SHERIFFDOM OF GRAMPIAN, HIGHLAND AND ISLANDS AT BANFF

[2021] FAI 54

BAN-B37-20

DETERMINATION

BY

SHERIFF ROBERT FRAZER

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

into the death of

WILLIAM BLACK

BANFF, 5 August 2021

DETERMINATION

The Sheriff having considered the information presented at the inquiry determines in terms of section 26 (2) of the Fatal Accidents and Sudden Deaths etc (Scotland) Act 2016 ("the Act") that:

(a) When and where the death occurred (s 26 (2) (a))

In terms of section 26 (2) (a) of the Act the death occurred at approximately 13.52 hours on Tuesday 26 January 2016 at the B9005 Fyvie to Methlick road, Aberdeenshire.

(b) When and where any accident resulting in death occurred (s 26 (2) (b))

In terms of section 26 (2) (b) of the Act an accident resulting in the death of William Black occurred at approximately 13.52 hours on Tuesday 26 January 2016 at the B9005 Fyvie to Methlick road, Aberdeenshire.

(c) The cause or causes of death (s 26 (2) (c))

In terms of section 26 (2) (c) of the Act the cause of William Black's death was multiple injuries sustained as a pedestrian in a vehicular collision with a lorry, registration number SV60 DHM, and driven by CP, an employee of DM Contractors, owners of the said vehicle.

(d) The cause or causes of any accident resulting in death (s 26 (2) (d))

In terms of section 26 (2) (d) of the Act the cause of the accident resulting in the death was the deceased, William Black, walking behind the said lorry whilst it was reversing when no banksman (signaller) was in place and he was unable to be seen by the driver, CP, as the deceased was in the driver's "blind spot".

(e) Any precaution which could reasonably have been taken and which might realistically have resulted in the death, or any accident resulting in the death, being avoided (s 26 (2) (e))

In terms of section 26 (2) (e), the positioning of a banksman to guide the lorry might realistically have resulted in the death or accident being avoided.

(f) Any defects in any system of working which contributed to the death or accident resulting in death (s 26 (2) (f))

In terms of section 26 (2) (f) there were no defects in the system of working which contributed to the death or accident resulting in death other than a failure to make all employees and contractors aware of the council's policies and procedures in relation to the reversing of vehicles whilst working on site or at a particular locus.

(g) Any other facts which are relevant to the circumstances of death (s 26 (2) (g))

In terms of section 26 (2) (g) there are no other facts or circumstances which are relevant to the death.

Recommendations

In terms of section 26 (1) (b) and (4) of the Act it is necessary to make 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 and, (d) the taking of any steps which might have realistically prevented other deaths in similar circumstances.

In all the circumstances of the case there are no formal recommendations to make given the changes that have already been made to the system of working by the council, other than to recommend that all external workers are supplied with the council's Health & Safety Handbook (the Blue Book).

NOTE

Introduction

[1] A fatal accident inquiry was held at Banff Sheriff Court on 24, 25 and 26 May 2021 and thereafter on 7 June 2021 into the death of William Black ("the deceased") which occurred on 26 January 2016, as result of a vehicular accident on the B9005 Fyvie to Methlick road, Aberdeenshire. At the time Mr Black was employed by Aberdeenshire Council as a charge-hand/foreman working in the Roads Department.

[2] Mr Black's death was reported to Crown Office and the Procurator Fiscal Service on or about 26 January 2016. The First Notice in relation to the inquiry was issued by the Procurator Fiscal on 21 December 2020. Four preliminary hearings in respect of the inquiry were conducted remotely by the Webex platform on 12 February, 12 March, 19 March and 16 April, all 2021.

[3] At the inquiry the Crown were represented by Roderick Urquhart, Procurator Fiscal Depute; the driver by Mark Donaldson, Solicitor Advocate, Clyde & Co and Aberdeenshire Council by Emma Toner, Advocate. The family of William Black did not participate.

[4] At the commencement of the inquiry parties presented a signed joint minute which was read out by Mr Urquhart. This ran to a total of 6 pages and 22 paragraphs and helpfully set out the factual position of the accident as well as the relevant facts and circumstances before and after, which also included details of the subsequent Police and the Council's investigations. In addition, much of the documentary evidence submitted by the Crown in its Inventory of Productions was agreed as true and accurate. These included:

(i) Autopsy report dated 29 January 2016

(ii) Book of photographs taken of the locus,

(iii) Scale plan of the locus

(iv) Training records for William Black and three other employees/witnesses

(v) Scottish Ministers Code of Practice for Safety at Street and Road Works

[5] Over the first three days of the inquiry the following witnesses gave evidence:

- WB, roads supervisor, Aberdeenshire Council
- CP, driver, DM Contractors
- MG, road worker, Aberdeenshire Council
- KM, road worker, Aberdeenshire Council
- ST, labourer, Aberdeenshire Council
- GM, self-employed digger driver
- DM, proprietor, DM Contractors
- ID, principal roads engineer, Aberdeenshire Council
- CM, Police Sergeant, Police Scotland
- NM, principal inspector, Health & Safety Executive
- PL, roads and landscapes manager, Aberdeenshire Council

Legal framework

[6] This inquiry was held in terms of section 1 of the Act and governed by the Act of Sederunt (Fatal Accident Inquiry Rules) 2017 ("the Rules").

[7] This was a mandatory inquiry in terms of section 2 of the Act as Mr Black died as a result of an accident whilst in the course of his employment.

[8] The purpose of the inquiry is set out in section 1 (3) of the Act as being to establish the circumstances of the death and to consider what steps (if any) might be taken so as to prevent other deaths in similar circumstances.

[9] In terms of section 26 of the Act the inquiry must determine certain matters, namely, when and where the death occurred; the cause or causes of death; the cause

or causes of any accident resulting in the death; any precautions which could have reasonably 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 also open to the Sheriff to make recommendations in relation to matters set out section 1 (4) of the Act.

[10] The Procurator Fiscal represents the public interest. The inquiry is not intended to establish liability, either criminal or civil. The inquiry is an exercise in fact finding, not fault finding. It is an inquisitorial process and it is not open to the Sheriff to engage in speculation of any sort. The determination is based solely on the evidence presented at the inquiry.

Summary

[11] William Black (born 5 April 1959) was employed as a foreman by Aberdeenshire Council who had worked in the Roads Department for 10 years. He had a hearing defect as a result of which he wore a hearing aid.

[12] As a team leader (or foreman) Mr Black was responsible for the organisation and operation of a team (squad) of employees tasked with carrying out road repairs within Aberdeenshire. The same team would usually work together, whenever possible, and all members of the team were well known to each other. The nature of the work normally encompassed road surfacing, as well as other road repairs.

[13] A team is normally made up of a foreman, at least one skilled worker and other road workers or labourers, depending on the size of a job. The work usually involves the use of a digger, a roller and a lorry for the purposes of excavation, rolling and transportation of materials. A skilled worker is someone who is skilled or specialist in use of certain types of equipment. It would be the responsibility of the foreman to organise the team and provide them with instructions.

[14] All employees of the Roads Department are expected to undergo training in their particular roles. A training record is kept for each individual and such a record is divided into those elements of the role which are identified as essential and those which are identified as desirable and dependant on the job content.

[15] In addition, all employees are issued with the council's Health and Safety Handbook which sets out the council's policy and procedure and is known as the Blue Book. The department and all senior staff have access to a larger and more detailed council publication entitled, "Operation Roads - Safe Systems of Work" and is known as the White Book. Contained within both publications is the council policy on Reversing of Vehicles on Operational Sites. This specifies that the reversing of vehicles will only be permitted where there is no alternative and, where unavoidable, a trained banksman (signaller) is in place to ensure the manoeuvre is carried out safely.

[16] Requests for road surfacing works were usually received by telephone or fax in the Roads Department head office and the job would then be allocated to a particular team.

[17] On 25 January 2015 a phone call was made by WB to the department in respect of emergency repair work to the B9005 road in Aberdeenshire. A works order was then issued on 26 January 2016 which had been signed by ID, the Principal Roads Engineer. The work involved the re-surfacing of and repairing pot holes on the section of the road between Fyvie and Methlick.

[18] As the work was classed as an emergency there was no other paper work issued other than a risk assessment document ("On Site Risk Assessment") which was to be completed prior to any work commencing by the team foreman and kept on site for reference during the course of the work being carried out.

[19] On 25 January 2016 Mr Black was spoken to by WB, the Roads Supervisor, to ask that his team carry out the work the following day. Mr Black was to take his usual team with him which at the time comprised MG, KM and ST, as well as CP, the lorry driver from DM Contractors and GM, the independent JCB driver. It was the responsibility of Mr Black, as the team foreman to complete the On Site Risk Assessment and ensure it was complied with.

[20] The work to the section of the road commenced in the morning of 26 January 2016. During the course of the morning the team completed half of the section of road to be repaired which ran in a northbound direction from Fyvie to Methlick. At approximately 1pm CP, the lorry driver, left the locus in order to collect more tarmacadam to lay on the other side of the road and complete the resurfacing which then ran in a southbound direction from Methlick back towards Fyvie.

[21] On his return to the locus CP was spoken to by Mr Black and told to turn his vehicle in the driveway of a property, adjacent to the road. Mr Black then instructed CP to reverse the lorry up the road towards Methlick in order that the tarmacadam could be deposited onto the road and subsequently and raked by the works team and then rolled. The distance that the lorry was to reverse was approximately 187.2 metres. No banksman was in place. As foreman the responsibility was on Mr Black to appoint someone as banksman, which had not occurred.

[22] In the course of the reversing manoeuvre Mr Black, together with KM and ST, walked part way up the opposite side of the road in the same direction as the lorry. As they did so Mr Black, without any indication or warning, walked across the road to the opposite carriageway. In doing so he walked behind the back of the lorry which was still reversing. As a result, the accident occurred whereby the back of the lorry collided with Mr Black. He was knocked to the ground and run over by the lorry's back wheels.

[23] CP, on stopping his vehicle, immediately went to assist Mr Black who was lying on the road. CP commenced CPR upon him. He was joined by Mr Bruce who had been called back to the site having visited it earlier in the day. They remained with Mr Black until an ambulance arrived. Paramedics took over from CP but at approximately 14.18 hours Mr Black was pronounced dead at the scene. The cause of death was multiple internal injuries sustained when the lorry collided with him. It was a matter of agreement between parties that death was almost certainly instantaneous.

[24] Following the accident an internal investigation was launched by Aberdeenshire Council. The police were also involved which led to CP initially being charged with a

contravention of section 3 of the Road Traffic Act 1988. He was subsequently acquitted of the charge on 22 August 2020 following trial at Banff Sheriff Court.

[25] As a result of the council investigation a number of changes had been made to Roads Department's internal systems. These are:

(i) the review and visually updating of the Blue and White Books

(ii) a standardised and detailed letter of instruction to all external contractors

(iii) enhanced training of all employees

(iv) electronic recording and storing of information on all work risk assessments

(v) regular and random on-site audits

(vi) enhanced risk assessment procedures

Witness evidence

[26] In addition to the factual summation above, all the witnesses gave their evidence in a succinct, sensitive and helpful fashion. I consider the following pieces to be of relevance.

[27] CP had worked for DM Contractors for approximately 10 years. He was previously employed in the Army where he had gained his HGV licence. He was used to working on jobs for Aberdeenshire Council and William Black was well known to him. They had worked together on a number of jobs together. CP trusted and respected Mr Black's judgement and experience.

[28] On the day in question CP had followed Mr Black's instructions. He did not question them. Mr Black told him to "put your head into the Smithy and then reverse

uphill". CP was candid in stating that he unaware of the council policy in relation to the use of a banksman or that vehicles should only reverse at a site or a locus where there was no other alternative available.

[29] The lorry was fitted with 5 mirrors; two either side and, one in the middle of the front windscreen. CP explained that there was a blind spot at the back of the lorry when reversing but he was satisfied that the mirrors were properly adjusted for his use and worked correctly.

[30] As he started to reverse CP could see all members of the team, including Mr Black, on the opposite side of the road. The reversing bleeper on the lorry was activated and working throughout the manoeuvre. As he continued to reverse he heard the blaring of a horn and a rumble on the back wheel. He stopped the vehicle then moved slightly forward before stopping and getting out. He discovered Mr Black lying at the back of the vehicle injured. CP immediately called 999 and commenced CPR on Mr Black.

[31] MG was the team's roller driver. He was a trained banksman. This entailed guiding traffic on site and in particular acting as traffic controller for any vehicle which had to reverse. He had worked for the council for 25 years and was fully aware of the policies on the use of banksmen and reversing procedures.

[32] On 26 January 2016 MG was part of the team working on the section of the B9005 road between Fyvie and Methlick. Mr Black was the foreman in charge. After the team lunch break he was asked by Mr Black to take his roller up the hill towards Methlick. He had not been asked to act as a banksman.

[33] KM was a road worker working in the team. He had been with the council for 6 months and was the most recent member of the squad. He recalled after the lunch break seeing the lorry driven by CP reversing up the road. It followed the roller driven by MG. He was part of the team, along with Mr Black and ST, which initially took a lift in the bucket of the JCB digger driven by GM. They had got out on the opposite side of the road from the lorry and continued to walk up the opposite side of the road towards Fyvie whilst facing the traffic. KM was behind Mr Black who unexpectedly started to walk across the road. Mr Black had not spoken to anyone about doing so. KM could not give any explanation for Mr Black doing this, other than he might have wanted to speak to CP. The lorry continued to reverse up the road and blocked KM's view of that side of the road as it passed him on the opposite side. The next thing he could recall was GM constantly sounding the horn of the JCB.

[34] ST was a labourer who had recently started worked on the same team. At the time of the accident he had been working for the council for 2 ½ years. Following the lunch break on 26 January 2016 he recalled CP, the lorry driver, returning to the locus having left to get a further supply of tarmacadam to surface the road. Mr Penfold had parked in the driveway of the property adjacent to the road. ST, KM and Mr Black all got into the bucket of the JCB being driven GM. Part way up the hill the JCB stopped and ST, KM and Mr Black got out. They continued to walk up the on the opposite side of the road. Initially they walked beside each other but Mr Black started to walk ahead and then crossed over to the other side of the road whilst carrying a rake. ST recalled hearing the lorry reversing up the road. It passed him on his left hand side as he

continued to walk up the opposite side of the road. He recalled the lorry coming to a stop and seeing Mr Black lying under it. He realised he had been run over. ST could offer no explanation as to why Mr Black crossed the road when he did.

[35] GM was a self-employed digger driver. In January 2016 he had been contracted to Aberdeenshire Council with whom he had worked for approximately 2 years. On 26 January 2016 he was part of the team, led by William Black, who had been working on the B9005 road between Methlick and Fyvie. After their lunch break GM gave Mr Black, KM and ST a lift in the bucket of the JCB digger up the gradient of the road heading towards Fyvie. Having dropped them off approximately half way up the road GM continued to drive up to another property adjacent to the road where he reversed back onto the road, facing downhill, in the opposite direction to which he had driven. After completing this manoeuvre, he saw Mr Black behind the back of the lorry as it was reversing. He immediately sounded his horn and flashed his lights at the lorry which continued to reverse and thereafter struck Mr Black, knocking him to the ground.

[36] GM confirmed that he was not familiar with the council's health and safety policies. He could not recall having previously seen the Blue or White books. He was not aware that a banksman should have been in place for a vehicle that was in process of reversing.

[37] DM is the proprietor of DM Contractors which is a plant hire business. His company had carried out work on behalf of Aberdeenshire Council for a number of years. CP worked for his company as a lorry driver and was designated for the work to be carried out on the B9005 road on 26 January 2016. DM had not been provided with

the council's White Book. He, nor his employees, had not been provided with any training or had any formal meetings in relation to the policy. Since the accident on 26 January 2016 DM had taken steps to fit each of the company lorries with a reversing camera so as to enhance the driver's visibility when reversing. There was no legal requirement to do so but DM considered that this made a significant difference to the vehicles' safety features.

[38] ID was employed by Aberdeenshire Council as the principal Roads Engineer, who covered the Formartine area. He had instructed the road repairs to the locus on 25 January 2016. He had become aware of storm damage to the edge of the B9005 when out driving and had called his colleague, WB, to request that the work commence immediately. Following the accident ID had assisted in the council's internal investigation. Regrettably no risk assessment of the job had been found. The responsibility for completing this lay with Mr Black, as the team foreman.

[39] Since the accident it was now council policy that an on-site risk assessment must be carried out in advance of work commencing and the relevant risk assessment forms require to be returned to the office and placed in the relevant works folder, in order to ensure availability for future inspections.

[40] ID explained that there were more road teams than vehicles. As a result, the council were in the habit of subcontracting such driving work to external or "embedded" contractors, which included DM Contractors. The system for such subcontracted work had also since changed to ensure that all contractors are now fully

aware of the council's Health & Safety policies, including the mandatory requirement that all reversing vehicles are supervised by a trained banksman.

[41] In addition, a pocket-sized version of the Blue Book was now issued to all employees in the Roads Department, to ensure it could be accessed at all times. ID also explained that individual employee training records showed the courses they had each completed. The fact that not all topics listed within these records had been completed did not preclude individuals from continuing to work with their teams.

[42] ID further explained that since March 2016 all approved contractors were now issued with a standardised letter which drew particular attention to the need for vehicles to only reverse with a banksman in place and to follow the necessary instructions. In February 2016 an update was issued to all supervisors which emphasised the need for vehicles to only be able to reverse with a properly trained banksman in place. In terms of health and safety, the White Book was now issued to all engineers, supervisors and foremen to ensure all are familiar with the relevant sections.

[43] ID also confirmed that there had not been any previous issues with Mr Black's competence. He was highly regarded as an employee and trusted foreman.

Police, council and health & safety investigations

[44] Police Sergeant CM was the officer responsible for the police investigation report into the accident. In particular he confirmed that the lorry was not fitted with a reversing camera and that the reversing alarm was working correctly. With reference to the relevant section of the report he confirmed that the lorry had reversed a total of

187.2 metres uphill without a banksman in place. Death had occurred as a result of the lorry colliding with Mr Black when was reversing. At the time it was heavily loaded with tarmacadam.

[45] NM was the principal Health & Safety Inspector based in Aberdeen with over 22 years' service. He spoke to the report dated 2 March 2021 which he had prepared. It represented his professional opinion in which he had been given access to the evidence ingathered by the police. In particular, he confirmed that wherever possible reversing was to be avoided in any construction work or site. Where necessary it should always be done with a signaller or banksman where vehicles and pedestrians are segregated. In accordance with the necessary policies a vehicle should only reverse where there is no other reasonable alternative. In the present case, in his opinion, it was not reasonably practicable to expect the lorry to have driven a further 3 miles up the road in order to turn but, in any event, there should have been a banksman in place and no explanation could be given for the absence of one.

[46] PL was the Road & Landscape Manager for Aberdeenshire Council. He had been in his current role for 8 years, having worked for the council for 33 years. His job was to provide strategic oversight as well as have the lead role in Health & Safety. Following the accident significant changes had been made in the council's systems and policies. A review of all policies and procedures were carried out. He considered that the reversing and banksman's policies were fit for purpose and did not require any alterations. There had never been any previous concerns around Mr Black, his team or CP, the contracted lorry driver.

[47] PL explained that the council operating guidance have since been published in a coloured and more pictorial form which was simple to view and easy to follow. In particular, it highlighted all pre-operation checks and the fact that the chargehand/supervisor was responsible for identifying risks and mitigation plans for avoiding them. This also included the specific section on "Reversing Vehicles on Operational Site" and the explicit use of a banksman in all situations where reversing was unavoidable. Copies of the Blue Book were now given to all road workers and copies of the White Book to all charge-hands, foremen and supervisors. There were also "toolbox" type talks delivered to all staff on a regular basis.

[48] In addition, all contractors must now meet the necessary requirements as set out in a document entitled "OP 30: Haulage Hire Procedure". This included ensuring that all contractors are sent the appropriate letter of engagement setting out the council's terms and conditions which specifically included the procedure for onsite vehicles when reversing.

[49] PL reported that audits are now regularly carried out and recorded in paper and electronic form to monitor data and trends. A monthly report now required to be sent to his department for review.

Submissions

[50] Parties helpfully provided written submissions in advance. These were supplemented with oral submissions which are briefly summarised below.

[51] Mr Urquhart, for the Crown, referred to the joint minute and invited the court to make findings accordingly. He submitted that it was apparent that Mr Black had sustained significant and multiple injuries and it was therefore highly likely that death was instantaneous.

[52] Mr Urquhart recognised that the systems which have been put in place by the council since the accident had made significant improvements to issues of recording and risk assessment. In particular it was apparent that all employees and contractors were now fully aware of the importance of the use of banksmen and reversing procedures at all road sites where work was ongoing.

[53] Mr Urquhart concluded by stating that had such procedures been in place at the time of the accident then the chances of it occurring would have been greatly reduced.

[54] Mr Donaldson, on behalf of CP, adopted his written submissions. He invited the court to conclude that Mr Black's death was a tragic accident which could have been avoided if Mr Black had not elected to walk behind the lorry whilst it was reversing without a banksman in place.

[55] Miss Toner, for the council, also adopted her written submissions. She recognised that had a more robust system been in place at the time of the accident it might have been avoided. She commended the changes that had been made by the council in its policies and procedures since the accident. However, she also submitted that even if the current system had been operating at the time, Mr Black had still placed himself behind a moving lorry without any explanation nor warning being given to any

of his work colleagues, including CP. That was, in her submission, the real cause of the accident for which responsibility ultimately rested with Mr Black.

Discussions and conclusions

[56] My findings in relation to section 26 (2) (a), (b), (c) and (d) of the Act are as set out at the start of this determination. There is nothing controversial within them which were, in any case, a matter of agreement between parties and all as reflected in the terms of the joint minute referred to above. That being the case I will simply concentrate on the remaining parts of section 26 (2), namely 26 (2) (e), (f) and (g).

Section 26 (2) (e)

[57] In relation to section 26 (2) (e) I will firstly consider any precautions that (i) could have been taken and, (ii), if so taken, whether Mr Black's death or the accident itself might, realistically, have been avoided.

[58] All parties were in agreement that had a banksman been in place at the time the lorry started to reverse then the accident and Mr Black's death might well have been avoided.

[59] I consider that the necessary policies and procedures of the council at the time were quite specific and clear in their terms; a vehicle should not reverse at a road works site without a trained banksman being *in situ* from the start of the manoeuvre to ensure it was done safely.

[60] In the present case there were two trained banksmen within the team namely, Mr Black and MG, who was operating the roller. Mr Black was also the foreman and, as such, responsible for the ongoing health and safety of everyone involved. He had received the necessary instructions for the work the day before and had been involved in the initial risk assessment exercise that was carried out. He was also a highly experienced roads workman who was very well respected by all concerned. I am satisfied that he therefore knew and understood the necessary policies and procedures and was capable of implementing them.

[61] It is apparent that no explanation was able to be given by any of the witnesses as to why Mr Black chose to walk behind the lorry as he did when it was reversing. He had given the instruction to CP, the driver, to carry out the manoeuvre which was done to ensure the vehicle was facing downhill when its load of tarmacadam was to be deposited onto the road surface. As foreman Mr Black could have told CP to drive the vehicle up to the roundabout and come back down the hill facing in the same direction. I consider that this was not done for understandable reasons of expediency in order to save time.

[62] After the lorry started to reverse Mr Black walked part way up the road on the opposite side of the carriageway in the company of his other work colleagues. Initially they had been given a lift part way by the JCB which was contrary to council policy and health and safety guidelines.

[63] None of Mr Black's colleagues could provide any explanation as to why Mr Black crossed the road when he did and walked behind the lorry. It clearly took everyone by

complete surprise. The first person to react was GM who repeatedly sounded the horn on his vehicle in order to try to warn CP as the lorry driver. No one else saw what was about to happen until it was too late and the collision with Mr Black had occurred.

[64] As the team foreman Mr Black had a responsibility to put a banksman in place before the lorry started to reverse. By not so doing he heightened the risk of the accident happening. Had he done so then, in my judgement, the accident and his tragic death would have almost certainly been avoided, as either he or MG would have been in place as the banksman.

[65] For the avoidance of any doubt I do not consider the fact that Mr Black was hard of hearing played any part in the accident. Little evidence of this was given other than witness ST stating that Mr Black would take his hearing aid out at night because it made the TV sound too loud. In addition, none of the witnesses had any difficulty conversing with him previously or on the day itself.

[66] I am also satisfied that CP, the lorry driver, was unaware of the necessity of a banksman requiring to be in place before he started to reverse. He had not been provided with a copy of the Blue Book nor was he aware of the council policy and reversing procedure, despite working with Mr Black and his team for some considerable time. I accept that appropriate steps have now been taken by the council to ensure all employees and contractors are aware of the policy. I also consider that the lorry mirrors and reversing alarm were operating satisfactorily and CP was well versed in using and relying on them.

[67] I also accept that had the lorry been fitted with a reversing camera at the time then the accident could have been avoided. However, this is not a mandatory requirement and I consider that the cost of fitting to council vehicles would be unnecessarily burdensome. DM, as the contractor, has taken steps to fit his vehicles with the apparatus at his own cost. For that he is to be commended but the council, in my judgement, cannot be criticised for not doing so when such a system is not legally mandatory. For these reasons whilst the fitting of a camera might have resulted in the accident being avoided I do not consider this to have been something that could have been realistically expected.

[68] I also consider that whilst it was possible for the lorry to have driven a further two or three miles to the nearest roundabout and then turned before driving back to the site this was not something that was realistically contemplated by Mr Black or CP, given the distance and time involved in doing so. This was also confirmed by NM in his evidence who did not consider it to have been a realistic option. Accordingly, whilst this would have resulted in the lorry not having to reverse which would, in all likelihood, have avoided the accident it was not something that, in the circumstances, could have been realistically expected.

Section 26 (2) (f)

[69] In relation to section 26 (2) (f) it is necessary to consider whether there were any defects in the system of working which could have contributed to the accident or, as a result, Mr Black's death.

[70] I consider that there was an adequate system for risk assessment when the work was instructed and that Mr Black, as foreman, was also under an obligation to assess any risks on site before any work commenced, as well as during the shift itself. Regrettably the risk assessment form could not be found. It would be wrong to speculate on whether that was due to an administrative oversight or failure on the part of Mr Black. He was on site from the commencement of the working day and I am satisfied that there was a plan in place for the work to be carried out in an agreed and orderly fashion. I also consider that following the lunch break, when CP returned from collecting the tarmacadam, it was Mr Black who gave him instructions to drive into the Smithy and thereafter reverse up the road. CP had worked with Mr Black on many previous occasions. As such, I consider he was entitled to trust Mr Black's judgement and rely on the instructions that were given to him.

[71] It is concerning that GM gave Mr Black, KM and ST a lift in the front bucket of the JCB part way up the road. However, there was no evidence of any other failures in duties under the Health & Safety legislation or the council policy. There was also no evidence of any previous failures. As already stated, Mr Black was widely regarded as reliable and responsible in his role as a foreman. Although this action should not have happened it did not, in any way, contribute to the accident which subsequently occurred.

[72] As stated above there was a failure to provide external workers and contractors with the relevant policies and procedures contained within the council's White and Blue Books. I consider that this amounted to a defect in the council's system of work but, it

has since been remedied and I accept that it is now standard practice to ensure that all "embedded" contractors are provided with this information which is in very clear and understandable written format. I also consider that appropriate steps have been taken to ensure training procedures are in place for council employees and appropriate "toolbox" talks are given regularly.

Section 26 (2) (g)

[73] In terms of section 26 (2) (g) of the Act I do not consider there are any other facts which have not been considered above which are relevant to the circumstances of Mr Black's death. I was not addressed by any of the parties in this regard. Accordingly, I have no findings to make in relation to this part of the section.

Section 26 (1) (b) and (4)

[74] In relation to section 26 (1) (b) and (4) of the Act no submissions were made by any of the parties in relation to any recommendations that could be made in order to prevent similar deaths in future. The general note to the annotated version of the Act in relation to the sub-sections make clear that,

> "There must be a real or likely possibility that the matters recommended may prevent other deaths in similar circumstances, rather than a remote chance that a similar death in the future might be prevented."

[75] Having regard to all of the above, with one exception (paragraph 76 *infra*), I do not consider that any further recommendations would result in a death in similar circumstances being avoided in future. Mr Black's tragic death occurred because, in my

judgement, he elected, without any explanation or warning, to suddenly walk behind the lorry which he had instructed to reverse up the road to enable the road surfacing work to continue. No explanation could be given for Mr Black's actions and none of the witnesses could understand why he chose to do what he did, when he was part of the squad which, quite properly, was walking up the other side of the road to meet the lorry when it would have ultimately stopped adjacent to the JCB digger. Mr Black did so in the absence of a banksman being in place prior to the reversing manoeuvre for which, as foreman, he was responsible. As a trained banksman he, more so than anyone, would have been aware of the risks involved.

[76] In reaching this conclusion I have also taken account of the steps taken by the council since the accident itself to improve its health and safety policies and procedures. I note that no changes were found to be necessary to the policies themselves but the information contained within them has now been reissued in a more visual and comprehensible form to all employees. I also note that such information is now provided to all external contractors to ensure that everyone is aware of the reversing procedure for any onsite vehicle. I note that all risk assessments are now not just recorded but stored within the council's information system (Sharepoint) which is readily accessible. I note that more audit checks are carried out with a record of them kept for reference so as to identify trends or potential failings. I further note that training programmes have been significantly enhanced and improved for all employees within the department.

[77] Taking all of this together I consider that appropriate steps have been taken to ensure that a proper and appropriate safe system of work is now in place on which the workforce has been properly informed.

[78] However, the one caveat to this is that I would recommend all external contracted workers are also provided with a copy of the pocket-sized Blue Book which is issued to all council employees. Despite working for the council for a number of years neither CP nor GM had been provided with one at the time they gave their evidence. PL indicated in an affidavit provided at the submission stage that a copy of the book was provided to embedded hired plant operators and workers in or about October 2017 but that is at odds with the evidence of CP and GM. This, in my judgement, is something that should be checked and is easily remedied. It should be done to ensure that all members of a works team, whether employed or external, have been provided with the relevant policies and procedures in written form.

Any other information, observation or comment

[79] I have therefore concluded that the accident and Mr Black's death could have realistically been avoided if a banksman had been in place at the start of and during the reversing manoeuvre by the lorry. Mr Black, as foreman, was responsible for the instructions given to the driver, CP. As a trained banksman himself, Mr Black was clearly aware of the risks involved in such a driving manoeuvre being undertaken without the necessary procedure in place. This was clearly contrary to the council's

policy with which Mr Black, as an experienced foreman and banksman, was very familiar.

[80] In addition, I am satisfied that the council has taken proactive steps to improve its health and safety procedures since the accident. This has included the distribution of the necessary documentary policies and information to all members of staff and external contractors, more training and, improved electronic risk assessment record keeping, including audits.

[81] Finally, whilst it is not a formal recommendation further consideration, in my view, should be given to the training protocols that are currently in place. In particular, if a course is regarded as essential then, in my view, that is mandatory and should be undertaken within a short but realistic timescale. It is troubling that, despite his lengthy service and position of responsibility, Mr Black had not completed some of the training courses on his record that were deemed to be essential. I would therefore suggest that this aspect be looked at further.

[82] In making these remarks I recognise that this inquiry is for the purpose set out above at paragraph 10 and is not a more general inquiry into the council's working practices.

[83] I have no other observations I would wish to make beyond stating that this was a tragic accident which could have been realistically avoided if a banksman had been put in place for which responsibility rested with Mr Black. Unfortunately, no rational explanation can be given for his actions which appear to have been out of character for someone who well liked, hardworking, reliable and trustworthy.

[84] I will therefore simply finish by joining with all parties in my expressing my sincere condolences to Mr Black's friends, colleagues and family for his very sad loss in these most tragic of circumstances.