SHERIFFDOM OF TAYSIDE, CENTRAL & FIFE AT KIRKCALDY

[2024] FAI 11

KKD-B235-23

DETERMINATION

BY

SHERIFF ELIZABETH McFARLANE

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

into the death of

GARY CAMPBELL

KIRKCALDY, 23 FEBRUARY 2024

Determination

The Sheriff having considered all of the evidence and the submissions of parties, determines in terms of section 26 of the Inquiries into Fatal Accidents and Sudden Deaths Etc (Scotland) Act 2016 ("the Act") that:

1. In terms of section 26(2)(a): *where and when the death occurred*

Gary Campbell, born 17 March 1989, ("Mr Campbell") who resided at Glenrothes, died at the premises of Oilfast Ltd, Dean Way, Orchardbank Industrial Estate, Forfar, ("Oilfast") at 10.44am on 15 March 2019.

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

The accident resulting in Mr Campbell's death occurred at approximately 10.14am on 15 March 2019 at the premises of Oilfast as detailed above. At the time, Mr Campbell was employed by Scania (Great Britain) Ltd ("Scania") as a workshop foreman. He had attended at the premises to carry out a repair on a Scania tanker lorry registration P600 FST ("the vehicle") owned by Oilfast. The repair was to replace a damaged airbag located within the second axle nearside suspension unit.

3. In terms of section 26(2)(c): *the cause or causes of the death*

The cause or causes of death were (a) traumatic asphyxia, (b) compressive facial blunt force trauma, (c) entrapment in tanker wheel arch.

4. In terms of section 26(2)(d): *the cause or causes of any accident resulting in the death*

When Mr Campbell arrived at the Oilfast's premises, he firstly shut off and isolated the air pipe on the vehicle that supplied the second axle nearside air suspension unit. He then inflated the three remaining suspension units to their maximum height presumably to create sufficient space to remove the damaged airbag. Mr Campbell then positioned himself between the second axle wing and tyre at the nearside whilst the vehicle body was raised and supported only by the remaining air bags. Whilst in this position, it appears that the second axle offside airbag failed catastrophically, causing the vehicle to drop from its suspended position, trapping Mr Campbell to his severe injury and death.

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

Reasonable precautions would have been for Mr Campbell to take the appropriate tools to carry out such a repair or alternatively, have the vehicle recovered to the Scania workshop. In addition, Mr Campbell should have followed Scania repair procedure initially making sure that the vehicle was parked on firm and level ground. He should then have raised the vehicle chassis using bottle jacks to give sufficient clearance and then inserted axle stands to prop and securely support the vehicle chassis in the raised position.

6. In terms of section 26(2)(f): *any defects in any system of work which contributed to the death, or any accident resulting in the death*

There were no defects in any system of work which contributed to the accident resulting in Mr Campbell's death.

7. In terms of section 26(2)(g): *any other factors which are relevant to the circumstances of the death*

There are no other factors which are relevant to the circumstance of Mr Campbell's death.

Recommendations

In terms of section 26(1)(b): having considered the information presented at the inquiry, no recommendations are made.

NOTE

Introduction and Contents

[1] This determination follows an inquiry into the death of Mr Campbell who died on 15 March 2019 at the premises of Oilfast, Forfar. It contains 13 chapters and an appendix, namely:

1. Introduction and contents
2. The legal framework
3. Participants and representation
4. The inquiry process
5. What happened
    - Background
    - Locus
    - Incident
    - Accident investigation
6. Productions and Labels
7. Witness statements
8. Summary of relevant evidence
9. Submissions
10. System improvements
11. Conclusions

The legal framework

[2] This was a mandatory inquiry under section 2(3)(b) of the Act as Mr Campbell's death was the result of an accident at work during the course of his employment.

[3] Fatal accident inquiries and the procedure to be followed in the conduct of such inquiries are governed by the provisions of the Act and the Act of Sederunt (Fatal Accident Inquiry Rules) 2017. In terms of section 1(3) of the Act, the purpose of an inquiry is to establish the circumstances of the death and to consider what steps, if any, may be taken to prevent other deaths occurring in similar circumstances. It is not the purpose of the inquiry to establish civil or criminal liability (section 1(4) of the Act).

[4] Section 26 of the Act requires the sheriff to make a determination, which in terms of section 26(2) is to set out the following five factors relevant to the circumstances of the death, insofar as they have been established to their satisfaction. These are:

(i) when and where the death occurred;

(ii) the cause or causes of such death;

(iii) any precautions that could have reasonably been taken, and if so might realistically have avoided the death;

(iv) any defects in any system of working which contributed to the death;

(v) any other facts which are relevant to the circumstances of the death.

[5] In terms of section 26 subsections (1)(b) and (4), the inquiry is to make such recommendations (if any) as the sheriff considers appropriate 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 other steps.

[6] In order to identify precautions which, had they been taken, might realistically have avoided the death, or to identify defects in the system of working which contributed to the death it is necessary that the sheriff is satisfied on the balance of probabilities that those precautions or the defects in the system of working contributed to the death. Likewise, in order to make recommendations the sheriff has to be satisfied that there is a reasonable possibility that the recommendations may prevent deaths in similar circumstances.

[7] The Procurator Fiscal represents the public interest. An inquiry is an inquisitorial process and the manner in which evidence is presented is not restricted. The Court proceeds on the basis of evidence placed before it by the Procurator Fiscal and by any other party to the inquiry. The determination must be based on the evidence presented at the inquiry and is limited to the matters defined in section 26 of the Act. Section 26(6) of the Act provides that the determination shall not be admissible in evidence or be founded on in any judicial proceedings, of any nature. This prohibition is intended to encourage a full and open exploration of the circumstances of a death, while also reflecting the position that it is not the purpose of a Fatal Accident Inquiry to establish civil or criminal liability (section 1(4)).

[8] The scope of the inquiry extends beyond mere fact-finding. It looks to the future and seeks to prevent deaths occurring in similar circumstances. Where the

circumstances have given cause for serious public concern an inquiry may serve to restore public confidence and allay public anxiety.

Participants and representation

[9] The Procurator Fiscal represents the public interest in a fatal accident inquiry and Mr Ul-Hassan, Procurator Fiscal Depute, appeared.

[10] Scania (Great Britain) Ltd was represented by Mr Donaldson, solicitor. Oilfast Ltd was represented by Neil Macdonald, solicitor.

[11] I am grateful to all three solicitors appearing at the inquiry for their professionalism and assistance in the conduct of the inquiry. Their cooperation and, in particular, the agreement of uncontentious matters by Joint Minute has greatly assisted the inquiry.

The inquiry process

[12] The First Notice of an Inquiry was received on 11 July 2023. An order was made for a preliminary hearing on 14 September 2023. Further preliminary hearings were held on 2 November 2023, 8 December 2023 and 3 January 2024. The inquiry was due to hear evidence on 5 and 6 February 2024. Given the substantial amount of evidence that was agreed, there was no need to hear oral evidence and the parties lodged written submissions with a brief hearing on 5 February 2024.

What happened

[13] This chapter sets out a narrative of what was established on the evidence. The evidence was non-contentious and agreed by the parties in the Joint Minute of Agreement.

Background

[14] Mr Campbell was aged 29 years having been born on 17 March 1989 and formerly resided at Glenrothes. He kept good health and had no significant medical history.

[15] Scania is a provider of trucks and buses for heavy transport applications and provides servicing and repairs.

[16] Mr Campbell was, at the time of his death, employed by Scania as a workshop foreman based at the Scania sales and servicing centre located at Arrol Road, Wester Gourdie Industrial Estate, Dundee. He had taken up that position on 4 March 2019 having previously been employed by Scania at their servicing centre in Nottingham from March 2018.

[17] Mr Campbell was a fully qualified HGV mechanic and his experience is set out in his CV (Crown Production 1). The CV lists, under experience gained whilst working as a shop floor technician at Princess Royal Barracks between 2008 and 2010, "going out on recovery jobs to diagnosing and repair 'along with' adhering to all health and safety aspects while working". His responsibilities as workshop foreman were to oversee the

daily running of the workshop, supervise workshop staff, and ensure that health and safety regulations and safe working practices were adhered to within the workshop.

Locus

[18] The incident occurred within a yard belonging to Oilfast. Oilfast delivers fuel oils to businesses and homes throughout Scotland. The incident was recorded on CCTV (Crown Label 1). At the time of his death, Mr Campbell was endeavouring to carry out repairs on a Scania tanker registration P600 FST. The tanker had suffered a suspected ruptured air bag within the air suspension unit of the second axle at the nearside.

Incident

[19] The incident occurred on 15 March 2019. Mr Ian Fleming, Workshop Controller at Scania Dundee received a call from Michael Millar, Operations Manager at Oilfast at around 8.00am indicating that their tanker registration P600 FST had a suspected airbag issue. Mr Campbell volunteered for the job. He travelled from the Scania centre in Dundee, driving Scania after sales support van registration WT15 ENM. He arrived at the Oilfast depot in Forfar at approximately 8.50am. Mr Campbell is seen on CCTV carrying out an initial inspection of the vehicle and thereafter beginning a repair on the vehicle. Mr Campbell positioned himself head first between the second axle wing and tyre. Whilst he was located in that position, at approximately 10.14am, the tanker is seen to suddenly move downwards and trap Mr Campbell.

[20] Mr Campbell was initially assisted by employees of Oilfast and others from nearby businesses.

[21] Emergency services attended with an ambulance arriving at approximately 10.29am, a police van arriving at approximately 10.30am, and fire and rescue services vehicles arriving at approximately 10.32am and 10.35am. Emergency services were unable to assist Mr Campbell and he was pronounced life extinct at 10.44am by ambulance technician/paramedic Isobel Worgan Blake.

Accident investigation

[22] An investigation following the joint protocol was overseen by Detective Constable Paul McIlravey assisted by Brendan Briody, (Inspector of Health and Safety Executive (HSE)) and Alick Williams (Vehicle Examiner of Driver and Vehicles Standards Agency (DVSA).

[23] The investigation found that the incident occurred because Mr Campbell was working beneath the tanker without having first deployed any additional external method of support, such as suitable axle stands.

[24] Mr Campbell was located between the wing and tyre, and it appears that the offside axle airbag failed catastrophically causing the tanker to drop from its unsupported position trapping him.

[25] Following subsequent examinations, no defects were found with the tanker which could have contributed to the accident.

Productions and labels

[26] Crown Production 1 is a true and accurate copy of Mr Campbell's CV. Said production also contains the Scania Job Description for Workshop Foreman Position.

[27] Crown Productions 2, 3, 4, 5 and 6 are books of photographs containing photographs of the locus and the vehicle taken after the fatal accident by Alistair Bell, Forensic Crime Scene Examiner.

[28] Crown Production 7 is a report by Alick Williams, Vehicle Examiner appointed by the Department of Transport under the Provisions of the Road Traffic Act 1988. Said report was signed on 1 May 2019.

[29] Crown Production 8 is a true and accurate copy of the employee declaration for receipt of health and safety policies, and two additional risk assessments for axle stands and working under a vehicle and trailer and tanker repair and inspection all signed by Mr Campbell following his workshop foreman employee induction on 4 March 2019.

[30] Crown Production 9 is a true and accurate copy of Scania Work Procedure 00-01 Lifting and Supporting on Stands.

[31] Crown Production 10 is a true and accurate copy of Scania Work Procedure 12-05 Air Suspension Rear Axle Safety

[32] Crown Production 11 is a true and accurate copy of the autopsy report on Mr Campbell by Dr David William Sadler and Dr Helen Brownlow dated 19 March 2019.

[33] Crown Production 11 is a true and accurate copy of the autopsy report on Mr Campbell by Dr David William Sadler and Dr Helen Brownlow dated 19 March 2019.

[34] Crown Production 12 is a true and accurate copy of the toxicology report on Mr Campbell by Dr Fiona Wylie and Dennis McKeown dated 4 June 2019.

[35] Crown Production 13 is a true and accurate copy of Scania Job Card 62554 dated 15 March 2019.

[36] Crown Production 14 is a true and accurate copy of Safe System of Work.

[37] Crown Production 15 is a true and accurate copy of Axle Stands and Jacks Test Certificates.

[38] Crown Label 1 is CCTV recorded footage at the locus that was recorded onto a hard drive at the locus. The footage is a recording of events on 15 March 2019 between 1008 hours and 1014 hours.

[39] Crown Labels 2 to 7 are various hand-held footage recorded at MTS, Bandeath Industrial Estate, Throsk, Stirling. Footage is a recording of the removal of several faulty items from the vehicle, namely, inboard r-clip, outboard r-clip, driver, inboard r-clip, driver side outboard r-clip, air pipe crimped with pliers, nearside drive axle (axle two) airbag, offside axle two airbag and offside axle two pedestal.

[40] Crown Production 35 is a true and accurate copy of a report prepared by Katie Dunlop, HM Specialist Inspector of Health and Safety (Human Factors Engineering) titled "Human Factors Review: Fatal Accident to Gary Campbell". This report was accepted as Ms Dunlop's evidence.

[41] First Inventory of Productions for Scania #1 is a background statement prepared by Paul Smith, Regional Director for Scotland and Aaron McGrath, Head of People Development.

[42] First Inventory of Productions for Scania #2 are job cards prepared by Scania showing the various types of work Mr Campbell was assigned to carry out which would have required him to use axle stands (eg removing vehicle wheels, air bag replacement, working underside of a vehicle) and using other types of lifting equipment between 24 April 2018 and 9 March 2019.

[43] First Inventory of Productions for Scania #3 is a technical diagram of the configuration of a rigid 6x2*4 three axle vehicle.

Witness statements

[44] Crown Productions 17 to 26 are true and accurate records of the statements provided to Police Scotland and/or The Health and Safety Executive by the following and are accepted as their evidence:

Crown Production 17: Crown witness number 1 Lindsay Duncan - General Manager Scania, Dundee;

Crown Production 18: Crown witness 2 Ian Fleming – Workshop Controller Scania, Dundee;

Crown Production 19: Crown witness 3 Patrick Brycelan – Workshop Technician Scania, Dundee;

Crown Production 20: Crown witness 4 Wayne Stirland - Night Shift Supervisor Scania Nottingham (Keltruck);

Crown Production 21: Crown witness 5 Gareth Allen - Depot Manager Scania Nottingham (Keltruck);

Crown Production 22: Crown witness 6 Paul McIlravey - Detective Constable Police Scotland;

Crown Production 23: Crown witness 7 Brendan Briody – HM Inspector HSE;

Crown Production 24: Crown witness 8 Alick Williams – Vehicle Examiner DVSA;

Crown Production 25: Crown witness 9 Michael John Millar - Operations Manager for Oilfast;

Crown Production 25: Crown witness 9 Michael ohn Millar - Operations Manager for Oilfast.

[45] Crown Production 27 is a statement of Crown witness 11 Alan Livingston - Group Safety Manager for Oilfast, taken on 27 October 2023 by Neil Macdonald, Solicitor, BTO Solicitors, 48 St Vincent Street, Glasgow, G2 5HS. The typed statement is a true and accurate record of the statement and is accepted as his evidence.

Summary of relevant evidence

[46] It is the evidence of Lindsay Duncan, General Manager, Scania Dundee, that he saw Mr Campbell's CV (Crown Production 1) on the Scania recruitment portal. At the time of the incident, Mr Campbell had been employed as a mechanic for over eleven

years. He served as a mechanic in the British Army for a number of years and thereafter progressed into positions of seniority. It is apparent that Mr Campbell was a very experienced mechanic who held positions of responsibility from early in his career.

[47] Mr Duncan subsequently interviewed Mr Campbell in person in late February 2019 for the position of Workshop Foreman. The role involved supervising a team of three other technicians and deputising for the Workshop Controller, Ian Fleming when required. Mr Campbell was successful at interview and started in his new role at Scania Dundee on 4 March 2019.

[48] Mr Campbell's role involved supervising a team of three other technicians and also deputising for the Workshop Controller, Ian Fleming as and when required.

[49] Mr Campbell did an induction session with Lindsay Duncan on 4 March 2019, which involved going through a number of Scania health and safety policies and risk assessments. During that session, they went over the Risk Assessments for i. axle stands and working under a vehicle and ii. trailer and tanker repair and inspection (Crown Production number 8). During the induction, the health and safety policies and risk assessments were discussed and Mr Campbell subsequently signed to confirm he had read and understood them. There was also discussion about Scania systems including "Multi" which is an online technical manual used by workshop technicians. Multi gives step-by-step guidance supplemented by illustrative diagrams for many tasks such as air bag replacement. Mr Campbell demonstrated an excellent knowledge of the Scania systems during his induction. Mr Duncan considered an air bag repair to be a routine job for a competent technician and the requirement to use axle stands as a standard

safety procedure. Mr Duncan confirmed that internal records show that on 30 April 2018, Mr Campbell received and signed to confirm that he had read and understood Scania Safe Systems of Work Update - Air Suspension Bags (Crown Production 14) issued to all technicians following an incident at another company.

[50] The evidence of Ian Fleming, Workshop Controller, Scania Dundee, was that Mr Campbell conducted himself very competently and professionally and seemed well-qualified for the role of Workshop Supervisor. When carrying out tasks, Mr Campbell demonstrated an awareness of appropriate safety measures such as the requirement to use scaffolding for work at height. Mr Fleming did not see Mr Campbell do anything in the workshop that he considered dangerous and he conducted himself in a professional manner.

[51] Based on discussions with Mr Campbell and observing how he conducted himself in the workshop Mr Fleming had no doubt about Mr Campbell's ability to undertake the air bag repair job off-site.

[52] According to Mr Duncan and Scania employees Aaron McGrath and Paul Smith (1st Inventory of Productions for Scania #1) the changing of an airbag on such a vehicle is a relatively straightforward job for a competent technician.

[53] Mr Fleming took the call from Oilfast at approximately 8.00am on the morning of the incident. He discussed the job with Mr Campbell, who had just come on shift. Mr Campbell confirmed he could do it and without hesitation volunteered. Mr Fleming provided Mr Campbell with the relevant job card (Crown Production #13) detailing the fault with the vehicle. He was provided with a risk assessment form and a breakdown

pad. He would complete the breakdown sheet with the details of the job and supply a copy of it to the customer, in this case, Oilfast. Mr Fleming told Mr Campbell to get in touch if he encountered any issues with the job.

[54] Given his experience, together with the training he had received from Scania and the nature of the job, Mr Campbell would have been aware that bottle jacks and axle stands would have to be used to carry out the job safely.

[55] Mr Campbell was allocated the after sales support van that day and was responsible for loading it with the tools and equipment required for the job. He would have been expected to take axle stands, bottle jacks, hand tools, his safety PPE and paperwork.

[56] At 9.24am on 15 March 2019, Ian Fleming received a WhatsApp message from Gary Campbell saying "Burst drive axle air bag".

[57] From the CCTV available and according to the report prepared by Alick Williams, DVSA Examiner appointed by the Department of Transport under the provisions of the Road Traffic Act 1988 (Crown Production #7), it would appear that Mr Campbell initially isolated the air supply to the nearside second axle unit and thereafter inflated the remaining units to their full height to allow access to remove the damaged unit.

[58] Mr Campbell then positioned himself between the axle two wing and tyre presumably to knock the unit off the chassis mounting with a hammer.

[59] Whilst located between the wing and tyre, the offside axle two air bag appeared to fail catastrophically causing the vehicle to drop from its suspended and unsupported position trapping Mr Campbell.

[60] Michael Millar, Area Director with Oilfast was working at the site on the day of the incident. He saw Mr Campbell working on the vehicle when he came out of a meeting. Later when he was on the phone to a customer, he heard a loud bang from outside. A colleague went out to investigate and came back in to tell Mr Millar that the mechanic was trapped in the lorry.

[61] Mr Millar went out to see Mr Campbell trapped and immediately called the emergency services.

[62] At the time of the accident, Ainis Elstins was employed as a mechanic by Harold Taylor Contractors based at Unit 9, Orchardbank Industrial Estate, Forfar, Angus, DD8 1TD where Oilfast's yard is located. Mr Elstins would occasionally assist Oilfast with minor repairs to their vehicles.

[63] Mr Elstins received a telephone call from Mr Millar. Mr Millar asked Mr Elstins if he had a jack that he could bring round because an airbag had blown on one of the lorries and a mechanic was trapped under the vehicle. Mr Elstins lifted a jack and headed straight to Oilfast's premises. Mr Elstins arrived at Oilfast's yard at approximately 10.20am.

[64] When he arrived at Oilfast's yard, Mr Elstins observed Mr Campbell jammed under the wheel arch of the vehicle. Mr Elstins took a bottle jack from the passenger side of his vehicle. He began to jack up the vehicle with the bottle jack to release

Mr Campbell. Mr Elstins was advised that Mr Campbell did not have a pulse and that there was no point in trying to jack up the vehicle in case it did more damage. The person who gave this advice was James Forbes who had previously worked in the army as a paramedic. Mr Elstins stopped his attempts to jack up the vehicle. He left everything where it was and waited for the police and ambulance to arrive.

[65] Emergency services attended with an ambulance arriving at approximately 10.29am, a police van arriving at approximately 10.30am, and fire and rescue services vehicles arriving at approximately 10.32am and 10.35am. Emergency services were unable to assist Mr Campbell and he was pronounced life extinct by ambulance technician/paramedic Isobel Worgan Blake at 10.44am.

[66] Mr Campbell did not have the correct equipment to carry out the job safely. In the event that this had been an oversight on his part, there were steps he could have taken to rectify the situation before undertaking the job. He could have returned to Scania's workshop to collect the equipment he needed. He could have arranged for the vehicle to be recovered to Scania's workshop. There was no reason for the job to be carried out as a matter of urgency and no pressure on Mr Campbell to complete the job quickly.

[67] According to Patrick Bryceland, Workshop Technician, Scania Dundee, to carry out an air bellow (air bag) repair a technician would need axle stands, bottle jacks, hand tools, and safety equipment. He estimated that on a vehicle of the type involved in this incident, an air bag repair would take in the region of an hour to an hour and a half. For a job off-site, he would expect to have a breakdown sheet and a risk assessment. The

breakdown sheet has all the details of the customer and the number of the job card. This gives details of the technician's time of arrival, the repair carried out and any advice provided to the driver. The sheet is double-backed and the driver or company would receive a copy of that when the job was complete. The technician would also be in possession of a risk assessment form and he would complete this prior to carrying out the repair and decide whether he could complete the repair depending on the individual circumstances. If he had any issues, the technician would be expected to contact management and make arrangements to have assistance on site or possible recovery of the vehicle if required.

[68] Mr Bryceland confirmed that if there was any aspect of a repair he was unsure about then he would either discuss the issue with one of the other technicians or refer to "Multi". He also confirmed that, at the time of the incident, there were approximately ten sets of suitable axle stands available within the workshop at Scania Dundee. This is confirmed by Crown Production 15, which also confirms the availability of suitable bottle jacks.

[69] The evidence of Wayne Stirland, Night Shift Supervisor, Scania Nottingham (Keltruck) was that, on the basis of working with him for approximately 12 months, Mr Campbell was confident, competent and knew what he was doing. Mr Stirland could speak to a number of record cards for jobs done by Mr Campbell where the use of axle stands was required.

[70] The evidence of Gareth Allen, Depot Manager, Scania Nottingham (Keltruck) was that Mr Campbell was considered competent to carry out work away from the

workshop. Mr Allen was also able to speak to a number of record cards for jobs done by Mr Campbell where the use of axle stands was required.

[71] Mr Williams, Vehicle Examiner attended at Oilfast's premises at 09.50am on 17 March 2019 to carry out an inspection of the vehicle at the locus and to prepare a report. In his report, Mr Williams makes reference to there being a 12-tonne hydraulic bottle jack positioned between the rear of axle two nearside leaf spring and the vehicle chassis. The bottle jack that Mr Williams is referring to in his report is the one that was brought on site by Mr Elstins. It did not belong to Scania or Oilfast and it was not present on site when Mr Campbell was carrying out the repair.

[72] Ms Katie Dunlop, HM Specialist Inspector of Health and Safety (Human Factors Engineering) prepared a report in relation to the incident dated 1 October 2021 (Crown Production #16). She concluded that Mr Campbell was a very competent mechanic. She reports that Scania produced evidence that they had provided adequate health and safety training that complied with recognised industry standards and HES guidance. Mr Campbell had received information, instruction and training pertaining to his job and had received information regarding a previous incident relating to a burst air bag. He was made aware of the risks and hazards arising from the work activity he was undertaking at the time of the incident.

[73] Ms Dunlop details in her report the way in which a person becomes skilled. This involves moving from conscious behaviours to automatic behaviours. A person moves through the stages of behaviour acquisition starting with knowledge based behaviour where they are applying new knowledge to unfamiliar circumstances which takes

mental effort. After some practice, the person acquires some rules about how to behave. This is rule based behaviour and requires less mental effort than knowledge based behaviour. It allows the person to perform a task quicker and generally more accurately. Finally, after sufficient practice the person will be able to perform the task without consciously thinking about the actions involved. This is skilled behaviour and is generally quicker and more accurate. It also allows the person to use their limited attentional capacity fully elsewhere.

[74] Ms Dunlop moves on in her report to discuss why humans make errors and this requires an understanding as to why humans fail. The causes of human failure pertinent to this incident can be either an error or violation. Ms Dunlop explains that an error is an action or decision, which was not intended that involves a deviation from an accepted standard and which leads to an undesirable outcome. A violation is a deliberate deviation from a rule or procedure.

[75] Ms Dunlop describes three types of violation: routine, situational and exceptional. A routine violation is one in which the breaking of a rule or procedure has become a normal way of working within a work group. A situational violation is one in which the breaking of a rule is due to pressures from the job such as being under time pressure, insufficient staff for the workload, not having the right equipment available or extreme weather conditions. An exceptional violation is one that rarely happens but is one in which a rule is broken even when there is an awareness that a risk is being taken. There is a belief that the benefits outweigh the risks.

[76] In her assessment of the evidence, Ms Dunlop states that Mr Campbell was an experienced and competent mechanic, technician and supervisor with many years of experience. He had impressed colleagues with his knowledge.

[77] In her opinion, Ms Dunlop states that Mr Campbell did not follow the procedure for the task and did not use axle stands or jacks that would have prevented the body of the truck from falling onto him when he was in a position to cause himself harm. In her opinion, this indicates that Mr Campbell committed a violation which was a deliberate deviation from rules, procedures, instructions and regulations.

[78] Ms Dunlop states that there was a reliance on Mr Campbell's competence by Scania and he was not supervised when carrying out tasks that he had not undertaken before such as filling the empty van or working practices off site. Against that, Ms Dunlop confirms that given his experience and level of competence, Mr Campbell would not require supervision for such basic tasks. He would have been aware of how to fill a van with tools and equipment required for the job.

[79] Importantly, Ms Dunlop states in her report that had Mr Campbell been supervised whilst putting the necessary tools and equipment in the van, he may still have committed a violation believing that he could do the task without the need for axle stands or jacks.

Submissions

[80] All parties provided written submissions. None of the parties considered that there were any findings to be made in relation to section 26(2)(f) or (g).

[81] As far as section 26(2)(e) is concerned, the Crown submitted that Mr Campbell did not take the relevant tools with him to carry out the job which was itself a routine job. If he had decided that he needed tools then he had options available to him to rectify the situation. It is not known why he did not return to Scania to collect the appropriate equipment or why he did not seek to have the vehicle recovered.

[82] Submissions on behalf of Scania in relation to this matter reflected the precautions that Mr Campbell should have taken before embarking on the repair. He should have moved the vehicle onto firm and level ground ensuring that the air pressure in the suspension system was released. He should then have used bottle jacks to raise the vehicle chassis to give sufficient clearance. He should then have inserted axle stands to prop and securely support the vehicle chassis in the raised position. The vehicle being adequately supported would have allowed him to carry out the repair without any risk of the vehicle subsequently moving and trapping him.

[83] The submissions on behalf of Oilfast were in similar terms to those of Scania.

System improvements

[84] Since the accident on 15 March 2019, Oilfast has made improvement to their health and safety practices. Anyone who attends Oilfast's premises is required to sign into the visitor's book on arrival and to sign out again when leaving.

[85] Whenever anyone new attends at Oilfast's premises for the first time, they must carry out a visitor induction. The induction highlights key risks on site. It also has a site

plan and shows where the emergency exits are. On the site plan, there are marked pedestrian walkways and in Oilfast's yard there are now clearly defined parking bays.

[86] In terms of personal protective equipment (PPE), everyone who attends on Oilfast's site must wear safety boots and a hi-visibility vest. If any PPE above that is required for a specific job that is being carried out on-site, then it is the responsibility of the contractor to provide it.

[87] Oilfast now has a supplier questionnaire. This is a questionnaire that is sent to any contractors in advance of any work being carried out on Oilfast's site asking questions about the nature of the work and how it will be carried out. Oilfast now requires a Risk Assessment and Method Statement to be sent by any contractors before they attend on-site.

[88] In October 2022, Oilfast appointed Alan Livingston as a Group Safety Manager. This is a new role that has been created by the company. The purpose of the role is to develop and improve, where possible, the health and safety policies and procedures of the company.

[89] After the accident, Scania decided that off-site call-outs of any description would only be carried out by trained and certified roadside assistance technicians using the dedicated Scania assistance van.

[90] There is no evidence to support that had these practices been implemented at the time of the incident they would have prevented the accident.

Conclusion

[91] It appears from all the evidence presented to the Inquiry that Mr Campbell was suitably qualified and trained to carry out the task that he was sent to do. This was a routine task. He was well aware from his training that there were procedures to follow and a safe system of work to carry out the task. The report prepared by Ms Dunlop is most helpful in that it highlights reasons as to why a competent and experienced mechanic like Mr Campbell, would deviate from rules, procedures, instructions and regulations. It is my opinion from all the evidence presented that Mr Campbell did not follow his training and took an unnecessary risk, which had tragic consequences. I cannot speculate as to why Mr Campbell decided to proceed with the repair without the appropriate tools or equipment. I can only conclude based on the evidence of Ms Dunlop that he committed a violation. Whilst Ms Dunlop indicates that there was maybe a gap in the supervision of Mr Campbell which would have seen him take the appropriate tools with him, he could still have chosen to proceed in the manner he did whether the tools were available or not.

[92] Finally, I would like to offer my most sincere condolences to Mr Campbell's family and friends for their loss.