SHERIFFDOM OF NORTH STRATHCLYDE AT DUNOON SHERIFF COURT

[2023] FAI 8

DNN-B44-22

DETERMINATION

BY

SHERIFF M J HIGGINS

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

into the death of

DAVID DRYSDALE PROVAN

DUNOON, 12 December 2022

Determination

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

1. That, in terms of section 26(2)(a) of the 2016 Act (where and when the death occurred), that David Drysdale Provan, born on 19 June 1962, died at 0934 hours on Wednesday 9 December 2020 on the A815 at Laglingarten, approximately 1.3 miles east of St Catherines near Cairndow, Argyll.

2. That, in terms of section 26(2)(b) of the 2016 Act (when and where any accident resulting in the death occurred), that an accident resulting in the death of Mr Provan

occurred at approximately 0845 hours on Wednesday 9 December 2020 on the A815 at Laglingarten, approximately 1.3 miles east of St Catherines near Cairndow, Argyll.

3. That, in terms of section 26(2)(c)of the 2016 Act (the cause or causes of death), that the cause of Mr Provan's death was Cocaine intoxication with chest and abdominal injuries due to road traffic accident (driver).

4. That, in terms of section 26(2)(d) of the 2016 Act (the cause or causes of any accident resulting in the death), that the cause or causes of an accident resulting in Mr Provan's death was a result of Mr Provan whilst driving a car transporter, registration YK19 ZRY, failing to react to a stationary Large Goods Vehicle, registration SL19 YAW, and colliding into the rear of said vehicle whilst intoxicated by cocaine.

5. That, in terms of section 26(2)(e) the 2016 Act (any precautions which (i) could reasonably have been taken, and (ii) had they been taken, might realistically have resulted in the death, or any accident resulting in the death, being avoided), in terms of the evidence led, and accepted by me, I am satisfied that there were no reasonable precautions identified which could have been taken by Mitchell Inglis Limited which might, realistically, have resulted in the death, or the accident resulting in the death, having been avoided.

6. That, in terms of section 26(2)(f) of the 2016 Act (Any defects in any system of working which contributed to the death, or any accident resulting in the death), in terms of the evidence led, and accepted by me, I am satisfied that there were no defects in the system of work relating to Mitchell Inglis Limited identified which contributed to the death, or any accident resulting in the death.

7. That, in terms of section 26(2)(g) of the 2016 Act (Any other facts which are relevant to the circumstances of the death), I am not satisfied that I can make any findings in relation to section 26(2)(g), given the limited evidence available and I am not prepared to draw any inferences to allow me to infer any other facts as being relevant to the circumstances of the death.

8. In terms of section 26(1)(b) of the 2016 Act, there are no recommendations to make which might realistically prevent other deaths in similar circumstances arising from the information provided to the Inquiry.

NOTE

Introduction

[1] This inquiry into the death of Mr Provan was held on 30 November 2022 by means of a WebEx Hearing. Mr Abbas Ali, Procurator Fiscal Depute, represented the Crown. Ms Ann Bonomy, Solicitor represented Mr Provan's employers, Mitchell Inglis Limited. Mr Provan's niece, Ms L A, and his brother Mr R P, were present at the Hearing. They did not wish to be represented at or to take part in the Hearing beyond listening to same.

[2] No oral evidence was presented at the Hearing. The Crown and employers had entered into a detailed and comprehensive Joint Minute of Agreement in advance of the Hearing. I am grateful to their efforts in that regard which clearly show the considerable advanced attention and thought they had given the matter. Their efforts assisted the court greatly.

Purpose of the Inquiry

[3] Fatal Accident Inquiries are governed by the 2016 Act and the Act of Sederunt (Fatal Accident Inquiry Rules) 2017. In terms of section 1(3) of the 2016 Act, the purpose of an Inquiry 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.

[4] It is of importance to note that the purpose of the Inquiry is not to establish civil or criminal responsibility.

[5] It is also of importance to note that the process is inquisitorial in nature.

[6] The Crown, that is to say, the procurator fiscal, represents the public interest at the Inquiry.

[7] The Inquiry into Mr Provan's death was mandatory in terms of sections 2(1) and (3) of the 2016 because his death occurred whilst he was in the course of his employment.

[8] As regards the circumstances of the death, in terms of section 26(1)(a) of the 2016 Act, the sheriff must make findings regarding the following:-

(a) When and where the death occurred;

(b) When and where any accident resulting in the death occurred;

(c) The cause or causes of death;

(d) The cause or causes of any accident resulting in the death;

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

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

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

[9] By virtue of section 26(1)(b) of the 2016 Act, the sheriff is entitled to make recommendations regarding the following:-

(a) The taking of reasonable precautions;

(b) The making of improvements to any system of work;

(c) The introduction of a system of work;

(d) The taking of any other steps;

which might, realistically, prevent other deaths in similar circumstances.

Factual circumstances

Background

[10] Mr David Drysdale Provan, ("Mr Provan"), date of birth 19 June 1962 was employed as a driver for Mitchell Inglis Limited, a vehicle body repair shop in Glasgow. He had been employed in this role for approximately 15 years in a full-time capacity. This role involved transporting customer vehicles to and from the vehicle repair shop and required him to drive all over the country.

Events of 9 December 2020

[11] On Wednesday 9 December 2020 Mr Provan left his place of work at Mitchel Inglis, 1033 South Street, Glasgow in an Isuzu N75.190 car transporter vehicle, registration number YK19 ZRY, to travel to Dunoon for collection of a customer vehicle. This is a Large Goods Vehicle (LGV) with the driver cab separate from the loading bay. Mr Provan was travelling alone with no passengers.

[12] Mr Provan arrived in Dunoon and loaded the customer vehicle, a Ford Galaxy, registration number M888 PEL, which was loaded with the front of the car facing the driver cab within the load bay of his vehicle. Mr Provan commenced the journey from Dunoon to Glasgow, travelling via the A815.

[13] At approximately 0845 hours John Haig was travelling north on the A815, approximately 1.3 miles north of St Catherines, Dunoon in a DAF CF Large Goods Vehicle, a rigid flatbed lorry, registration number SL19 YAW. Mr Haig's vehicle was carrying an abnormal load, that being a static caravan, to Loch Awe, Taynuilt. Mr Haig was being escorted by a Renault Traffic van, registration number SC14 XEV, driven by Darren Paul which is used to escort abnormal loads. Mr Paul's role was to warn oncoming drivers of the wide load and to communicate any potential problems to Mr Haig. Mr Paul's said vehicle was marked as a self-escort vehicle with high conspicuity markings and amber flashing lights fitted. Mr Paul travelled at a reasonable distance ahead of Mr Haig's vehicle. Police Scotland had been notified of the transfer previously and the witnesses were authorised to self-escort.

[14] Mr Haig travelled along a long straight section of road, approximately 0.3 miles in length before negotiating a right hand bend which leads on to a further straight section of the road at Laglingarten House. Mr Haig followed behind Mr Paul's vehicle. Mr Haig checked his rear view camera and did not observe any vehicles behind him.

[15] At this time, Keith Craig was driving westbound on the A815, driving a rigid LGV, registration mark K200 AMT, also in the course of his employment as a delivery driver.

[16] Mr Craig entered on to the same section of straight road and observed Mr Paul's escort vehicle travelling towards him with the lights activated, indicating it was escorting a vehicle behind. Shortly thereafter, he observed the DAF LGV driven by Mr Haig come into view behind the escort vehicle. Mr Haig had been alerted by the escort vehicle of Mr Craig's oncoming LGV and slowed his vehicle to crawling pace, before briefly coming to a halt. Mr Craig moved his vehicle into a layby and flashed his headlights with the intention of allowing the DAF LGV being driven Mr Haig space to proceed.

[17] At this time Mr Provan was travelling east in his said vehicle on the A815 and negotiated the right hand bend before turning on to the straight section of road at Laglingarten House, approximately 1.3 miles east of St Catherines near Cairndow, Argyll. Mr Provan failed to react to Mr Haig's stationary DAF LGV and collided with the rear of same, shunting it forward a short distance.

[18] The collision was captured by a dashboard cam fitted to Mr Craig's vehicle.

[19] Mr Haig and Mr Craig attended to Mr Provan's vehicle and noted there to be catastrophic damage to the driver's cab, trapping Mr Provan within the vehicle.

[20] Brian Packwood and Alistair Mackechnie, had been travelling North separately from each other on the A815. They were in the course of their employment as a delivery driver and joiner, respectively. They arrived at the locus behind Mr Haig's DAF LGV vehicle. Mr Mackechnie was a volunteer firefighter.

[21] Mr Packwood immediately telephoned the emergency services and requested an ambulance.

[22] Mr Packwood and Mr Mackechnie attempted to assist Mr Provan by checking if he could breathe but they were unable to gain access due to the cab crushing him.

[23] John Lamont was travelling southbound in his tractor on the A815 to Dunoon and arrived at the scene. He was asked by Mr Mackechnie, to mobilise his tractor to pull away the cab from Mr Provan.

[24] Mr Mackechnie and Mr Craig attached tow straps to Mr Lamont's tractor and a pillar on Mr Provan's vehicle thereby allowing Mr Lamont to pull the cab back and remove it from Mr Provan. This provided the said witnesses with space to check on Mr Provan. However Mr Provan appeared unresponsive at this time.

[25] At approximately 0850 hours Paramedic Lorne Campbell was dispatched to attend the scene of the collision. She was accompanied by Ambulance Technician Gerard Gray. On arrival, Ms Campbell observed Mr Provan to be unresponsive with a severe head injury and pupils fixed and dilated. At this time Mr Provan had no pulse and was not breathing. Ms Campbell and Mr Gray then attached a defibrillator which

showed an agonal rhythm which very quickly tuned to asystole. They were unable to perform CPR due to lack of access as Mr Provan was entrapped in the vehicle. Ms Campbell pronounced Mr Provan's life extinct at 0934 hours on 9 December 2020.

[26] During this time a number of divisional and road traffic Police Officers had arrived at the scene of the collision. Police Sergeant Craig attended at the scene and took on the role of Senior Investigating Officer and Police Constable Colin May was assigned as Investigating Officer. Police Constable John O'Hara and Police Constable Stuart Paterson also attended the scene in their capacity as Collision Investigators. The area was immediately secured for evidential purposes.

[27] Mr Haig was required under the terms of Section 172 of the Road Traffic Act 1988 to confirm the driver of the DAF LGV. He confirmed that he was the driver of the vehicle. Mr Haig was thereafter required under Section 6 of the Road Traffic Act 1988 to provide a specimen of breath for the purposes of a roadside breath test. He provided a negative breath test and also a negative roadside drugs test.

[28] Mr Provan was conveyed to the Queen Elizabeth University Hospital, Glasgow.

[29] At the time of the collision on 9 December 2020, Mr Provan was acting in the course of his employment as a driver for Mitchell Inglis Limited.

Collision Investigation Report

[30] Police Constables John O'Hara and Stuart Paterson attended at the scene of the collision at approximately 1200 hours on 9 December 2020 and, following a detailed examination of the scene and the two vehicles, prepared a Collision Investigation

Report. As part of their examination they prepared a reconstruction of events and in their Report noted as follows:-

> "John Haig's DAF HGV exited the right hand bend near to Laglingarten House, and slowed down to walking pace to allow the opposing goods vehicle to move into the bell mouth of the junction on the south side of the road.
>
> David Provan negotiated the right bend at approximately 36 mph as he junction leading to Laglingarten House. Despite having the opportunity of a view of the slow moving DAF HGV ahead for approximately 6.28 seconds, he failed to react and collided with rear of the caravan and vehicle tow bar, before coming to a stop almost immediately, opposite the junction to Laglingarten House.
>
> David Provan was trapped within his vehicle and died as a result of injuries sustained in this collision".

[31] The conclusion of the Collision Investigation Report states as follows:-

> "This collision is the result of David Provan driving the Isuzu box van east on the A815 and colliding with the rear of the slow moving DAF HGV, which was under escort.
>
> At the material time, it was daylight, overcast and visibility was good. Traffic conditions were light.
>
> The DAF HGV was equipped with flashing orange beacons to the rear, which were in operation at the time of this incident. Its rear position lamps were illuminated and the brake lights were checked and found to be in working order. It was carrying a large green coloured caravan 3.7 metres wide which was appropriately marked with projection markers.
>
> Given the width of the load and the likelihood of coming into conflict with other road users, and in particular other heavy goods vehicles, the driver John Haig often has to stop or slow down in order to allow such vehicles to pass or pull over. This was the case in the events leading up to this collision.
>
> David Provan was alone with the Isuzu box van, and was negotiating a sweeping right hand on the approach to the crash locus. Upon reaching a point 100 metres west of the junction to Laglingarten House, he would have had the opportunity of a view of the slow moving DAF HGV ahead. It is generally accepted that the reaction time for a driver (the time that passes between the moment the driver observes the need for action and the moment he takes the action) is one to two

> seconds. Tachograph data has shown that he was travelling within the speed limit at approximately 36mph, which shows that he had approximately 6.28 seconds available to him in which to react and has failed to do so.
>
> There was no evidence either on the roadway or on the tyres of the vehicle itself, that the Isuzu box van underwent emergency braking. A mechanical examination of the Isuzu box van revealed no defects with the steering or braking systems.
>
> It is unknown why David Provan failed to react to the slow moving DAF heavy goods vehicle in the roadway ahead of him. It is clear that he had control of the vehicle, as he managed to negotiate the sweeping right hand bend and tachograph data shows that his speed was steady and constant".

Vehicle Examination Report

[32] At approximately 1500 hours on Monday 14 December 2020 a mechanical examination was carried out on the DAF CF LGV driven by the Mr Haig and the Isuzu N75.190 LGV driven by Mr Provan by Police Constable Glen Discombe and Police Constable Sally Ann Nicol. Neither of the vehicles examined were found to have any obvious defects which could have contributed to this collision.

Further Investigation

[33] A brief examination of the rear of Mr Provan's vehicle by witness Police Constables Stuart Campbell and Colin May on 9 December 2020 identified the Ford Galaxy vehicle being transported had been secured by 2 ratchet straps fitted to the front wheels. They observed this may have been insufficient to prevent the vehicle's forward momentum whilst within the rear of the vehicle.

[34] Police Constable John O'Hara commented on whether this had any bearing on the accident and on best practice in relation to securing a transported vehicle. In his response he states as follows:-

> "The weight of the vehicle was found to be within its maximum authorised mass, and as such the load should not have had a bearing on the ability of the vehicle to reduce speed".

He also said as follows:-

> "… cars and light vans up to 3,500 kg being transported on flatbed or curtain-sided trailers require to be secured with lashings on all four wheels, with chocks on at least two … only the front wheels were lashed to the flatbed, and although no chocks were in place, it cannot be ruled out that they dislocated as a result of the collision.
>
> Despite the lack of lashings to the rear wheels, the load did not dislocate and certainly did not make contact with the leading edge of the box body. It is the collision investigators opinion that the manner in which the load was secured, did not have a bearing on the collision".

[35] Mr Provan's vehicle was fitted with an electronic winch, used to load vehicles on that could not be driven on. There were no other loading or safety mechanisms other than the straps used to tie the Ford Galaxy vehicle to Mr Provan's vehicle. The gross weight of Mr Provan's vehicle with the Ford Galaxy on board was 7500 kg, the maximum gross weight permitted. The weight of Mr Provan would have meant the vehicle exceeded 7500kg. However, the weight of Mr Provan's vehicle was immaterial to the collision as noted by witness Constable Colin May as follows:-

> "The dashcam footage and physical evidence at the locus confirmed that there was no emergency braking. The collision was purely down to the fact that, for an unknown reason, David Provan failed to observe and react to the presence of the large goods vehicle in front of him".

Post Mortem and Police Enquiries

[36] A post mortem examination was conducted on 24 December 2020 at the Queen Elizabeth University Hospital, Glasgow by Consultant Forensic Pathologist, Dr Gemma Kemp and the cause of death was recorded as:-

> "1a: Cocaine Intoxication with chest and abdominal injuries due to road traffic collision (driver)".

[37] It is stated in the conclusion of the report that:-

> "Post mortem examination findings indicate that David Provan died as the result of cocaine intoxication together with chest and abdominal injuries sustained as the driver in a road traffic collision……
>
> …….Cocaine and its inactive metabolites, benzoylecgonine and ecgonine methyl ester, were found in the blood indicating the use of cocaine within a few hours before death…...
>
> …...In summary, Mr Provan was under the influence of the stimulant illicit drug cocaine at the time of a road traffic collision in which he sustained significant chest and abdominal injuries; the death is therefore considered to have been caused by both the drug intoxication and trauma….. ".

[38] Police Scotland carried out analysis of two mobile phones in Mr Provan's possession at the time of his death and made enquiries with his family but were unable establish where he may have obtained cocaine from.

Submissions

[39] In submissions, the Crown asked me to make formal findings in terms of sections 26(2)(a), (b), (c) and (d) and advised that they had no submissions to make as regards findings under sections 26(2)(e),(f) and (g).

[40] In submissions, the employers asked me to make formal findings in terms of sections 26(2)(a), (b), (c) and (d) . They asked me to make a finding in terms of section 26(2)(e) that there were no reasonable precautions that could have been taken by them which might realistically have resulted in the death or the accident causing the death to have been avoided. They asked me to make a finding in terms of section 26(2)(f) that there were no defects in any system of working which contributed to the death or any accident resulting in the death. They did initially ask me to make a particular finding under section 26(2)(g) but ultimately withdrew that request and asked me to make no finding.

[41] The Crown and employers did not invite me to make any recommendations and, I make no recommendations, under section 26(4) of the 2016 Act.

Conclusion

[42] I am satisfied that I should make formal findings of the time, date, place and cause of Mr Provan's death.

[43] I am satisfied that I should make a formal finding that there were no reasonable precautions identified which could reasonably have been taken by Mitchell Inglis Limited which might realistically have resulted in the death, or the accident resulting in the death, having been avoided.

[44] I am satisfied that I should make a formal finding that there were no defects in the system of work relating to Mitchell Inglis Limited identified which contributed to the death, or any accident resulting in the death.

[45] I am satisfied that I should make no findings in terms of section 26(2)(g) of the 2016 Act.

[46] I have no recommendations to make in terms of section 26(1)(b) of the 2016 Act.

[47] Finally, I join the Crown and Mitchell Inglis Limited, in offering my condolences to the family of Mr Provan.