

SHERIFFDOM OF TAYSIDE, CENTRAL AND FIFE AT STIRLING

[2024] FAI 35

STI-B8-24

DETERMINATION

BY

SHERIFF DEREK J HAMILTON

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

into the death of

GREGOR HENDERSON DEAKIN

STIRLING, 20 SEPTEMBER 2024

The Sheriff having considered the evidence, the written and oral submissions presented at the inquiry, the productions and the terms of the joint minute, finds and determines in terms of section 26 of the Inquiries into Fatal Accidents and Sudden Deaths etc.

(Scotland) Act 2016 (“the 2016 Act”);

- (i) In terms of section 26(2) (a) of the 2016 Act, Gregor Henderson Deakin (Greg Deakin), born 14 December 1972, was pronounced dead at 15.40 hours on 6 October 2021, at Ardeonaig, Killin.
- (ii) In terms of section 26(2)(b) of the 2016 Act, the accident resulting in Greg Deakin’s death took place just before 14.35 hours on 6 October 2021, the time when the first call to emergency services was made. The

accident occurred at the pier area of Loch Tay within the grounds of Ardeonaig Hotel, Killin.

(iii) In terms of section 26(2)(c) of the 2016 Act, the cause of Greg Deakin's death was multiple injuries, specifically;

- a. Drowning;
- b. Accident whilst operating mini-excavator;

These injuries were sustained whilst Mr Deakin was working in the course of his employment with Ardeonaig Limited and was driving a tracked excavator on a loch pier. The tracked excavator toppled into the loch trapping Mr Deakin in the enclosed cab.

(iv) In terms of section 26(2) (d) of the 2016 Act, the accident was caused by;

- (1) the tracked excavator, being driven by Mr Deakin, toppling into the loch, trapping Mr Deakin in the enclosed cab.
- (2) The tracked excavator reversing around a 90° corner.
- (3) the width of the tracks on the tracked excavator being greater than the width of the pier upon which it was being operated.

(v) Makes no findings in terms of section 26(2)(e) of the 2016 Act.

(vi) Makes no findings in terms of section 26(2)(f) of the 2016 Act.

(vii) In terms of section 26(2)(g) of the 2016 Act the following facts are relevant to the circumstances of the death;

- (1) Long reach excavators are commonly used to place material in a body of water to avoid having to enter the water.

Recommendations

In terms of section 26(1)(b) of the 2016 Act there are no recommendations as to any of the matters mentioned in sub-section (4) which might realistically prevent other deaths in similar circumstances.

NOTE**Introduction**

[1] A fatal accident inquiry was held under the Inquiries into Fatal Accidents and Sudden Deaths etc. (Scotland) Act 2016 into the death of Gregor Henderson Deakin, who died on 6 October 2021. He was at the time of his death a director and employee of Ardeonaig Limited, and his death was the result of an accident which occurred in the course of that occupation. In terms of section 2(3) of the 2016 Act, an inquiry was required to be held into the circumstances of his death.

[2] The Procurator Fiscal first received notice of Mr Deakin's death on 8 October 2021, and issued notice of the inquiry on 10 January 2024. The first order was granted on 17 January 2024. A preliminary hearing was held at Stirling Sheriff Court on 1 March 2024. That hearing was continued to 9 May 2024, then to 12 July 2024 and finally to 30 July 2024. The inquiry, where evidence was led and submissions presented, was held at Stirling Sheriff Court on 6 September 2024. I wish to thank parties for their detailed preparation, and for their presentation of relevant statements and documents together with thoughtful submissions, which focussed on the main issues for the inquiry. Their

efforts meant that this inquiry could be dealt with in a timely manner and without potentially sensitive and distressing evidence having to be led orally.

[3] At the inquiry, representation was as follows;

Procurator Fiscal: Mr Ul-Hassan, Procurator Fiscal Depute

Family, Mrs Nina Deakin: Ms Bone, Solicitor Advocate

All preliminary hearings were conducted via the medium of WebEx facility. The inquiry was held in person, with one witness, Hannah McDonald, HM Inspector of Health and Safety, giving her evidence in person.

[4] Much of the evidence for this inquiry was not in dispute and was capable of agreement. A detailed Joint Minute of Agreement between the Crown and the family was tendered to the inquiry. This covered, *inter alia*, a number of productions and a number of witness accounts which were all lodged and agreed, and were considered by the inquiry. That greatly assisted the inquiry and reduced the oral evidence that required to be heard.

The legal framework

[5] This inquiry was held under section 1 of the 2016 Act and governed by the Act of Sederunt (Fatal Accident Inquiry Rules) 2017 (SSI 2017/103). The inquiry was initiated by the Procurator Fiscal, who represents the public interest, in accordance with her statutory duty to do so. The purpose of an inquiry under section 1(3) of the Act is (a) to establish the circumstances of the death and (b) consider what steps, if any, might be taken to prevent other deaths in similar circumstances. The inquiry is an inquisitorial

process and, under section 1(4) of the Act, it is not its purpose to establish civil or criminal liability.

Introduction

[6] Greg Henderson Deakin was aged 48 at the time of his death, having been born on 14 December 1972. He lived in Glasgow with his wife and two children.

[7] At the time of his death Mr Deakin was a director of a number of companies. Other family members were directors of some of the companies. Ardeonaig Limited is a hotel and holiday let company and is a wholly owned subsidiary of Luxury Cottages Loch Tay Ltd. Ardeonaig Limited had two directors, Mr Deakin and Heys & Co (Holdings) Ltd. Mr Deakin and other family members were also directors of Heys & Co (Holdings) Ltd.

[8] Ardeonaig Limited owned the Ardeonaig Hotel on Loch Tay, Killin, together with holiday cottages in the grounds of the hotel, and the adjoining pier where the accident occurred. The hotel, excluding the holiday cottages and pier, was let to a hotel operator at the time of the incident, and was in the process of being renovated by Ardeonaig Limited. Ardeonaig Limited did not have any direct employees. Due to a downturn in business at one of Mr Deakin's other companies (a furniture company), two of that company's employees, William McShane and Lawrence McPake, were employed by Mr Deakin to carry out maintenance work at the Ardeonaig Hotel.

Pier project

[9] Mr Deakin had been renovating the Ardeonaig Hotel for around a year prior to the accident on 6 October 2021. As part of improvement works a marina had been created. Works were ongoing to improve, strengthen and extend the pier at the marina. Mr Deakin had prepared a method statement for the work (Crown Production 17). It provided that;

“Excavation equipment and earth moving equipment to operate from high ground and stay out of water at all times, except where, for example, the digger arm and bucket need to enter water to carry out excavation, with the machine itself sitting on dry ground.”

[10] As there were less than five employees involved in the work, no written risk assessment was legally required. Planning permission was not required for the work.

The pier

[11] The marina and pier were situated approximately 200 metres from the main hotel building. A single track led from the hotel to the marina. The pier was an L shaped walkway constructed of concrete, and it extended out from the single track into the water in a generally northern direction. The width of the existing pier was later measured and photographed by HM Specialist Inspector, Graham Martin. The pier ran approximately northwards for a distance (on its longest side) of 38m. Over that length its width varied from 3m at the beginning to 3.155m at the far end, narrowing at points along its length to 3.05m and 2.87m. The pier then turned 90 degrees right where it ran in an eastern direction for a distance (on its shortest side) of 3.85m, and with a width

of 2.015m. On its longest side it measured 7.05m (3.155m + 3.85m). An Environmental Officer who had inspected the site the day before the accident had noted the surface of the concrete pier looked flat and appeared to have no structural issues. He noted however that there appeared to be some subsidence at the end of the east projection of the pier.

The project

[12] Rocks had been taken by a dumper truck from construction work at the hotel, and had been deposited in a pile at the side of the single track leading down to the pier. The rocks were to be loaded by a tracked excavator into the front bucket of the dumper truck. The rocks were to then taken by the dumper truck on to the northbound section of the pier and placed on the pier some distance up that section of the pier. From there they were to be picked up by a tracked excavator, taken further along the northbound section of the pier and round on to the eastbound section of the pier, where they were to be placed in the water to extend the pier eastwards. The larger boulders were to be placed on the outside of the proposed extension, with the smaller boulders being used to infill the middle. Once the boulders were in place, they were to be concreted over to form the extension to the pier.

Equipment

[13] The dumper truck was a Benford Articulated Dumper, a standard machine with a front tilting bucket. It is shown in Crown Production 11 (Photo 0327 at page 234). It had been owned by Mr Deakin for some years.

[14] The tracked excavator was a JCB 8080ZTS excavator. JCB describe it as a midi excavator. The excavator was owned by Kilrevin Holdings Ltd. Mr Deakin was a director of that company. The excavator had been owned by Mr Deakin and/or the company for some years.

[15] Normal operation of the tracked excavator (“the excavator”) and its specification is detailed in Crown Production 7, a report prepared by Peter Dodd, HM Inspector of Health and Safety dated 7 December 2021, titled “The operating principles of a tracked excavator”, which was written in response to Mr Deakin’s accident.

[16] The excavator had a hydraulically operated main boom consisting of two sections, the boom and dipper arm, that were linked end to end. On the end of the dipper arm the bucket was fitted. The boom could be swung left or right independent of the rest of the excavator.

[17] The excavator was driven and operated from a seated position in an enclosed operator’s cab located at the front nearside corner of the upper structure. The upper structure was mounted on a tracked undercarriage on which it was able to rotate 360 degrees.

[18] The primary means of access and egress for the cab was through a rear hinged opening door, fitted on the nearside. The door could be secured in the open position.

An alternative exit through the rear window of the cab was provided for use in an emergency. To use the emergency exit necessitated either pulling a ring attached to the window rubber that released the window glass allowing it to be pushed out, or breaking the glass.

[19] The excavator used a hydraulic system to provide power for all of its drive, steering and braking functions. The excavator was driven and steered by the use of two independent levers located in front of the operator, one for each travel motor. Each lever was attached to a centrally pivoted pedal on the floor of the cab that was also located in front of the operator. This provided the operator the option of either pushing/pulling the levers or pressing the pedals. By moving one lever/pedal in one direction and the other lever/pedal in the opposite direction, the excavator would be able to rotate within its own length. Unlike a car, the tracks operate independently of each other. The vehicle was able to rotate 360 degrees. The upper structure mounted on the tracked undercarriage was also able to rotate 360 degrees. If the upper structure rotated 180 degrees the response of the excavator to the operation of the lever/pedal would be reversed.

[20] The excavator's dimensions are detailed in Appendix 1 of Mr Dodd's report. The excavator can operate with three different widths of track, which vary from 2.2 metres to 2.45 metres.

Equipment training

[21] The work was to be largely undertaken by Mr Deakin. He was to be assisted by employees from one of his other companies who were on site carrying out renovations to the hotel. Mr Deakin operated the dumper truck and the excavator. The others involved simply operated the dumper truck

[22] Dumper truck – the dumper truck was, from time to time, operated by Mr Deakin, Lawrence McPake and William McShane. It is understood Mr Deakin had owned the dumper truck for some years. Neither Mr McPake nor Mr McShane had any formal construction training, other than some manual handling training which was relevant to their normal roles as a furniture delivery drivers. They had no specific training for driving a dumper truck, or for working near water. Prior to the accident, Mr McShane had only driven the dumper truck a few times, and had driven it on to the pier. There was no evidence of Mr Deakin having had any formal training in the operation of the dumper truck. The role of the dumper truck and of Mr McPake, Mr McShane or Mr Deakin as the driver of it were not relevant to the circumstances of the accident.

[23] Tracked Excavator – It is understood Mr Deakin and/or one of his companies had owned the excavator for some years. Mr Deakin was the only person who operated the excavator. There was no evidence that Mr Deakin had had any formal training in the operating of the equipment. He was noted to be very competent using the excavator. It was said he used the excavator about once a month at the marina.

The accident

[24] On the days prior to the accident, Mr Deakin had been seen driving the dumper truck up and down the pier and dropping boulders into the water adjacent to the pier. On 6 October 2021, he had used the dumper truck to deposit some more boulders into the water. Sometime around 14.00 hours, Mr Deakin had called William McShane out to the end of the pier to discuss the procedure to be adopted to extend the pier. At that point in time, the excavator was situated on the short part of the pier which extended eastward. The cab and boom were facing eastwards to the end of the pier and the water. The bucket of the excavator was over the water at the end of the pier. Mr Deakin explained the procedure he wished to be adopted, and that was as detailed above (“The Project”). The excavator was firstly going to be used to reposition the larger boulders which were already in the water. The intention was then for Mr Deakin to drive the excavator back to the loch side to fill the dumper truck, and for the dumper truck to take the boulders out on to the pier. From there Mr Deakin would collect the smaller boulders and deposit them into the water.

[25] In order to get to the smaller boulders, which were to be loaded on to the dumper truck and then part way up the northbound section of the pier, Mr Deakin would have had to track the excavator along the short eastbound part of the pier, then turn 90 degrees to travel southwards along the main length of the pier to where the boulders lay. From the position of the excavator, Mr Deakin could have either tracked backwards or rotated the excavator in order to track forwards. This could have been done in one of two ways. The upper structure could have been turned 180 degrees. This

could have been done without having to initially move the tracks of the excavator. The cab would then have been facing forwards, but the levers/pedals used to drive the excavator would have operated in reverse fashion. Alternatively the whole excavator could rotate on its own footprint, but that would have resulted in the tracks extending significantly further over the sides of the pier.

[26] Mr McShane left Mr Deakin in the cab of the excavator and started to walk back along the pier towards the dumper truck. Mr McShane heard a crunching noise which he believed was caused by the tracks of the excavator on the concrete pier as it tracked backwards and cut the corner of the pier on the excavator's offside. When Mr McShane turned around he saw the excavator tipping into the water, and Mr Deakin in the cab holding on to the glass. At the same time, believed to be around 14.30 hours, a fisherman, Ashley Allibone, who was positioned approximately 40 metres across from the pier, heard a "big splash" and saw the excavator submerging under water.

[27] Mr McShane ran back to where the excavator had been and stood for about 10 to 20 seconds, expecting Mr Deakin to come out of the cab. When he did not do so, Mr McShane called over to the nearby fisherman, Ashley Allibone, for assistance, and then telephoned the emergency services. Mr Allibone immediately made his way to the pier, and was there as Mr McShane was on a call to the emergency services.

[28] It is believed that as the excavator entered the water it must have rolled over, as it came to rest with the nearside of the cab, (where the door was positioned, and which had been furthest away from the side of the pier over which the excavator had toppled) lying against the bottom of the loch. Efforts were made to try and get to Mr Deakin and

to remove him from the cab. Mr McShane went into the water and on to the excavator. He tried to break the window of the excavator with a boulder, but was unable to do so as the window was under water and would not break. Mr McShane then telephoned up to the Ardeonaig Hotel for assistance. A joiner working at the Ardeonaig Hotel, witness Stuart McLean, a ground worker, Daniel Kirk, and Lawrence McPake all immediately attended the locus by car. Mr McLean returned to the hotel to get a metal pinch bar. Mr McShane again went out onto the boom of the excavator to try to smash a window by using the pinch bar, but again was unsuccessful. He threw the pinch bar at a window, but toppled over into the water. Mr McShane had to stop as he was too cold from being in the water, and Mr McLean entered the water to help him out.

[29] The excavator lay in the water on its offside. The cab was fully submerged and Mr Deakin was unable to escape from the cab. Mr Deakin was eventually removed from the cab by Scottish Fire and Rescue Service personnel. Attempts were made, but without success, to resuscitate Mr Deakin and life was later pronounced extinct.

Response, scene attendance and chronology

[30] The chronology of the involvement of the emergency services was as follows:

14.35 hours – call to Scottish Ambulance Service, Helimed 76 Team, Central Scotland Helicopter Emergency Service.

14.39 hours – Police Sergeant Malcolm O'May and Police Constables

Stephen Nicol and Gavin Macrae, based at Callander Police Office, dispatched to

attend Ardeonaig Hotel, Killin in relation to a digger having fallen off a pier into water and one male within.

14.44 hours – call to Scottish Fire and Rescue Service reporting a male trapped in a JCB which had fallen into water at the Ardeonaig Hotel, and with a male stuck underneath.

14.58 hours - John Pritchard, paramedic, and Darren O'Brien, paramedic c/o Scottish Ambulance Service, Helimed 76 Team, Central Scotland Helicopter Emergency Service, landed at the locus.

15.03 hours –Anthony Dowling, Calum Frost, Iain Watson and Christopher McLarty, all Retained Fire Officers, Scottish Fire and Rescue Service, attended at the locus. They found the excavator submerged in water immediately upon arrival at the pier. Calum Frost stamped on a window of the excavator, causing the window to break, before he and Iain Watson removed Mr Deakin, from the cab and, with the assistance of Mr Dowling and Mr McLarty, removed Mr Deakin from the water. Mr Deakin was unresponsive. He was carried to the air ambulance crew where CPR was commenced by the Fire Officers under the direction of the air ambulance crew, which also assisted.

15.25 hours Police Constables Nicol and Macrae, arrived at Ardeonaig Hotel, Killin. CPR on Mr Deakin was still ongoing.

15.40 hours –paramedics, having consulted with medical personnel, ceased attempts to resuscitate Mr Deakin and pronounced life extinct.

Cause of death

[31] A post mortem examination of Greg Deakin's body was carried out on 15 October 2021, by Doctors Robert Ainsworth and John Clark, both forensic pathologists. Their report of said examination is Crown Production 3. Said report recorded the medical cause of death as;

1a Drowning

1b Accident whilst operating a mini-excavator

The deceased had no significant past medical history and was not prescribed regular medications.

[32] A toxicology report confirmed that analyses for alcohol, prescription and drugs of abuse gave negative results.

Health and Safety Executive investigation

[33] HSE commenced an investigation into the accident involving Mr Deakin. Hannah McDonald, HM Inspector of Health and Safety, and Ailsa Halcrow, a visiting officer, both of Health and Safety Executive attended at the site on 7 and 8 October 2021. They attended again on 18 October 2021 when the excavator was removed from the water and taken off site. On 8 November 2021, Hannah McDonald contacted Peter Dodd, HM Inspector of Health and Safety, Health and Safety Executive, seeking his opinion on how the tracked excavator operated, and the consequences (for inspecting and functionally testing it) of it being submerged. Crown Production 7 "The operating principles of a tracked excavator" is the report produced by Peter Dodd which

details his findings. Ms McDonald also took advice from Mr Graeme Martin, HM Specialist Inspector, of the Construction Engineering Specialist Team, on the method of work being undertaken by Mr Deakin.

Examination of the excavator

[34] There was no service record for the excavator. Crown Production 16 is an e-mail from JCC Group Limited which indicated the last engine service was carried out in or around 2018. A number of invoices were produced which showed regular repair and maintenance of the excavator during 2020 to 2021.

[35] The mechanical examination of an item of mobile plant such as an excavator, for evidence of defects that may have contributed to an accident, would be achieved through a combination of inspection of the mechanical and hydraulic components, and a functional test that included the response of the excavator to the operator controls. In the opinion of Mr Dodd, any evidence of defects of the mechanical and hydraulic components was likely to have been severely compromised due to the prolonged immersion of the excavator in the loch.

[36] Because all of the excavator functions were achieved by the use of hydraulics, the excavator would need to have been functioning to observe how the excavator would respond to the movement of the operator's controls. In order to conduct a full examination of the machine, including a functionality test, the machine would have required the engine to have been turned over and the electrics switched on. After being submerged in the loch for a prolonged period, the excavator would have required

extensive remedial work (which could have compromised any evidence) to enable it to function. Whilst it would have been possible to ascertain whether the operator's controls in the cab moved as expected, there would be no evidence to demonstrate how the excavator was responding at the time of the accident.

[37] The various systems in the excavator containing the service fluids, their integrity and their contents, would have been severely compromised due to the immersion of the excavator in the water. That would have prevented evidence being obtained that could have identified them as a contributory factor in the accident. Had there been a hydraulic issue, there would likely have been evidence of that on the pier. There was an absence of any fluids on the pier which would indicate a mechanical fault.

[38] Scrape marks were noted on the edge of the pier ,as shown in photographs 44 to 59 of Crown Production 4 (book of photographs) taken by Nicola Mann, Senior Forensic Scene Examiner on 7 October 2021.

Safety measures

[39] An alternative exit through the rear window of the cab was provided for use in an emergency. To use the emergency exit necessitated either pulling a ring attached to the window rubber that released the window glass allowing it to be pushed out, or breaking the glass. It would be normal for machinery of this type to have a hammer, or something similar attached beside a window to enable the window to be smashed in an emergency. It could not be ascertained if the excavator was equipped with such an implement. There was found to be much debris in the cab when it was removed from

the water, and any hammer or other such implement, had it been there, could easily have been dislodged in the accident and fallen to the bottom of the loch.

[40] Following investigation, Hannah McDonald concluded that Mr Deakin was in control of all the works on the site. There were no safety procedures in place for use of the excavator on the pier. A hierarchy of control should have been followed to establish if work on the pier was required or if the risk of the work could be removed by working from the loch side. Long reach excavators are commonly used to place material in a body of water because they do not need to enter the water and they stay away from the danger. If work had to be completed from the pier, operatives working on the pier should have been trained in working on or near water, and knowledge of the safety mechanisms of the excavator should have been known as part of the emergency procedures.

[41] There was industry standard training for the operation of the type of excavator involved in the pier project. There was no evidence of Mr Deakin having completed any formal training in the operation of the excavator or in construction or operation of construction plant. The excavator had been owned by Mr Deakin for some years and it had been well maintained.

Investigation's findings

[42] At the section of the pier where the excavator was positioned, the tracks were wider than the pier (the pier being 2015mm wide and the tracks at least 2200mm wide).

The manufacturer's specification for the excavator stated the tracks were between 2200mm and 2450mm wide.

[43] Due to the absence of any fluids on the pier that would indicate a mechanical fault and the fact that the excavator tracks were too wide for the pier, Ms McDonald found it reasonable to assume that the reason for the accident was down to the excavator being too wide for the pier and slipping off the side causing the excavator to roll into the water.

[44] That conclusion was supported by the evidence of Mr McShane who heard a crunching noise and by scrape marks on the surface of the pier at the corner where the excavator toppled off the pier.

Conclusion

[45] A hierarchy of control could have established if work on the pier was required or if the risk of the work could be removed by working from the loch side. Long reach excavators are commonly used to place material in a body of water, because they do not need to enter the water and they stay away from the danger.

[46] There were no safety procedures in place for use of the excavator on the pier. If work had to be completed from the pier, operatives working on the pier should have been trained in working on or near water.

[47] Mr Deakin had been involved in many manual projects involving his various businesses over many years, and he was experienced in using construction equipment. He had owned and used the excavator for many years. The excavator had been

regularly maintained and there was no evidence of any defects at the time of the accident.

[48] Mr Deakin was described by one of his employees as one of the hardest working men he knew, and one who had a wealth of knowledge and attention to detail.

[49] Quite simply this tragic accident was caused by Mr Deakin using equipment and a method of working on the pier which were inherently unsafe. The excavator was on this occasion too large to operate on the pier. Its tracks were wider than the width of the pier, thereby allowing little room for error when manoeuvring the excavator. There was no room for Mr Deakin to rotate the excavator on its own tracks. Mr Deakin elected to reverse the excavator. He could have rotated the top structure 180 degrees. The cab would then have been facing forwards, but the levers/pedals used to drive the excavator would have operated in reverse fashion. Even doing this however would still have placed Mr Deakin in some danger due to the size, and particularly the width, of the excavator's tracks. Mr Deakin had to negotiate a 90 degree bend in an excavator which quite simply was too large to operate safely on the pier. It was during that turning manoeuvre, that the tracks slipped off the edge of the pier and the excavator toppled into the water.

[50] Tragically, the excavator did not come to rest on the side which first entered the water. The excavator appears to have toppled over with its nearside coming to rest facing downwards to the bottom of the loch. This preventing Mr Deakin escaping from the cab, or rescuers entering into the cab, through the excavator door. Because the windows of the excavator were underwater, those trying to assist Mr Deakin were

initially unable to smash the glass. The cab was fitted with a rear window which could be opened as an emergency escape by either pulling a rubber ring attached to the seal, or by smashing the glass. There may have been many reason why Mr Deakin could not use the emergency escape, but there was no evidence from which any conclusions could be drawn.

[51] I read with care what Mrs Deakin had to say about her husband. Mr Deakin had been involved in many business ventures and he was clearly an enthusiastic and hardworking man. He was a family man, a man who was cheerful and upbeat and a man with a zest for life. He was not selfish with his talents and enthusiasm, and he shared them with his local community.

[52] I offer my condolences to Mr Deakin's wife, to his two young children and to his wider family. I thank the various witnesses and participants in this inquiry. I also thank the participants' representatives who all dealt with the preparation for and the conduct of the inquiry with great sensitivity, diligence and skill.