SHERIFFDOM OF GRAMPIAN, HIGHLAND AND ISLANDS AT ELGIN

[2024] FAI 26

ELG-B90-23

DETERMINATION

BY

SHERIFF DAVID B HARVIE

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

into the death of

ERIC GRANT MCLEOD

ELGIN, 31 May 2024

Determination

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

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

The late Eric Grant McLeod, was born on 28 August 1947. His life was pronounced extinct at 1802 hours on 18 August 2020 at Dr Gray's Hospital, Elgin.

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

The accident resulting in the death took place at around 1040 hours on 18 August 2020 at Heatcare House, St Andrews Road, Lhanbryde.

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

The cause of death of the said Eric Grant McLeod was a head injury due to a fall from height while at work.

In term 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 was a fall from height after Mr McLeod lost his balance whilst using an extendable ladder atop a flat roof.

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)

Mr McLeod had not been expected by the Company to be working at height. He did so contrary to instruction. There are no precautions which could reasonably have been taken that might realistically have resulted in the death, or any accident resulting in the death, being 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 the death)

Mr McLeod's employers, Heatcare Oil and Gas Limited, did not provide suitable or sufficient monitoring or supervision throughout the period that he carried out work alone at Heatcare House. No formal system of monitoring or supervision was in place. An adequate system of supervision and monitoring would in all likelihood have identified and prevented that work, given the number of days over which Mr McLeod must have been working at height prior to the accident.

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

The Company did not provide work at height training to Mr McLeod, which training might have discouraged Mr McLeod from using a ladder to paint at height.

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

a) The Company should ensure that it maintains an adequate, risk assessed and documented system to monitor and supervise all of its employees who engage in lone working.

b) The Company should ensure that all of its employees who engage in trade and maintenance work receive work at height training.

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, by a Notice under section 17(3) of the 2016 Act, as a mandatory inquiry in terms of section 2(3) of the 2016 Act, namely that Mr McLeod died as a result of an accident in the course of his employment or occupation.

[2] The purpose of this inquiry as set out in section 3 of the 2016 Act, is 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. An inquiry is an exercise in fact finding, not fault finding. It is not open to me to engage in speculation. An 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 from the death occurred, the cause or causes of 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 me to make recommendations in relation to the matters set out in subsection 4 of section 1 of the 2016 Act.

Introduction

[4] This inquiry was held into the death of Eric Grant McLeod, hereinafter referred to as Mr McLeod, who died aged 72 years, having been born on 28 August 1947. He is survived by his wife, Mrs Catherine Anne McLeod.

[5] Mr McLeod died at 1802 on 18 August 2020 at Dr Gray's hospital, Elgin, having fallen from a ladder that morning at Heatcare House, St Andrew's Road, Lhanbryde.

[6] Mr McLeod was employed as a part time painter and decorator by Heatcare Oil and Gas Limited ("the Company") from 2015 onwards.

[7] Ms Fraser, Procurator Fiscal Depute, represented the Crown, Mr Cahill, solicitor, represented the Company. No other parties were represented.

[8] Preliminary Hearings were held by Webex at Elgin Sheriff Court on 8 September and 12 October 2023. A Rule 3.7 Note was lodged on behalf of the Company which stated that it was likely to be disputed whether there was a defect in the system of work and whether the Company could have taken a reasonable precaution which could have prevented the death. At the Preliminary Hearing on 8 September, the Company made clear that it would be challenging whether Mr McLeod had been working for the Company on that particular day. The Company position was that Mr McLeod had been

working in violation of an order from a Director and that works at the property had ceased on 4 August 2020.

[9] The inquiry proceeded in person at Elgin Sheriff Court with evidence over four days between 23 November 2023 and 1 March 2024 inclusive, one scheduled day in January having been lost due to adverse weather conditions affecting solicitors' travel. As a result of discussions between parties and the court on 23 November, Mr McLeod's wife, Mrs Catherine McLeod, was added to the original list of Crown witnesses and gave evidence on 13 December 2023. Submissions were heard on 26 April 2024. Parties lodged a joint minute of agreement on 23 November 2023. I accepted the facts set out in the joint minute of agreement. The majority of the findings in fact are drawn from the joint minute of agreement.

[10] The Crown lodged an inventory of productions, which are reflected in findings in fact at paragraphs 23 to 36.

[11] The Crown led evidence from eight witnesses

a) Gemma McBean (eyewitness)

b) Peter Deeming (eyewitness)

c) Andrew Craig (painter and former Heatcare employee)

d) Christopher Jack (supervisor/employee with Heatcare)

e) Mrs Catherine McLeod (spouse)

f) Callum McCombie (Director of Heatcare)

g) Darren McLeod (Director of Heatcare)

h) Norman Schouten (HSE Inspector)

[12] The Company did not lead evidence.

The facts

[13] Eric Grant McLeod was born on 28 August 1947.

[14] Mr McLeod was as an experienced painter and decorator who had worked in that trade most of his adult life. Having retired after over thirty years with the Stewart Milne group, he was employed on a part time basis by the Company from 2015 until his death.

[15] Mr McLeod is survived by his wife, Mrs Catherine Anne McLeod.

[16] Mr McLeod died at Dr Gray's Hospital, Elgin. His life was formally pronounced extinct at 1802 hours on 18 August 2020. He was 72 years old.

[17] The cause of death was as a result of a head injury sustained after a fall from height. Mr McLeod was working as a painter and decorator and was painting the vacant, former offices of his employer, Heatcare Oil and Gas Limited at Heatcare House, St Andrew's Road, Lhanbryde, IV30 8PO.

[18] Mr McLeod's role was on an ad hoc basis. He was not given set hours each week, but rather was allocated jobs by his nephew Darren McLeod, a director at the Company, or by one of the Company supervisors, Christopher Jack.

[19] Darren McLeod led on the job at Heatcare House and it was he who instructed Mr McLeod to carry out the work.

[20] The Company are now located at Mansefield House, Land Street, Keith AB55 5AW.

[21] Heatcare House is a two storey building with bilateral single storey flat roofed extensions. The flat roofs have parapet walls to the front and side. The flat roofs are approximately three metres high and the parapet walls are thirty centimetres high.

[22] Mr McLeod was using a three stage ladder to paint the exterior of the building and a second step ladder on which to balance a pot of paint. Mr McLeod had climbed the ladder which had been placed on top of one of the single storey flat roof extensions to reach the right hand gable end, when he lost his balance and fell onto the flat roof of the extension, striking his head on the parapet wall.

[23] Crown Production number 1 comprises a book of 21 photographs taken on 19 August 2020 by Norman Schouten, HM Inspector of Health and Safety and in particular:

i) Photographs 1 to 9 were taken in the compound of Elgin Police Station and are photographs of the step ladder involved in the incident used to balance a pot of paint.

j) Photographs 10 to 21 were taken at Heatcare House, St Andrew's Road, Lhanbryde.

k) Photographs 10 and 11 show the right hand side of the front of Heatcare House. The gutters and downpipes have been freshly painted, as has the front wall elevation up to eaves height.

l) Photograph 12 shows the front of the chimney on the right. Fresh paint may be seen.

m) Photograph 13 shows the right hand gable from the front looking at some wiring.

n) Photograph 14 shows the gable side on with visible fresh paint, including under the eaves and the gable side of the chimney breast.

o) Photographs 15 and 16 show the ladders used by Mr McLeod which were recovered lying on the ground beside the property.

p) Photograph 17 shows apparent blood visible on the parapet wall on the right hand side flat roof extension.

q) Photograph 18 shows the flat roof adjacent to the parapet wall with apparent blood visible on the ground.

r) Photograph 19 shows the flat roof adjacent to the gable end.

s) Photograph 20 shows the flat roof looking back to the point where photographs 18 and 19 were taken.

t) Photograph 21 shows the three stage ladder used by Mr McLeod.

[24] Crown Production number 2 comprises a book of 13 photographs taken on 18 August 2020 by Scene Examiner Mathew Clark at 1409 hours on 18 August 2020.

[25] Crown Production number 3 comprises a copy of email correspondence sent from Darren McLeod, Director of the said Company and nephew of Mr Eric McLeod, to Norman Schouten, HM Inspector of Health and Safety.

[26] Crown Production number 4 comprises a copy of a job sheet provided by the Company to Mr McLeod relating to the painting work to be undertaken at Heatcare House on 15 May 2020.

[27] Crown Production number 5 comprises a copy of a job card completed by Mr McLeod and submitted to the Company in relation to painting work undertaken at Heatcare House.

[28] Crown Production number 6 comprises an "Epix" computer screen printout held by said Company showing the job allocation of the work to be undertaken by Mr McLeod, a description of the work to be carried out and the date by which the work was to be completed.

[29] Crown Production number 9 comprises a copy of email correspondence sent from Darren McLeod to Normand Schouten relating to said "Epic" computer screen printouts.

[30] Crown Production number 11 comprises the post mortem report authored by Doctor Leighanne Margaret Deboys, Consultant Forensic Pathologist.

[31] Crown Production number 12 comprises the Final post Mortem conclusion report authored by said Doctor Deboys.

[32] Crown Production number 13 comprises a copy of the Standard Operating Procedures regarding work at height provided by said Company.

[33] Crown Production number 14 comprises a copy of the Health and Safety Executive Guidelines for Safe use of Ladders and Step Ladders.

[34] Crown Production number 15 comprises a copy of the Health and Safety Executive Guidelines on Protecting Lone Workers, How to manage risks of working alone.

[35] Crown Production number 16 comprises job cards completed by Mr McLeod in respect of maintenance works at other properties, including in Elgin and Lossiemouth on 17 August 2020.

[36] Crown Production 17 comprises purchase orders for paint materials required for the job at Heatcare House.

[37] That the witness statements of the Crown witnesses Andrew James Robert Craig, Christopher Alister Jack, Shaun Dale Strachan, Dr Andrew John Morrison Hay, Dr Gavin Tunnard, Grant James Douglas Thomson, Jacqueline Elizabeth Gault, Robert Wild Goose, Mathew Wakefield Clarke, should be treated as their parole evidence.

[38] The parties lodged statements provided to HSE and Police Scotland by Norman Schouten, Gemma McBean, Peter Deeming, Catherine McLeod, Darren McLeod and Calum McCombie.

[39] Heatcare Oil and Gas Limited is a private limited company established in 2000, which provides all trades property maintenance and repair services, primarily for housing associations in Aberdeenshire, Moray and Highland region. The Company has its registered office at 6/7 Queens Terrace, Aberdeen AB10 1XL, with their office address being Mansfield House, Land Street, Keith. The former premises for said Company was Heatcare House, St Andrew's Road, Lhanbryde IV30 8PO. The said Company employs 83 people.

[40] The Company issues employees with an electronic PDA containing the "Epix" software programme which provides the instructions for the work to be undertaken

along with the appropriate health and safety guidance to be followed when undertaking said work. Employees have been directed by the Company to read health and safety guidance and acknowledge that they have read and understood the guidance before undertaking any work.

[41] Mr McLeod did not have a PDA or access to the Epix system. Mr McLeod was not monitored in the same way as other Company employees, nor did he have access to the same health and safety guidance on the PDA as other Company employees.

[42] Mr McLeod often worked alone and unsupervised. He used his own van. The Company did not know when Mr McLeod arrived at or left a job.

[43] No risk assessment was carried out by the Company for working at height and no method statement or construction phase plan was drawn up for Mr McLeod painting Heatcare House, as he was not instructed to be working at height. Mr McLeod did not have a company vehicle with tracking technology and on the date of his death, was working alone.

[44] Mr McLeod was not provided with work at height training by the Company. He was not comfortable working at height.

[45] No Mobile Elevating Work Platform (MEWP), scaffolding or third party contractor was ever arranged by the Company to carry out external painting at height at Heatcare House.

[46] Painting the entire interior and exterior of Heatcare House would have taken up to five weeks for a solo painter and required an estimated 70 litres of paint.

[47] Mr McLeod was instructed to do the work by Darren McLeod on 15 May 2020, when the two men walked round Heatcare House together, discussing the job. Mr McLeod was told to fit the work around other maintenance jobs he would be allocated on behalf of the Company at various locations.

[48] Mr McLeod submitted job cards for his work at Heatcare House over ten days, 18 to 22 and 25 to 29 May 2020 and was paid for that work.

[49] The external masonry paint, which had been ordered when the job was allocated to Mr McLeod, was delivered on 18 June 2020.

[50] Christopher Jack marked the job at Heatcare House as complete on the Epix system on 23 June 2020.

[51] Mr McLeod did not submit any other work cards for the exterior part of the job. No work cards for the exterior works have ever been found. Mr McLeod was not paid for the work he did at Heatcare House after 29 May 2020.

[52] On 17 August 2020, Mr McLeod carried out maintenance jobs in Elgin and Lossiemouth on behalf of the Company.

[53] On 17 August 2020, Christopher Jack and Mr McLeod spoke by phone. Christopher Jack told Mr McLeod that there were no other maintenance jobs that week.

[54] On the morning of 18 August 2020, Mr McLeod told his wife, Catherine McLeod, that he was going to carry out further painting at Heatcare House.

[55] The incident which caused the fatal injuries to Mr McLeod occurred at around 1040 hours on 18 August 2020 at the former premises of said Company at Heatcare House, St Andrew's Road, Lhanbryde, IV30 8PO.

[56] By 18 August 2020, the exterior works were largely complete, including all of the lower wall areas, all of the guttering, the downpipes and most of the wall areas at height.

[57] Mr McLeod had been working alone at height over several days, the details of which remain unknown.

[58] Mr McLeod's work at Heatcare House was not inspected or supervised by the Company between 15 May and 10 July and thereafter between 10 July and 18 August, all 2020.

[59] On 4 August 2020 Darren McLeod zero charged the job at Heatcare House on the Epix system, which meant that no further work could be added to the job.
Darren McLeod did not enquire whether Mr McLeod was owed further payment for his work at Heatcare House, nor did he inspect the work, before zero charging the job.

[60] In a police statement given at 1242 on 18 August 2020 at Dr Gray's Hospital, Elgin, Darren McLeod stated *inter alia* that Mr McLeod had "been told not to paint at high places on the outside" and "not to worry about the gables, just to leave them".

[61] Mr McLeod was not required to paint the roof and the gable end. He should not have been using a three stage ladder to access the chimney breast and the roof.

[62] The three stage ladder was not secured, but Mr McLeod did not fall because said ladder was not secured.

[63] There was no defect in the ladder which contributed to the incident.

[64] No edge protection was installed on the flat roof.

[65] Immediately following the incident, the emergency services were contacted by Gemma McBean. The Police Service of Scotland, the Scottish Ambulance Service and the Scottish Fire and Rescue Service arrived in response. Paramedics from the Scottish Ambulance Service arrived on the scene and attended Mr McLeod while he lay in situ on the flat roof. He was removed from the flat roof by paramedics with the assistance of the Scottish Fire and Rescue Service and taken to Dr Gray's Hospital, Elgin to be stabilised, prior to being transferred by ambulance to Aberdeen. At Dr Gray's Hospital, a CT scan revealed that Mr McLeod had sustained unsurvivable head injuries whereupon palliative treatment was provided until his death was pronounced at 1802 hours that day.

[66] Norman Schouten, Health and Safety Inspector, met with Darren McLeod and Calum McCombie, both directors of the Company, at Heatcare House on 19 August and again on 26 August 2020. During the meetings, neither Director said that the job had been closed two weeks earlier, nor that Mr McLeod should not have been at Heatcare House on 18 August 2020.

[67] On 26 August a post mortem examination was carried out by Doctor Leighanne Margaret Deboys, consultant Forensic Pathologist. The cause of death was certified as 1a) Head injury. 1b) Due to a fall from height.

The evidence

[68] The Crown and the Company entered into a joint minute of agreement which was tendered to the court on 23 November 2023. For reasons which I will explain, I

emphasise now that the parties are bound by those agreed facts. In particular, the Crown is bound by its agreement that there was no risk assessment, construction phase plan or method statement for the painting of Heatcare House, as Mr McLeod was not instructed to be working at height and that Mr McLeod was not required to paint the roof and the gable end.

[69] The conduct of both Gemma McBean and Peter Deeming is to be commended. Both were members of the public who were passing by Heatcare House at the time of the accident and both reacted swiftly in seeking to assist Mr McLeod and call for the emergency services to attend. Had they not been in the vicinity, Mr McLeod would likely have lain unaided for some considerable time.

[70] Mr Deeming noted whilst passing the site earlier in the morning that Mr McLeod was using a pole with a roller to paint a wall, which he remembered thinking at the time was quite a safe way of carrying out the task.

[71] Mrs Catherine McLeod, Mr McLeod's wife, was an entirely credible and reliable witness. She and Mr McLeod were married for over thirty years. After retiring from Stewart Milne group aged 67, he had agreed to help out his nephew Darren McLeod at Heatcare Oil and Gas Limited on a part time basis. On the morning of 18 August 2020, her husband had been in good spirits. She had no concerns about his health. He had no ongoing health issues following stents being inserted whilst he was in his 60's. He said he had work to do at Heatcare House. It had started as a "rush job", as the Company had had interest from potential tenants. Mr McLeod had been asked to paint inside and out. She did not know if he had been told to paint the entire exterior. He had described

it as a "big job". He had done a lot of the work, but it was no longer a rush and he had been asked to fit completion around other jobs. She recalled hearing that her husband and Darren McLeod had a telephone conversation in which there was discussion about hiring scaffolding or a cherry picker/MEWP. Mr McLeod did not think Darren McLeod was keen on hiring any equipment. At no stage had her husband raised any concerns with her about the job at Heatcare House. He had never been keen on ladders and would not wash the windows at home or agree to do a job at height for his brother. She did not expect her husband to be working at height that day. After her husband's death, Darren McLeod had come round to pick up outstanding job cards. There were no June, July or August cards for the job at Heatcare House. The Company paid for the work shown on the cards after Mr McLeod died.

[72] Calum McCombie, one of the Company Directors, was not a reliable witness. His recollection was inconsistent and often contradictory. His evidence was peppered with qualifications such as probably, would have, imagine and believe. Much of that arose from his efforts to recall what Darren McLeod had told him and, equally crucially, when he had been told. Mr McCombie did not commission Mr McLeod to do the work at Heatcare House, which fell within Darren McLeod's geographic area of responsibility within the Company. Calum McCombie, Darren McLeod and Shaun Strachan, a now former Director, held a de-brief prior to meeting with Norman Schouten on 26 August 2020. No record was kept. Mr McCombie was able to provide a helpful description of the Epix system, in particular the use of screens in the headquarters from which one could see the real time locations of the Company vehicles, enabling the Company to

track employee whereabouts and, in his words, to see when everyone was safely home. Mr McLeod was the only lone working tradesman employed by the Company who had neither a PDA nor a works vehicle with tracking system. The Company required Mr McLeod to use the work card system which had been in place prior to the introduction of the Epix system. There had been no formal risk assessment prior to making this exception. To a large extent, Mr McCombie had been reliant on Darren McLeod to manage the job at Heatcare House, which he accepted was a bigger job than the maintenance work normally carried out by the Company. Mr McCombie's evidence added little other than serving to undermine the later evidence of Darren McLeod, leaving the impression that Darren McLeod's position regarding Eric McLeod's death had evolved over time.

[73] Darren McLeod, another Company Director, was not a compelling witness. On some key points, he was neither credible nor reliable. Mr McLeod was Darren McLeod's uncle. He confirmed that no attempt had been made to train Mr McLeod on the use of Epix that the Company had not provided him with work at height training and that enough paint had been ordered to paint the entire interior and exterior of Heatcare House. He confirmed that he took the lead in respect of the job at Heatcare House and liaised directly with Mr McLeod, rather than through a supervisor. He was the job supervisor. Despite the initial urgency given the potential of tenants for an empty building at a time when the Company was considering redundancies due to Covid, he said that he did not have a plan as to how the painting at height was to be completed. He had not made enquiries regarding a third party contractor, a MEWP or scaffolding,

nor had he sought to support Mr McLeod with an apprentice or the Company's other painter, Andrew Craig. He had "held off" doing a risk assessment or method statement for the work at height, but said it should have been done. Mr McLeod had been furloughed for two weeks in June, prior to the arrival of the masonry paint. During the occasion he visited Heatcare House on 10 July 2020, the interior painting was complete, but to his recollection the exterior work had not begun. He said Mr McLeod told him the lower part of the exterior was complete at the end of July. He did not go to inspect the work. He did not know that exterior work at height had been completed by Mr McLeod until he attended on the day of the accident. By then, the entire building, bar the chimney breast and upper gable at one end, had been done. His evidence was that he had told Mr McLeod during the week of 27 July 2020 that no further work was to be carried out at Heatcare House. He said that on 1 August 2020 he had again told Mr McLeod that no further work was to be carried out at Heatcare House. He had used "sharp" words. He said that he closed the job on the Epix system on 4 August 2020, which meant that no further work could be added to the job. Prior to closing the job, he had not thought about whether Mr McLeod was due any further payment for his work, nor had he inspected the work at Heatcare House. To the extent that his evidence is consistent with the statements he gave to the police on 18 August 2020 and HSE on 26 August 2020, I accept the evidence he gave in court that he told Mr McLeod on 15 May 2020 not to work at height and later told him, most likely on 1 August 2020, not to paint the gables. The statement does not mention the term "roller height" which was a significant feature in the evidence of both directors. In his police statement,

Darren McLeod stated, "It's almost like a side job for him (Mr McLeod), and there's no rota or anything to track his work there." In the absence of independent evidence, I am not satisfied on the balance of probabilities that Darren McLeod instructed Mr McLeod to stop working at Heatcare House during the week of 27 July 2020 or during a conversation said to have taken place between the two on 1 August 2020. Further, as evidence by his email to Norman Schouten the HSE Inspector dated 28 August 2020, production number 3, Darren McLeod "zero charged" the job on 4 August 2020. It had already been closed on the system by Christopher Jack on 23 June 2020, prior to Darren McLeod attending at Heatcare House on 10 July 2020.

[74] Christopher Jack, a Company Supervisor, was a hesitant, unimpressive witness. In court he said that he had spoken to Mr McLeod on the Monday prior to the accident and told him the Company had no work for him that week. He had not expected Mr McLeod to do any work for the Company that week. This contrasts with his HSE statement, in which he stated only that he told Mr McLeod that there was no "maintenance" work. Mr McLeod had been asked to fit the work at Heatcare House around maintenance jobs, which generated income for the Company. I do not accept Mr Jack's evidence in court that he told Mr McLeod that there was no work for him that week or his evidence that he had not expected Mr McLeod to be working for the Company that week. More generally, he described the health and safety information on the Epix system as standard and that you do not need to read it. He had never had a job like the one at Heatcare House, both in terms of number of days or the heights involved. He had never seen Mr McLeod work at height. He had never seen a company risk

assessment for any job, despite being with the Company for nine years, including as a supervisor. He had collected the interior paint for the job and delivered it to Heatcare House on 15 May 2020. Despite his role as a supervisor, he was unclear about what had been discussed with Mr McLeod, emphasising that Darren McLeod had led on the job at Heatcare House, albeit the Epix record showed that Mr Jack had closed the job on the system on 23 June 2020.

[75] Andrew Craig, a painter who worked for the Company at the relevant time, was an excellent witness, who gave great assistance to the court regarding the nature and extent of the task at Heatcare House, the likely timescales to complete the job, the appropriate methodology involving a MEWP or scaffold and the quantity of materials which would be required. He was familiar with Heatcare House and estimated it would take a lone painter and decorator five weeks to complete the entire interior and exterior. In his experience, ladders were used for inspecting or for access, not for working at height.

[76] Mr Schouten is a Health and Safety Inspector with five years' experience, prior to which he practised as a medical doctor. He holds a post graduate Diploma in Regulatory Health and Safety. He attended at Heatcare House on 19 August 2020 and had taken some photographs of the scene and equipment. He classed the work Mr McLeod had been doing as painting at height, for which he regarded the three stage ladder as not appropriate, largely because of the time required at height to complete such a task and also because it was being carried out by a lone worker over a period of days. A MEWP or a scaffold should have been used. Barriers should have been

installed at the top of the flat roof. For a period of at least six weeks between the start of July and 18 August 2020 the Company had no knowledge of the work Mr McLeod was doing at Heatcare House. Six weeks was too long in respect of any lone working employee. He would have expected a lone worker on such a task to be supervised with a weekly site inspection and regular phone calls about progress with the work. He thought that had such monitoring and supervision taken place, it was possible that the Company could have stopped Mr McLeod from working at height at an earlier stage. He met with the Directors, Darren McLeod and Calum McCombie, on 19 August and thereafter on 26 August 2020. The Directors advised him that Mr McLeod had been instructed not to work at height, but neither expressed any surprise that Mr McLeod was at the site during either meeting. Neither said Mr McLeod should not have been working for the Company that day. Neither said that the job had been closed on 4 August 2020. When he had received the email from Darren McLeod highlighting that the job had been zero charged on 4 August 2020, he had not appreciated the significance which the Directors would place on that record during the Inquiry. He opined that it is not safe to work on a flat roof without further control measures as a person may fall from an unprotected edge. Whilst he thought that the Epix system was good, it did not replace the need for supervision. In any event, Mr McLeod did not have access to the Epix system. The Company did not know when Mr McLeod was at work or what he was doing. No system was in place for Mr McLeod to inform the Company that he was working at Heatcare House. Mr Schouten had been unable to ascertain the extent of Mr McLeod's career health and safety training. Mr McLeod would have benefitted from

work at height training on how and when to use ladders to inform how he carried out his work. The Company had not provided such training to Mr McLeod. He said that whilst Health and Safety Regulations may have required a risk assessment, construction phase plan and method statement to be in place, if he had conducted an inspection at the Company, assuming Mr McLeod had been told not to work at height, he would not have expected to see such paperwork. Mr Schouten was asked by Mr Cahill for his opinion, were the court to make certain findings in fact, which are set out in more detail at paragraph 98 below. Mr Schouten opined that were Mr McLeod working at height contrary to an instruction, then he would be in breach of his duties as an employee under section 7(1)(a) of the 1974 Act. Mr Schouten further opined that were he working at Heatcare House having been told there was no work to do there, Mr McLeod would in those circumstances be in breach of section 7(1)(b) of the Act.

Submissions

[77] Both the Crown and the Company provided written submissions in advance of the hearing on submissions, for which I am grateful.

Crown submissions

[78] The Procurator Fiscal submitted that the court should make findings under sections 26(2)(a) to (d) per the joint minute of agreement tendered to the court on 23 November 2023.

[79] The Procurator Fiscal then posited two scenarios on the basis of her recollection of the evidence and invited the court to determine which it preferred:

u) The position advanced by the Company, that Mr McLeod had been instructed to paint the interior and lower half of the exterior of Heatcare House, to "roller height", fitting the job around other work instructed by the Company. The job had been shut down on 4 August 2020 following a disagreement between Darren McLeod and Mr McLeod on 1 August 2020. Darren McLeod had made it clear that no more work was to be carried out at Heatcare House and that, for reasons known only to himself, Mr McLeod had returned to Heatcare House and completed the exterior painting, in the face of an instruction and not being remunerated for his work as the job had been closed.

Or alternatively,

v) Mrs McLeod had discussed the job with her husband, said that he was to paint the entire exterior of Heatcare House and that he was to fit that around other work for the Company. Mr McLeod was in possession of sufficient external paint to cover the entire building, including the guttering which had already been painted at height as at the time of his death. Heatcare had made no inquiries to instruct any third party contractor to carry out the work at height, erect scaffolding or hire a MEWP, nor had the Company's other painter, Andrew Craig, been booked to assist. Mr McLeod had been left with no viable option other than to paint the exterior alone, which he had

> clearly been doing for some time given the guttering and downpipes had been freshly painted along with the majority of the upper parts of the building. Mr McLeod had required to use the three stage ladder to reach the high sections as no alternative had been provided. The Company had not produced a construction phase plan showing what the safe method of completing the task was to be.

The Crown invited the court to find that the Directors were not credible and reliable witnesses and submitted that, on the balance of probabilities, the evidence supported the second scenario.

[80] Regardless of scenario a) or b), the Crown invited a finding that there had been a lack of suitable and sufficient supervision of Mr McLeod which could reasonably have been taken and might realistically have resulted in the death or the accident leading to the death, being avoided. It was submitted that in terms of section 26(2)(e), a reasonable precaution would have been to supervise Mr McLeod in the same way as other employees by using the Epix system and a company vehicle fitted with a tracker. The Epix system drew employee attention to the health and safety considerations for the task. It kept track of employee locations and when tasks were complete. But for passers-by witnessing the fall, Mr McLeod may have lain unnoticed for an unknown period. Even accepting the Company scenario, whereby Mr McLeod had carried out work he was expressly instructed not to do, that itself might have been detected at an earlier stage had Mr McLeod been on the Epix system and his unauthorised unsafe work practices intercepted.

[81] The Crown invited the court to find under section 26(2)(f) that, irrespective of the status of the employee, if there is a safe system of work in place to supervise and monitor lone working employees this should apply to all employees. During his investigation, Mr Schouten had accepted that Mr McLeod was not expected to be working at height on 18 August 2020. Mr Schouten had identified that use of the three stage ladder to carry out a job at height of this nature and duration was not a safe system of working. A construction phase plan should have been drawn up, albeit the Crown accepted that, Mr Schouten's evidence had been that no plan was required. HSE guidelines on working at height should be adhered to and employees should be provided with a MEWP or scaffolding platform to enable access to the area in a safe manner. Had Mr McLeod been supervised in the same way as other Heatcare employees, his use of a ladder to work at height might have been identified at an earlier stage and the accident prevented.

[82] The Crown volunteered that if the court found that Mr McLeod had acted of his own volition, his actions could be characterised as unexpected and therefore not forming part of any system of working.

[83] In its written submissions, the Crown did not invite the court to make any findings under section 26(2) (g), however, during oral submissions, the Procurator Fiscal submitted that the court may consider findings regarding the lack of lone worker supervision in the context of a safe system of work as being relevant to the circumstances of the death, if it was not satisfied that Mr McLeod ought to have been working at Heatcare House on the day he died.

Submissions on behalf of Heatcare Oil and Gas Limited

[84] On behalf of the Company, it was accepted that the Crown's submissions on findings under sections 26(2)(a) to (d) were well founded.

[85] The foundations of the submission on behalf of the Company, were that-

w) Mr McLeod was expressly told not to do more work at Heatcare House. The Company did not expect him to be there as the job had been closed on 4 August 2020.

x) As agreed in the joint minute, Mr McLeod was instructed to paint Heatcare House both inside and out, but limited by an instruction not to work at height, which meant that he was not to use a ladder.

[86] Mr Cahill submitted that there were no precautions in terms of section 26(2)(e) by act or omission of the Company which might realistically have resulted in the death, or any accident resulting in the death being avoided, nor in terms of section 26(2)(f) were there any defects in any system of working which contributed to the death or the accident.

[87] It was accepted by the Company that there were potential shortcomings in the way they had monitored Mr McLeod when he was carrying out work at Heatcare House. Darren McLeod had accepted that he had not been to Heatcare House between 10 July and 18 August 2020. The Company did not know when Mr McLeod was working at the property between 10 and 27 July. It was accepted that the Company ought to have ingathered Mr McLeod's job cards and inspected the work at Heatcare House prior to the job being zero charged. However, it was submitted that it could not

be said that the shortcomings contributed to the death or any accident resulting in the death in terms of section 26(2)(f). Darren McLeod had instructed Mr McLeod to cease work at Heatcare House during the week of 27 July and again on 1 August 2020. Mr McLeod should not have been working at Heatcare House the day he died. He had done so contrary to instruction. In those circumstances there were no precautions which could reasonably have been taken to avoid the accident, nor any system defects which had contributed to it.

[88] It was accepted that were the court to have concerns about Darren McLeod's evidence, the Company recognised that there had been no attendance at Heatcare House to supervise or monitor Mr McLeod's work and that the Company was not aware of the extent of work which had been completed at the property.

[89] Mr Schouten was not concerned by the absence of a written risk assessment, construction phase report or method statement, given that Mr McLeod had been instructed not to work at height. Indeed, the Crown had entered into a joint minute, the terms of which set out that no such documentation had been prepared, as Mr McLeod had been instructed not to work at height.

[90] No recommendations were advanced on behalf of the Company.

[91] Mr McLeod was not on the Company Epix system as it was said that he would not be able to use the device and the application. The Company had made an allowance for him to be employed and had used an alternative system, in keeping with the Company's previous paper based system where Mr McLeod would be allocated work by Christopher Jack or Darren McLeod.

[92] A risk assessment had been carried out by Darren McLeod during a site visit with Mr McLeod on 15 May 2020. No risks were identified to complete the work, so no written report was prepared. The job was raised on the Epix system that same day and paint was ordered. Work was to commence on 18 May for ten days. Darren McLeod next visited Heatcare House on 10 July 2020 to issue PPE. He noted that the internal works were complete, but that the external works had not been started. Darren McLeod's evidence was that Mr McLeod was told not to carry out any further work at the property during the week of 27 July. He had been advised by Mr McLeod that the lower exterior work had been completed and told him to leave the high level work. This instruction had been repeated during a face to face encounter on 1 August 2020 when the two were watching a football match on television. Darren McLeod had zero charged the job on 4 August 2020, which meant that no further work could be done on the job. The Company was entitled to expect that no other painting works would be carried out by Mr McLeod.

[93] It was submitted that Darren McLeod should be accepted as a credible and reliable witness, supported by the parole evidence of Calum McCombie, Christopher Jack, Andrew Craig and the contemporaneous entries on the Epix system. There was no direct evidence which contradicted the Company's position that Mr McLeod had been instructed not to work at height at the property and that he had been expressly told during the week beginning 27 July and on 1 August 2020 to stop all work at the property.

[94] It was acknowledged that there were available sources from which contrary inferences might be drawn, such as the quantity of paint which had been ordered to complete the entire building, the fact that Mr McLeod had been working at height on 18 August 2020 and that photographs produced in evidence showed that by that date the property had already been painted at areas that would have required work at height. In the context of supervision, the court was invited to accept that there ought to be some recognition of the Covid-19 pandemic which prevailed at the time and the consequent other demands on Darren McLeod.

[95] It was accepted that there were problems with Calum McCombie's reliability, so where accounts differed, Darren McLeod's evidence should be preferred.

[96] In discussion, it was accepted during their meetings with Norman Schouten on 19 and 26 August 2020, neither director had expressed any surprise that Mr McLeod was working at the site, nor had they told Mr Schouten that the job had been closed on the Epix system two weeks earlier.

[97] The Company disputed the Crown's submissions regarding Mrs McLeod's evidence. When asked by the Procurator Fiscal Depute, Mrs McLeod had said she could not recall if her husband said that he had been told to paint all of the exterior of Heatcare House.

[98] The Crown had entered into a joint minute tendered to the court on 23 November 2023. It could not depart from those agreed facts at this stage. In particular, the Crown had agreed as fact that no risk assessment, method statement, or construction phase plan had been drawn up for Mr McLeod painting Heatcare House, as

he was not instructed to work at height. The Crown had also agreed as fact that Mr McLeod was not required to paint the roof and the gable end, nor should he have been using a 3 stage ladder to access the chimney breast and the roof. The inquiry had been conducted by the Company on the basis that those facts were agreed.

[99] The court was invited to find that based on the available evidence, on balance, the following had been established as fact:

y) At some point during the week beginning 27 July 2020 Eric McLeod was informed by Darren McLeod on behalf of the Company that there was no further work to be carried out at Heatcare House.

z) On 1 August 2020 Eric McLeod was expressly told by Darren McLeod that there was to be no further work carried out at Heatcare House.

aa) On 4 August 2020 Darren McLeod closed the job at Heatcare House on the Epix system, which meant that no further work could have been added to the job.

bb) On Monday 17 August 2020 Christopher Jack, supervisor for the Company, informed Eric McLeod that there was no work for him that weekend and, in response, Mr McLeod stated that he would be doing work for a neighbour (not on the instruction of the Company).

[100] The proposed findings had been put to the HSE Inspector Norman Schouten and he had offered the view that, if accepted by the court, Mr McLeod would have been in breach of his duties under section 7(a) and (b) of the Health and Safety at Work etc Act 1974 on 18 August 2020, that there was nothing the Company ought to have done on

the morning of 18 August 2020 in relation to Mr McLeod and that the Company would not have been in breach of section 2 of the 1974 Act.

[101] The Company submitted that there was no reasonable precaution which it might have taken that might realistically have resulted in the death, or any accident resulting in the death being avoided. Any such precaution required to be something more than a remote, fanciful or notional possibility that, if taken, might have prevented the death. Reference was made to the Scottish Government's Policy Memorandum which accompanied the Fatal Accidents and Sudden Deaths (Scotland) Bill at paragraphs 178 and 179, which it was submitted was intended to address the concerns expressed by Sheriff Ruxton in her 2014 determination into the death of Kathryn Beattie. It was submitted that the word "realistically" should be given its ordinary meaning and required an assessment if the practicability of alternative options. Reference was also made to *Re D* 2008 1 WLR 1499 regarding the evidential standard in the context of serious allegations such as had been advanced by the Crown regarding the alleged instruction to paint the entire building, which ran contrary to the terms of the joint minute.

[102] The Company accepted shortcomings in relation to supervision from 10 July 2020. The Company acknowledged that they did not know the exact dates when Mr McLeod was working at the property prior to the instruction said to have been given to him to cease work at the property during the week of 27 July 2020. It was submitted that was not relevant to a question of whether there was a defect in the system of work under section 26(2)(f), as the Company was entitled to rely on the express instruction to

cease work. Even if Mr McLeod had been operating the Epix system, no other work at the property could have been issued after the job was closed. Given the instruction by Christopher Jack, there would have been no work recorded on the Epix system for monitoring purposes.

[103] Given the concessions made by the Company, it was accepted that, even if the court found that Mr McLeod had been instructed not to do any more work at Heatcare House, a finding under section 26(2)(g) in relation to there being a lack of a system of work in place to monitor Mr McLeod as a lone worker at Heatcare House between 10 July and 18 August was open to the court.

Discussion

[104] There is no doubt that, tragically, Mr McLeod fell from a ladder having lost his balance whilst painting the chimney stack and gable end at Heatcare House on 18 August 2020.

[105] What is unusual about this case, brought by the Crown as a mandatory inquiry following a death at work and notwithstanding parties agreement of a detailed joint minute, is the extent to which there remain disputes about what the employee was instructed to do by his employer at the start of the job, whether he was later instructed not to carry out any further work on the job and indeed, even whether he was working for his employer on the day he died.

[106] Per the joint minute, the Crown and the Company agreed that Mr McLeod was working as a painter and decorator and was painting the vacant company premises at

Heatcare House in Lhanbryde, that he was not instructed to be working at height and that he was not required to paint the roof and the gable end at the premises.

[107] Mr McLeod had been told that the Company had potential tenants for Heatcare House and that there was an urgency to the work. Notwithstanding the apparent importance of that business opportunity, especially in the context of the prevailing impact of the Covid pandemic and the pressure on potential redundancies, there is no company record specifying the work required, no method statement as to how it was to be carried out, in particular in relation to work at height, the anticipated timescales, nor is there a written risk assessment either for the job at Heatcare House, or for Mr McLeod being tasked to work alone despite his not having access to the Epix system or any vehicle tracker.

[108] Mr McLeod was a hugely experienced painter and decorator who may well have received training on working at height during the course of his many years of previous employment with a large building company. There is no evidence that he received such training from Heatcare Oil and Gas Limited between joining the Company in 2015 and his death in 2020, despite such training being made available to other employees in 2018.

[109] Notwithstanding the absence of training, his health and that he was not on the Epix system, Mr McLeod was regularly instructed to work alone. On such occasions, the Company did not know when Mr McLeod arrived at a job, or when he left a job, until Mr McLeod submitted a work card seeking payment. There was no fixed pattern for submission of the job cards, as evidenced by the cards collected from Mrs McLeod after the accident, which clearly do not include any of the many days when Mr McLeod must

have been working alone painting the exterior of Heatcare House. It appears that these cards simply do not exist. Days, indeed weeks, passed and the Company was oblivious about the extent of Mr McLeod's work on the exterior at Heatcare House.

[110] Mr McLeod did not work fixed hours or days. He was given work on an ad hoc basis. He was not provided with a work vehicle. He was not provided with a PDA, so did not have access to the Epix system which provided employee location details to the Company and employees with health and safety information. There was no evidence that the Company provided any health and safety information to Mr McLeod. Work cards were processed retrospectively and intermittently. In almost every sense of the word, particularly in relation to the job at Heatcare House, the Company's approach to employing Mr McLeod can be characterised as "casual".

[111] An entry on the Epix system shows that the job at Heatcare House was zero charged on 4 August 2020 by Darren McLeod. The job was zero charged even although Darren McLeod knew that his uncle had carried out substantial painting work at the site for which he had not submitted work cards.

[112] That Darren McLeod did not tell either the police on 18 August, or Mr Schouten on 19 or 26 August 2020, either that the job had been closed or that he had told his Uncle Eric not to do any more work at Heatcare House on at least two occasions, is a real concern to the court in assessing his credibility.

[113] The shifting positions adopted by Mr McCombie simply serve to further undermine the courts confidence in Darren McLeod's evidence. For example, I can see no mention of the term "roller height" in either Directors witness statements, yet it was

used regularly by both in evidence. When pressed, Mr McLeod was not able to explain clearly what the term meant.

[114] The joint minute was tendered before the court heard evidence from either director. In submissions, the Crown sought to distance itself from its terms, particularly those parts in which it had agreed that Mr McLeod was not instructed to be working at height and that he was not required to paint the roof and the gable end.

[115] The Company was entitled to prepare for and conduct the Inquiry on the basis of the facts which had been agreed.

[116] I do not accept the Crown submission regarding Mrs McLeod's evidence about Mr McLeod being instructed to paint the entire exterior of Heatcare House. That is not what she said. Her answer to the Procurator Fiscal Depute's question was that she did not know if her husband had been asked to paint all of the exterior.

[117] Whilst I understand why the Crown may have wished to distance itself from the terms of the joint minute having heard from the Company Directors, on the balance of probabilities, I would, in any event, have found that Mr McLeod was not instructed to be working at height and that he was not required to paint the roof and the gable end. I do so largely because that position is consistent with the statement Darren McLeod gave to the police within a couple of hours of the accident. I find the embellishments since then less convincing.

[118] Mr McLeod should not have been working at height that tragic day. Per the joint minute, I find that he was not instructed to work at height and was not required to paint the roof and the gable end. The joint minute also says that the Company did not carry

out a risk assessment for working at height and no method statement or construction phase plan drawn up for Mr McLeod painting Heatcare House, as he was not instructed to be working at height. In other words, it is accepted in the joint minute that the Company did not expect Mr McLeod to be working at height and that a written assessment, statement and plan were not expected to be in place. That is consistent with the HSE position set out by Mr Schouten. I make no finding or recommendation regarding the absence of said documentation.

[119] The use of a ladder was not suitable for the extended periods required to complete the painting at height over several days. The HSE guidance on the Safe Use of Ladders and Stepladders states that, as a guide, if the task would require staying up a leaning ladder or step ladder form more than 30 minutes at a time, it is recommended that consideration be given to alternative equipment. The work at height at Heatcare House required either a MEWP or scaffold.

[120] Mr McLeod owed duties under section 7 of the 1974 Act, whereby:

> "It shall be the duty of every employee whilst at work –
>
> > (a) To take reasonable care for the health and safety of himself and of other persons who may be affected by his acts or omissions at work; and
> >
> > (b) As regards to any duty or requirement imposed on his employer or any other person by or under any of the relevant statutory provisions, to cooperate with him so far as is reasonably necessary to enable that duty or requirement to be performed or complied with."

[121] When asked by Mr Cahill about four specific suggested findings which the court might make, all as set out in paragraph 98 above, Mr Schouten opined that, were the court to make such findings, Mr McLeod would have been in breach of his duty to

Heatcare under section 7(1)(a) by working at height when instructed not to do so and under section 7(1)(b) by working at the site when instructed not to do so.

[122] Whilst I am satisfied that Mr McLeod was instructed by Darren McLeod not to work at height, I am not satisfied that the job had ceased or that Mr McLeod had been told to stop work at Heatcare House. I am not satisfied that Mr Jack told Mr McLeod that there was no work, as opposed to no "maintenance" work, which is what he said in his statement. I do not make any of the findings in fact suggested to Mr Schouten by the Company, as set out in paragraph 98 above.

[123] The Company had no idea that Mr McLeod was working at Heatcare House on 18 August 2020. Indeed, to this day, they have no idea when, how often, or how long Mr McLeod worked at Heatcare House between 29 May 2020 and 10 July 2020 and again after 10 July until 18 August 2020. He worked there alone throughout. That Mr McLeod was not adequately supervised at Heatcare House is beyond doubt. Even on the day that he died, the evidence demonstrates that Mr McLeod used both a roller to paint without a ladder and later used a ladder to paint at height. Even that day, had he been visited by a supervisor, this tragedy may have been averted.

[124] There was no evidence of the Company ever providing health and safety training to Mr McLeod. Mr McLeod did not have access to the health and safety advice on the Epix system which was available to every other tradesman who worked for the Company. In particular, he was not included in the work at height training which the Company arranged in 2018. The excuse that he was not expected to work at height does not stand up. The Company claim that their policy is that no employee is expected to

work at height, and yet training was provided to its other trades people. Mr McLeod should have been included.

Recommendations

[125] Whilst the Epix system used by the Company provides monitoring, tracking, work allocation and health and safety features, it is not a substitute for supervision. The Company should ensure that it maintains and operates an adequate, risk assessed and documented system to monitor and supervise all of its employees who engage in lone working.

[126] The Company should ensure that all of its employees who engage in trade and maintenance work receive work at height training.

Closing remarks

[127] Finally, I would like to formally record my previously expressed condolences and deepest sympathy to Mr McLeod's family for their tragic loss.