**SHERIFFDOM OF GRAMPIAN, HIGHLAND AND ISLANDS AT INVERNESS**

**[2024] FAI 5**

INV-B268-23

DETERMINATION

BY

SHERIFF SARA L MATHESON

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

into the death of

**ALAN JONES**

INVERNESS, 8 February 2024

**Determination**

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

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

The late Alan Jones, born 18 January 1958, died at approximately 04:15 hours on 30 September 2022 at the A9 Dunblane to Scrabster trunk road at Black Mount, east of the junction with the A938 Carrbridge.

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

The accident resulting in death took place at approximately 04:15 hours on 30 September 2022 at the A9 Dunblane to Scrabster trunk road at Black Mount, east of the junction with the A938 Carrbridge.

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

The cause of the death of said Alan Jones was multiple injuries as a consequence of being the driver in a vehicular collision.

**In terms of section 26(2)(d) of the 2016 Act (the cause or causes of any accident resulting in the death)**

The cause of the accident resulting in the death of said Alan Jones was his loss of control of his vehicle for some reason, which cannot be determined, which meant he did not or could not prevent the lorry he was driving from crossing the centre line markings into the oncoming traffic lane and colliding head on with an oncoming lorry.

**In terms of section 26(2)(e) of the 2016 Act (any precautions which (i) could reasonably have been taken and (ii) had they been taken, might realistically have resulted in death, or any accident resulting in death, being avoided)**

Given that the precise mechanism of the accident which resulted in the lorry being driven by said Alan Jones colliding with the oncoming lorry is unknown it cannot be

determined whether there are precautions which might realistically have resulted in that accident being avoided.

**In terms of section 26(2)(f) of the 2016 Act (any defects in any system of working which contributed to the death or the accident resulting in death)**

Given that the precise mechanism of the accident which resulted in the lorry being driven by said Alan Jones colliding with the oncoming lorry is unknown it cannot be determined that there were defects in any system of working which contributed to the death or the accident resulting in death.

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

There are no other facts relevant to the circumstances of the death of said Alan Jones.

**Recommendations**

**In terms of sections 26(1)(b) of the 2016 Act (recommendations (if any) as to (a) the taking of reasonable precautions, (b) the making of improvements to any system of working, (c) the introduction of a system of working, (d) the taking of any other steps, which might realistically prevent other deaths in similar circumstances)**

There are no recommendations.

**NOTE**

**Legal framework**

[1] This inquiry was held in terms of section 1 of the 2016 Act and was governed by the Act of Sederunt (Fatal Accident Inquiry Rules) 2017 (hereinafter referred to as "the 2017 Rules"). This fatal accident inquiry was presented by the Crown as a mandatory inquiry in terms of section 2 of the 2016 Act as Mr Jones died as a result of an accident in the course of his employment or occupation.

[2] The purpose of this inquiry as set out in section 3 of the 2016 Act, is to establish the circumstances of the death and to consider what steps, if any, might be taken to prevent other deaths in similar circumstances. It is not intended to establish liability, either criminal or civil. An inquiry is an exercise in fact finding, not fault finding. It is not open to me to engage in speculation. An inquiry is an inquisitorial process. The Crown, in the form of the Procurator Fiscal, represents the public interest.

[3] In terms of section 26 of the 2016 Act the inquiry must determine certain matters, namely where and when the death occurred, when any accident resulting in the death occurred, the cause or causes of the death, the cause or causes of any accident resulting in the death, any precautions which could reasonably have been taken and might realistically have avoided the death or any accident resulting in the death, any defects in any system of working which contributed to the death, and any other factors relevant to the circumstances of the death. It is open to me to make recommendations in relation to the matters set out in subsection 4 of section 1 of the 2016 Act.

**Introduction**

[4] This inquiry was held into the death of Alan Jones. He was a 64 year old man who was employed as a heavy goods vehicle driver by Northwards Ltd. In turn Northwards Ltd provided agency services to Tesco Stores Ltd. He died on 30 September 2022 when a lorry he was driving in the course of his employment collided with an oncoming lorry on the A9 road at Black Mount, near the Carrbridge junction.

[5] A preliminary hearing was held by Webex at Inverness Sheriff Court on 15 November 2023. I was advised that there was no evidence likely to be in dispute and that the Crown would finalise and lodge a joint minute of agreement.

[6] The inquiry proceeded by Webex at Inverness Sheriff Court on 1 February 2024. Ms Sun, Procurator Fiscal Depute, represented the Crown. Mr MacDonald, solicitor, represented Mr Jones' employer, Northwards Ltd, and Ms McDonnell represented Tesco Stores Ltd. No other parties were represented. Parties lodged a substantial joint minute of agreement. I accept the facts set out in the joint minute of agreement. The findings in fact listed below are largely derived from the joint minute of agreement.

[7] The Crown also lodged an inventory of documentary productions on a pen drive as follows:

1. Post Mortem Report
2. Death Certificate
3. Collision Investigation Report – Police Service of Scotland
4. Album of photographs showing locus
5. Map showing locus

6. Dashcam footage - front

7. Dashcam footage - rear

8. MOT certificate for H3 ETV

9. Inspection sheet for H3 ETV dated 25 August 2022

10. Inspection sheet for H3 ETV dated 12 July 2022

11. Tachograph data Alan Jones August 2022

12. Tachograph data Alan Jones September 2022

13. Trailer tracker records for H3 ETV

14. Timesheets – Alan Jones

15. DVSA collision examination report form lorries

16. DVSA collision examination report form trailers

17. DVSA photographs of H3 ETV lorry

18. DVSA photographs of trailer

[8] As there was no dispute between parties as to the evidence the inquiry proceeded on the basis of the joint minute of agreement, which was read by Ms Sun.

**The facts**

[9] Alan Jones (hereinafter referred to as Mr Jones) was aged 64 years, having been born on 18 January 1958 and formerly resided in Inverness. He is survived by his wife, and adult son.

[10] Mr Jones was, at the time of his death, employed by Northwards Ltd, as a Heavy Goods Vehicle driver and had been since July 2021. He held a full substantive driving

licence and had held category C entitlement since 1 April 1991. Category C authorises a driver to drive heavy goods vehicles.

[11] Mr Jones was understood to be of reasonable health. He had pernicious anaemia, a B12 deficiency, for which he received an injection every two months from his doctor. This was diagnosed in 2021. He suffered from high blood pressure for which he was prescribed medication and was reviewed every two to three years. Mr Jones previously suffered from blood clots, but this had not caused any issues prior to his death. He previously suffered a blood clot in December 2019 and a second clot in 2020, before being prescribed medication to prevent any further clots.

[12] Northwards Ltd have a contract with Tesco Stores Ltd. to distribute goods to the Highland and Islands area from their Livingston Distribution Centre. Mr Jones had been driving the route from Inverness to Livingston and return weekly for the three months prior to his death and knew the route well.

[13] The white Man 480 TGX articulated heavy goods vehicle, registration H3 ETV (hereinafter "the deceased's lorry"), driven by Mr Jones at the time of his death, was last inspected and serviced on 25 August 2022 by ETV Inverness and all applicable items were found to be serviceable. The details of this inspection are contained in Crown production number 9.

[14] The locus of this collision is the A9 Dunblane to Scrabster public road at Black Mount, east of the junction with the A938 Carrbridge. The A9 Dunblane to Scrabster public road runs generally south to north, however, specifically at the locus it runs from east to west. The locus was a two-way undivided carriageway and was comprised of

tarmacadam which was in a reasonable state of repair and was subject to the National Speed Limit of 60 miles per hour for motor cars. The speed limit for HGVs was 50 miles per hour, as set by the HGV Speed Limit (M9/A9 Trunk Road) Regulations 2014. There was no street lighting present nor was there CCTV covering the locus.

[15] At the time of the collision, weather conditions were windy and wet, it was during the hours of darkness and visibility was good. The road surface was wet and traffic flow was very light.

[16] At about 19.00 hours on 29 September 2022 Mr Jones commenced his shift at Northwards' yard based at 33 Harbour Road, Inverness and collected the subject vehicle. He was to travel from Inverness to the Tesco Livingston Distribution Centre, with an empty Tesco trailer and to return to Inverness with a loaded Tesco trailer. Mr Jones was alone within his vehicle.

[17] About 22.30 hours on 29 September 2022, John Halloran, commenced his shift as an HGV driver for Tesco at their Livingston Distribution Centre, Livingston. About 23.00 hours, same date, Mr Halloran left the Livingston Distribution Centre driving a white Mercedes Actros, articulated heavy goods vehicle, registration YN69 PWX (hereinafter "the Mercedes HGV") to travel to Tesco Extra, Inverness with a load of supermarket groceries. Mr Halloran was alone within his vehicle.

[18] At 00.44 hours on 30 September 2022, Mr Jones sent a text to Gary Smith, Northwards Operations Manager, to advise him that the lorry was loaded for the return journey to Inverness. At 01.53 hours, Mr Jones refuelled at Broxden Services, Perth and appeared to be fit and well from CCTV at the location.

[19] At about 02.15 hours, same date, Mr Jones had a general conversation with his son, Mr Thomas Jones, which lasted for several minutes. Mr Jones appeared to be in good spirits.

[20] About 02.15-02.20 hours, Mr Halloran arrived at Tesco Extra, Inverness where his vehicle was unloaded by Tesco staff before being loaded with empty crates to return to the Livingston depot. About 02.50 hours, Mr Halloran pulled away from the loading bay and parked at Tesco's car park, Inverness where he had a 47 minute break. His journey to Livingston Distribution Centre resumed at about 03.40 hours.

[21] At about 04.15 hours on 30 September 2022, Mr Jones was travelling northwards on the A9. Towards the end of a long sweeping left hand bend, his HGV began to drift and crossed over from the northbound lane, into the southbound lane, where his vehicle struck Mr Halloran's vehicle, which was travelling south.

[22] Mr Halloran had no time to take any evasive action.

[23] The HGV tractor units collided within the eastbound (southbound on the A9) lane. The offside of the deceased's HGV impacted with the offside of the trailer unit of the Mercedes HGV being driven by Mr Halloran, causing catastrophic damage to the deceased's tractor unit. The rear and offside of both trailer units were destroyed and parts of both were strewn across the locus.

[24] The deceased's HGV travelled up the grass verge with the uphill gradient of same causing it to overturn, coming to rest on its nearside.

[25] The Mercedes HGV came to rest on the southbound verge, with the trailer unit facing in a south easterly direction and the tractor unit at an angle facing southward.

[26] Witness Stewart Smith, who was travelling north behind Mr Jones' vehicle at about 55 mph, saw that the deceased's HGV had started to drift into the oncoming southbound carriageway and then collided with the Mercedes HGV driven by Mr Halloran. Mr Smith stopped and provide assistance and immediately contacted the emergency services.

[27] About 04.30 hours, same date, the police witnesses Wayne Latimer, Craig Strang, Brigita Pusinskaite and John Beverly arrived at the locus where they observed the two HGVs with significant damage. They observed Mr Jones motionless within the cab of his vehicle, suspended by his seatbelt, clearly with non-survivable injuries that were not compatible with life.

[28] About 04.38 hours, same date, witnesses Victoria Emslie and Grant Jamieson, paramedic and technician for the Scottish Ambulance Service arrived on scene, where they observed Mr Jones suspended within his cab.

[29] At 04.45 hours on 30 September 2023, witness Victoria Emslie pronounced Alan Jones' life extinct.

[30] Mr Halloran sustained superficial injuries and was conveyed to Raigmore Hospital, Inverness as a precaution by an Inverness ambulance crew, where he was treated for cuts to his face.

[31] Crown production number 6 - Copy Dashcam Footage - contains video footage from a dashcam system with a front mounted camera fitted to the Mercedes HGV driven by Mr Halloran. The footage shows the deceased's HGV cross the white line into the oncoming vehicle.

[32] Mr Jones' body was conveyed to Raigmore Hospital Mortuary, and on 4 October 2022 was examined by Doctor Natasha Inglis, Consultant Pathologist. Crown production number 1 is a Post Mortem Report and contains a true and accurate record of her findings.

[33] In terms of said Post Mortem Report, the causes of Alan Jones' death were: 1a Multiple injuries due to (or as a consequence of) 1b Motor Vehicle Collision (driver).

[34] The pathologist could not entirely exclude that Mr Jones had a cardiac event prior to the collision as he was known to suffer from hypertension. No other evidence of natural disease which could have contributed to his death was found. The deceased was not under the influence of alcohol or drugs.

[35] The road was closed and the locus preserved until the arrival of the police witnesses Constables Mark Dalloway and Ross McTaggart, both from Road Policing Unit, who attended and took photographs of the locus and carried out a detailed forensic collision investigation. The findings of their investigations are contained in Crown production number 3 - Collision Investigation Report.

[36] The deceased's HGV and the Mercedes HGV were seized and recovered to Sheriffmill Motor Company Ltd, Sheriffmill Road, Elgin for examination.

[37] On 4 October 2022 at Sheriffmill Motor Company Ltd premises, Elgin, at the request of Police Scotland and in the presence of two police officers, witnesses Henry Mackie and Malcolm Brown, both Vehicle Examiners, examined the deceased's HGV and the Mercedes HGV respectively. No defects were found on either vehicle which contributed to the collision.

[38] Copies of the deceased's HGV tachograph record, which contained Mr Jones' driving record from 1 August 2022 to 27 September 2022, per Crown productions numbers 11 and 12 were obtained and reviewed by police witness Constables Mark Dalloway and Ross McTaggart. These were found to be in order with no driving infringements on the day of the accident.

[39] On 30 September 2022 at Raigmore Hospital, police witnesses carried out an eyesight test with the witness Halloran, which he passed. He also provided negative tests for alcohol and drugs. Police officers carried out a cursory search on Mr Halloran's mobile phone for use at the time of the collision, with nothing untoward noted.

[40] Mr Jones' mobile phone and tablet computer from his HGV were examined, and no evidence of use at the time of the collision was found.

[41] Crown production number 3 is a true and accurate copy of the report prepared by Police Constables Mark Dalloway and Ross McTaggart. The findings of the report were that the deceased lost control of his vehicle, crossed the centre line and collided with the HGV being driven by Mr Halloran in the centre of the eastbound (southbound on the A9) lane. The cause of this loss of control cannot be established; the police considering that the most likely explanation was the deceased being overtaken by sleep or a medical episode.

**The evidence**

[42] Ms Sun for the Crown intimated that all the evidence to be presented at the inquiry was contained within the joint minute of agreement, which she read out. The

salient facts from the joint minute of agreement are noted above and the principal joint minute of agreement is lodged with the inquiry papers. Mr MacDonald and Ms McDonnell confirmed that they had no additional evidence to lead on behalf of Northwards Ltd and Tesco Stores Ltd respectively.

**Crown submissions**

[43] Ms Sun lodged written submissions on behalf of the Crown. These constituted formal submissions in relation to time and location of death and of the accident resulting in death, based on the evidence contained in the joint minute of agreement. Likewise, she made formal submissions in relation to the cause of Mr Jones' death, in accordance with the findings of the pathologist. Ms Sun very properly submitted that as the underlying cause of Mr Jones' accident is unknown and cannot be determined she was not in a position to suggest reasonable precautions in terms of section 26(2)(e) of the 2016 Act. Ms Sun made no submissions in relation to sections 26(2)(f) and (g) of the 2016 Act.

[44] Ms Sun went on to express, on behalf of the Crown, her condolences to Mr Jones' family and friends.

**Submissions on behalf of Northwards Ltd**

[45] On behalf of Northwards Ltd Mr MacDonald presented helpful written submissions. By and large, these aligned with the Crown submissions. He submitted that the cause of the accident should be determined as unknown, as to do otherwise

would be speculation. He submitted that in terms of section 26(2)(f) of the 2016 Act, in light of the evidence, I should conclude that there were no defects in any system of working which contributed to Mr Jones' death or the accident resulting in his death.

[46] Mr MacDonald also took the opportunity to extend his client's deepest sympathies to Mr Jones' wife, son and wider family and friends.

**Submissions on behalf of Tesco Stores Ltd**

[47] Ms McDonnell also presented helpful written submissions. By and large, these aligned with the Crown submissions and those of Northwards Ltd. She submitted that the reason for Mr Jones' loss of control cannot be established and it flowed from that, that there were no defects in any system of working which contributed to Mr Jones' death or the accident resulting in his death.

[48] Ms McDonnell also wished to extend her client's condolences to Mr Jones' family and friends.

**Discussion and conclusions**

[49] What caused Mr Jones' tragic death is clear. The lorry that he was driving north on the A9 crossed the centre line into the path of an oncoming lorry, driven by Mr Halloran, with catastrophic and instantly fatal consequences for Mr Jones. It is clear from the evidence that Mr Halloran could have done nothing to prevent the collision.

[50] As far as the evidence shows neither driver was under the influence of drink or drugs. Neither driver was on their phone or any other device. Neither was driving a

vehicle that had a mechanical problem. Both were experienced HGV drivers. Both were familiar with the A9. The road surface was in satisfactory condition. Visibility was good. An examination of Mr Jones' tachograph shows he had been working reasonable hours and habitually took appropriate breaks during his shifts. He seemed to be in good spirits.

[51] Although it is very clear what happened, on the evidence it is not possible to ascertain the reason why the accident happened. It remains unknown why Mr Jones allowed his lorry to cross over the white centre line into the oncoming carriageway. He may have been distracted for some unknown reason. He may have fallen asleep. He may have suffered some medical event, of unknown seriousness. Mr MacDonald submitted that I cannot engage in speculation as to the cause of the accident and there is insufficient evidence to support any inference as to the cause of the accident. I agree with this submission. Thereafter, all parties submitted, as the cause of the accident cannot be determined, it is not possible to establish any reasonable precautions. Nor is it possible to make recommendations for the future. I also agree with these submissions.

[52] In these circumstances I am constrained to make the formal findings required by the 2016 Act, as set out above.

[53] In closing this Determination, I join with others in expressing my sympathy to the family and friends of Mr Jones.