbuilding.

u. Mr Pryde used his tools to remove some screws from one of the roof sheets.

v. Mr Cumming proceeded to open his upstairs curtains. Having done so he saw from a stair window a hole in the roof of the outbuilding.

w. This hole was 5 or 6 feet from the right hand end of the outbuilding, and 3 or 4 feet from the front eaves. It was in an area between two of the roof beams.

x. Mr Cumming ran to the outbuilding and went inside. He found Mr Pryde lying on the concrete floor, just to the right of the hole in the roof. The roof had collapsed under Mr Pryde's weight and he had fallen through.

y. Although generally fragile, the roof was strongest at its edge, along a line between the location of the ladder and the place where Mr Cumming had seen Mr Pryde standing a few moments before. It is unclear why Mr Pryde had moved off this line and onto a weaker area of the roof where the hole was located. In particular it is unclear whether he had been walking on the roof at the time, or whether he had tripped or stumbled

z. Mr Pryde's fall was not interrupted or broken by any of the contents of the outbuilding. He was found by Mr Cumming lying flat on his back on the floor, with his legs out straight and his arms at his side. Mr Pryde was unconscious. His eyes were shut. He was breathing heavily, almost like a snore. There was no apparent bleeding injury.

aa. Mr Cumming immediately phoned 999 and asked for an ambulance. He made this call at around 1053 hours.

bb. While waiting for the ambulance Mr Cumming, who had first aid training from his career as a police officer, tried to get a response from Mr Pryde. He shouted his name, pinched his ear and rubbed his knuckles on his chest. There was no response.

cc. Mr Cumming loosened Mr Pryde's clothing to check for signs of injury, but could not see any. He detected a strong pulse. He kept talking to Mr Pryde, who had begun to move his legs and rub his face, but remained unconscious.

dd. An ambulance arrived at around 1110 hours. Two ambulance technicians attended on Mr Pryde and assessed his condition. They observed that his Glasgow Coma Scale score was very low and that his pupils had unequal dilation.

ee. The ambulance technicians requested the attendance of a trauma team. On the way to the scene this team's vehicle was involved in a road traffic accident. As a result they did not reach Mr Pryde until around 1205 hours. Mr Pryde was removed to hospital at around 1225 hours.

ff. On admission to Ninewells Hospital Mr Pryde was assessed and found to have suffered a severe traumatic brain injury. He was admitted to the intensive care unit.

gg. Mr Pryde did not regain consciousness. After a multi-disciplinary discussion at consultant level it was determined that his prognosis was extremely poor and that there was no surgical option to manage his injuries.

hh. Following discussion with Mr Pryde's family a planned withdrawal of life saving treatment was initiated. Mr Pryde's life was pronounced extinct at 1410 hours on 8 February 2023 by Dr Stephen Waite.

ii. A post mortem examination of Mr Pryde was carried out by Dr David Sadler, Consultant Pathologist, on 16 February 2022. He correctly certified the cause of death as "1a. Crainiocerebral Injuries 1b. Blunt Force Trauma 1c. Fall From Height (outbuilding roof, at work)."

jj. Dr Saddler correctly identified that the injuries which Mr Pryde had sustained were typical of a backwards fall, indicating that the rear of Mr Pryde's skull had come into contact with the concrete floor of the outbuilding following the fall.

kk. On 22 February 2022 David Charnock, an investigator with the Health and Safety Executive, attended at [address withheld], spoke with Mr Cumming and with Mr Pryde's relatives, and produced a report into the circumstances of the accident.

ll. As Mr Charnock confirmed, the fragility hazard associated with asbestos cement sheet is well known in the construction industry. Falls through fragile roofs such as that in the present case are one of the biggest causes of fatal accidents in the building maintenance sector.

mm. The dangers associated with working on fragile roofs have long been well known. They are the subject of specific, free and readily available HSE guidance: *Fragile Roofs – Safe Working Practices* GEI55 (November 2012).

nn. In circumstances such as the present where use of a mobile elevated work platform was neither practically possible, nor financially proportionate to the cost of the work, Mr Pryde should, in accordance with the said Guidance, have dismantled and removed the roof from below, thereby avoiding any need to walk or stand on it. A small scaffold or platform could have been erected inside the outbuilding for the purpose of cutting the roof screws and safely lowering the concrete and asbestos sheets.

oo. Mr Cumming later removed the roof himself by this means, following discussion and advice from Mr Charnock.

Submissions

[8] The PF sought formal findings in respect of section 26(2)(a) to (d) of the 2016 Act. The findings sought were based on the uncontroversial evidence and my findings closely mirror those sought by the PF.

[9] The PF sought the following finding in relation to section 26(2)(e): that it would have been a reasonable precaution for Mr Pryde to have dismantled the fragile roof from below, and not stood on top of it, and that had he done so this might realistically have resulted in the accident which resulted in the death being avoided.

[10] As regards section 26(2)(f), the PF submitted that it would not be appropriate to consider making a finding, as it was not possible to determine whether the accident was reflective of Mr Pryde's system of working or an isolated error of judgment. Mr Pryde did not discuss with Mr Cumming his system of work, or any risk assessment which he may or may not have carried out.

[11] The PF submitted that there were no other facts which were relevant to the circumstances of the death in terms of section 26(2)(g).

[12] In the light of the evidence and proposed findings, the PF did not invite the Court to make any recommendations in terms of section 26(1)(b).

Discussion and conclusions

[13] Section 26(2)(a) of the 2016 Act (when and where the death occurred):

In this inquiry there was no dispute as regards when and where the death occurred. It is clear from the undisputed evidence that John Pryde was declared dead by Dr Stephen Waite at Ninewells Hospital, Dundee, at 1410 hours on 8 February 2022.

[14] Section 26(2)(b) of the 2016 Act (when and where any accident resulting in death occurred):

There was also no dispute as regards when and where the accident resulting in death occurred. It took place around 1050 hours on 7 February 2022 at an outbuilding to the rear of the domestic dwelling house at [address withheld].

[15] Section 26(2)(c) of the 2016 Act (the cause or causes of death):

The cause of death was clear and uncontroversial. It was due to craniocerebral injuries resulting from blunt force trauma, as certified by Dr David Saddler following post-mortem examination.

[16] Section 26(2)(d) of the 2016 Act (the cause or causes of any accident resulting in death):

Mr Pryde was a self-employed joiner, who had been contracted to remove and replace a shallow pitched roof of mixed concrete and asbestos to the said outbuilding. It is apparent that an area of the roof collapsed while Mr Pryde was standing or walking on it and he fell around 2.5 metres onto the concrete floor below, striking the back of his head, and sustaining the injuries from which he later died.

[17] 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):

It would have been a reasonable precaution for Mr Pryde to have dismantled the roof from below, in accordance with the said published HSE guidance, and as was later carried out by Mr Cumming. Had Mr Pryde done so, he would not have needed to go onto the roof at all. The roof was fragile by construction and by age. The dangers of standing or working on such roofs were well known. It was possible to cut the screws attaching the roof to the beams from below, as Mr Cumming himself later did. A small scaffold or platform could have been erected inside the outbuilding for the purpose of cutting the roof screws and safely lowering the concrete and asbestos sheets.

[18] 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):

It is not possible on the available evidence to determine whether there were defects in Mr Pryde's system of working or whether his death resulted from an error of judgment on his part in the particular circumstances of the present case. Mr Pryde did not discuss with Mr Cumming how he intended to do the work, nor did he advise him as to whether or not he had carried out a risk assessment. Mr Cumming said that Mr Pryde had cut some of the screws to one of the roof sheets very shortly prior to the accident. This might suggest that he intended to do all the work from above, but this cannot be determined with any confidence. As an experienced joiner who had worked on roofs it seems likely that Mr Pryde would have been well aware of the risks involved in doing so. It is therefore hard to know why he chose to go onto the fragile roof of Mr Cumming's outbuilding as he did. As Mr Charnock pointed out, the small scale and relatively low height of the building may have led Mr Pryde to underestimate the risk. Tragically however, and as this case shows, a fall from as little as 2.5 metres can be fatal.

[19] Section 26(2)(g) of the 2016 Act (any other facts which are relevant to the circumstances of the death):

The evidence heard at the inquiry did not identify any other factors which were relevant to the circumstances of the death.

Recommendations

[20] Section 26(1)(b) of the 2016 Act (recommendations (if any) as to (a) the taking of reasonable precautions, (b) the making of improvements to any system of working, (c) the introduction of a system of working, (d) the taking of any other steps, which might realistically prevent other deaths in similar circumstances):

The inquiry did not identify any matter which necessitated the making of a recommendation. The risks of working on roofs such as that which featured in the present case, and the precautions which can be taken to address these risks, have long been well known, and have already been addressed in the said publically available HSE guidance.

Postscript

[21] Like the PF, I offer my condolences to Mr Pryde's family in this determination.