SHERIFFDOM OF GLASGOW AND STRATHKELVIN AT GLASGOW

[2026] FAI 14

GLW-B1297-25

DETERMINATION

BY

SHERIFF PAUL ANTHONY REID

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

into the death of

GEORGE ALAN BOYLE

GLASGOW, 10 April 2026

Determination

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

1. In terms of section 26(2)(a) of the 2016 Act (when and where the death occurred), the late George Alan Boyle (hereafter Mr Boyle), born 16 August 1959, died on 21 October 2020 at 1152 hours within the commercial premises situated at Unit 1B, 95 Westburn Drive, Cambuslang, Glasgow, G72 7NA.

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

approximately 1000 hours on 21 October 2020 within the commercial premises at Unit 1B, 95 Westburn Drive, Cambuslang, Glasgow, G72 7NA.

3. In terms of section 26(2)(c) of the 2016 Act (the cause or causes of death), the cause of death was crush asphyxia caused by an accident at work when Mr Boyle was trapped under a fallen metal fixture.

4. In terms of section 26(2)(d) of the 2016 Act (the cause or causes of any accident resulting in the death), the immediate cause of the accident resulting in the death of Mr Boyle was that part of the casing, which was immediately adjacent to the point where the angle bracket had been lifted had broken away, causing the angle bracket to fall forward trapping Mr Boyle underneath.

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), make the following observations.

(a) It would have been a reasonable precaution for the employers of Mr Boyle to make him aware of the practice of lifting accessories being marked clearly with red or yellow paint. Those marked with yellow paint signifying they were not to be used. They should be marked clearly with the chosen colour of paint. The photograph at Crown Production 4 at page 7 shows the eyebolt used in this accident to be predominantly marked coloured yellow though there are clear traces of red shown.

(b) It would have been a reasonable precaution to ensure that the employers of Mr Boyle raised awareness among employees of the importance of lifting procedures; conduct a full review of method statements; have toolbox talks on the practice of slinging and rigging; conduct periodic assessment to identify training needs; and to designate a particular individual to manage, review and approve all lift plans prior to the commencement of the task. At the time of the accident Mr Boyle was assisted by fellow employees, Mr Plawgo and Mr Wilson. Both employees confirm in their statements dated 3 November 2020 they had not been trained in lifting or slinging. In addition, the Health and Safety Report dated 30 April 2021, lodged as Crown Production 8 reveals that the eyebolt used in this accident was of insufficient size to completely fit onto the hook of the gantry crane. These are issues which would have been addressed if a system of advanced review was in place prior to these tasks being undertaken.

(c) For the employers of Mr Boyle to identify safe lifting points on the angle bracket such as by using a colour coded system. This is a matter of importance given the circumstances of this accident. Within Crown Production 4 at pages 20 and 21, there are photographs of the second angle bracket on the premises which clearly reveal a crack running from a lifting point to an edge.

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 accident resulting in death), there are no defects in

any system of working which contributed to the death or the accident which resulted in the death of Mr Boyle.

7. In terms of section 26(2)(g) of the 2016 Act (any other facts which are relevant to the circumstances of the death), other than my observations above there are no other facts relevant to the circumstances of the death of Mr Boyle.

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.

NOTE:

The legal framework of the inquiry

[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 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 Boyle died as a result of an accident in the course of his employment.

[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 of Mr Boyle 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 on fact finding, not fault finding. The inquiry process is an inquisitorial one in which the procurator fiscal represents the public interest.

[3] In terms of sections 26(1)(b) and 26(4) of the 2016 Act, the inquiry must determine certain matters namely when and where the death occurred, when any accident resulting in the death occurred, the cause or causes of death, the cause or causes of any accident resulting in 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 death. It is open to the sheriff to make recommendations in relation to matters set out in sub-section 4 of section 1 of the 2016 Act. The sheriff is not obliged to make recommendations. This is a discretionary power.

Introduction

[4] This inquiry was held under section 1 of the Act. It was a mandatory inquiry in terms of sections 2(1) and (3) of the Act as Mr Boyle died because of an accident which occurred in the course of his employment. The procurator fiscal lodged a notice of the inquiry on 14 August 2025. Following preliminary hearings which occurred on 17 October and 22 December both 2025, the inquiry itself took place at Glasgow Sheriff Court on 23 March 2026.

[5] Two parties were represented at the inquiry. Mr Ul-Hassan, procurator fiscal depute for the Crown and Ms Ann Bonomy, solicitor for Walkerweld Engineering Limited. The narrative of facts I refer to later was derived from the joint minute and productions. No oral evidence was led at the inquiry. Members of the family of Mr Boyle were present. They were not formally represented. They did assist the inquiry by answering and clarifying matters which arose in the course of the presentation of the evidence. A joint minute of agreement was entered into by parties. Parties invited me to make formal findings only in relation to sections 26(1)(a) – (d) of the 2016 Act. Neither of the parties invited me to make any recommendations.

[6] The following productions were lodged and referred to in the joint minute:

(a) Post-mortem report.

(b) Risk assessment.

(c) HSE expert reports.

(d) A number of statements from 40 witnesses were also provided.

Narrative of the facts

[7] At the time of his death Mr Boyle was 61 years of age having been born 16 August 1959. He formerly resided at 8 Glenduffhill Road, Baillieston, Glasgow, G69 6BD. Mr Boyle was employed by Walkerweld Engineering Limited as a machine operator. He had been employed by the company for a period of 10 days at the time of his death. The company's premises at Unit 1B, 95 Westburn Drive, Cambuslang, Glasgow, G72 7NA were shared with another company, Mitchell Engineering Group

Limited. Both companies were commercially related. The premises had not been subdivided. Employees of both companies could move freely within the premises.

[8] The premises consisted of two main areas, namely the machine shop and the fabrication shop. The accident occurred at a machine situated within the machine shop, namely an Anyak HMV 5000 bed milling machine.

[9] The machine had a bed onto which a workpiece was secured. A moveable milling head then machined material away from the workpiece to form the desired shape. On occasion, depending upon specific aspects of the workpiece, supplementary support was required to hold the workpiece securely in position while it was being machined. For this reason, angle brackets were sometimes used. An angle bracket is a large L shaped fabrication that incorporates multiple holes and slots. It is bolted into position on the mill bed and then the workpiece is secured to the bracket. The accident involved one of two similar angle brackets each of which weigh approximately 2 tonnes. They were stored in a designed storage area. When required, they were lifted into position using an overhead gantry crane. They did not incorporate any designated lifting points.

[10] The component involved in the fatal incident was an angle bracket constructed of cast iron. Cast iron is a hard non-malleable material which cannot be bent, stretched or reshaped. It maintains structure and stability under compression. It is considered a suitable material for an angle bracket, as it is being used in order that another most likely heavier metal workpiece can be secured to it. The mass weight of the angle bracket was subsequently calculated to be approximately 1.3 tonnes.

[11] On the day of the accident Mr Boyle was given the task of using the bed milling machine to manufacture components that were for the oil industry. A fellow employee, Mr Plawgo, a machinist, was asked to assist Mr Boyle. The overhead gantry crane was operated by a Mr Steven Wilson.

[12] Mr Boyle attached an eyebolt to the angle bracket to enable it to be lifted by the gantry crane within the premises. The lifting capacity of the crane was 2.5 tonnes. The movement of the angle bracket was well within its capacity. Mr Boyle fastened an eyebolt to one end of the angle bracket and connected a chain sling between the eyebolt and the lifting hook of the gantry crane. Mr Wilson controlling the movement of the gantry crane elevated the hook to take the weight of the workpiece. Mr Boyle and Mr Plawgo removed bolts holding the workpiece in place on the angle bracket. Once the bolts had been removed Mr Wilson was able to use the gantry crane to lift the workpiece off the machine with the intention of placing it on the ground. Mr Wilson used the gantry crane to move the angle bracket approximately 25 yards from the machine. The same process was repeated with the second angle bracket without mishap. With all the equipment removed from the machine, Mr Boyle asked Mr Wilson to return 30 minutes later.

[13] Mr Plawgo then assisted Mr Boyle with cleaning the boring machine and repositioning sections of it to accommodate the next workpiece to be dealt with. Mr Wilson was asked to return to assist with using the gantry crane to lift an angle bracket onto the machine. Mr Boyle linked the hook of the gantry crane into the eyebolt in the angle bracket. Mr Wilson, using the gantry crane, lifted the angle bracket off the

ground and moved it slowly towards the boring machine. When the angle bracket was almost entirely over the bed of the boring machine, and approximately half an inch above it, Mr Boyle moved directly in front of the angle bracket to ensure the slots in it lined up with the holes in the boring machine. He placed a hand on each side of the angle bracket.

[14] Whilst the angle bracket was being slowly moved over the boring machine, the eyebolt broke through the top of the angle bracket. This caused the angle bracket to detach from the eyebolt and gantry crane, causing it to fall partially onto the bed of the boring machine and tip forward. Mr Boyle attempted to move out of the way of the angle bracket as it fell. However, it struck him on the back folding him forward under its weight. The eyebolt remained attached to the gantry crane.

[15] Following the accident an assessment was carried out by a specialist inspector from the Health & Safety Executive which identified the angle bracket had fallen because part of the casting which was immediately adjacent to the point where it had been lifted, had broken away.

Submissions

[16] Both parties helpfully lodged written submissions.

[17] The Crown submissions concluded the death of Mr Boyle resulted from failures in the company's safe system of work in respect of the conduct of lifting operations. There was inadequate supervision, ineffective planning, the absence of a lifting plan and an essential component in the process, namely the eyebolt had not been subject to a

current LOLER thorough examination. These failings were compounded by a lack of suitable training for the personnel involved. The lifting operation was consequently carried out in a manner which was unsafe whereby Mr Boyle was in such proximity to the suspended load that he was fatally struck by it when it became detached. Proper supervision would likely have prevented this. Following the accident the employer instituted immediate remedial steps to address the aforesaid issues.

[18] In so far as Ms Bonomy is concerned, her written submissions confirmed the cause of the accident was the sudden failure of the material of the angle bracket adjacent to the chosen lifting point. She indicated it was not known whether the failure was as a consequence of a sudden overload or a progressive failure that developed over time. She conceded it would have been a reasonable precaution for Mr Boyle's employers to make him aware of the custom and practice of marking lifting accessories with red or yellow paint. In particular those marked with yellow paint were not to be used. Further it would have been a reasonable precaution for the deceased to have chosen a more suitable lifting point on the angle bracket which would have been in accordance with any previous training he had. It was apparent and obvious to all those involved that the choice of the lifting point was entirely inappropriate and those who were involved were at a loss as to why that point was chosen.

Discussion and conclusions

[19] It is clear from the evidence presented to the inquiry that all possible steps were taken to assist Mr Boyle upon the incident occurring.

[20] On the available evidence at the inquiry, I have determined that Mr Boyle died as a result of crush asphyxia because of the falling of the angle bracket trapping him beneath it.

[21] Whilst the precise reason for why it fell cannot be established definitively, a reasonable inference may be drawn from the evidence of the HSE specialist inspector that the cause of the accident arose as a result of a defective piece of the angle bracket, namely its casing. I do not consider it appropriate to make comment upon whether Mr Boyle had used an appropriate lifting point during this task. No evidence was led indicating whether this indeed was the case or not. It would be inappropriate to speculate.

[22] I have not identified any matter which would require a finding beyond the formal findings in terms of section 26(2) of the Act as set out earlier. In that I concurred with submissions of both the procurator fiscal depute and Ms Bonomy.

[23] In closing I join with parties in expressing my sincere condolences to the family and friends of Mr Boyle whose loss has been deeply and sincerely felt by all involved.