SHERIFFDOM OF LOTHIAN AND BORDERS AT EDINBURGH

[2026] FAI 8

EDI-B398-24

DETERMINATION

BY

SHERIFF IAIN W NICOL

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

into the death of

JAMES OSBOURNE MURRAY

Edinburgh, 9 February 2026

[1] The Sheriff, having considered the information presented to the Inquiry, determines in terms of section 26 of the Fatal Accidents and Sudden Deaths etc. (Scotland) Act 2016 that:

1. In terms of section 26(2)(a) of the Act, James Osbourne Murray died at 17:26 hours on 23 August 2022 at junction 1 of the westbound carriageway of the M8 motorway, next to the Hermiston Gait roundabout.

2. In terms of Section 26(2)(b) of the Act, Mr Murray was involved in a road traffic accident at approximately 16:03 at the aforementioned locus.

3. In terms of section 26(2)(c) of the Act, the cause of Mr Murray's death was:

    1a. Head and chest injuries and

1b. Road traffic incident (driver).

4. In terms of section 26(2)(d) of the Act, the cause of the accident resulting in Mr Murray's death is as follows: Mr Murray was driving a DAF XF Heavy Goods Vehicle, registration number YX13 ZWG with trailer attached. The trailer contained approximately 41 pallets laden with paper and plastic. The load was not secured to prevent it from moving. The load did not fill the trailer. As Mr Murray took a left-hand bend at the Hermiston Gait roundabout to join the westbound carriageway of the M8 motorway, the load shifted towards the offside of the trailer, causing the trailer and tractor unit to topple onto their offside. This resulted in Mr Murray sustaining the fatal injuries.

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

a. The preparation of a load plan by R Drummond (Carriers) Limited or Interflex, and provided to Mr Murray, with specific information to enable him to understand the nature of the load, it's weight and the requirements to be put in place to ensure stability of the load in transit;

b. Clear information being provided to Mr Murray on exactly what he was required to do to ensure the load did not move in transit;

c. Written communication between R Drummond (Carriers) Limited and Interflex on the steps which required to be taken and by who in relation to ensuring load stability; and

d. Effective supervision and auditing to ensure that drivers and loaders were fulfilling the requirements to ensure load stability.

6. In terms of section 26(2)(f) of the Act, the following are defects in systems of work which contributed to the death or the accident resulting in the death:

a. No load plan had been prepared by R Drummond (Carriers) Limited (trading as Drummond Distribution), as Mr Murray's employer, or Interflex, the consignor of the load, in relation to the load which Mr Murray was transporting;

b. The risk assessments which had been prepared were inadequate to identify the risks associated with load instability and the reasonable measures which ought to have been taken to mitigate those risks;

c. No communication took place between the employer and consignor prior to the fatal journey in relation to implementation of and compliance with HSE Guidance (HSG136) to

(i) reflect who required to do what in relation to securing the load; and

(ii) monitoring compliance, to ensure the load remained in a safe and stable condition until it reached its destination.

d. Neither the employer nor consignor provided sufficient training to their employees to ensure drivers and loaders were aware of, and clearly understood when dangers could potentially arise with load shifting, having regard to the nature and weight of the load, how it was stacked, and the securing methods deployed.

e. Neither the employer nor consignor provided supervision of employees to monitor compliance with safe loading procedures.

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

8. In terms of sections 26(1)(b) and 26(4) of the Act:

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 are commented on throughout this determination. The employer has taken the appropriate steps to take reasonable precautions and improve systems of work as a result of the accident. The consignor does not appear to have done so. I make two recommendations at the end of this determination.

Legal framework

[2] This Inquiry was held under the Fatal Accidents and Sudden Deaths etc. (Scotland) Act 2016 ("the Act"). It was a mandatory Inquiry in terms of Section 26(2)(3) of the Act due to Mr Murray's death arising whilst he was acting in the course of his employment in Scotland. The Act requires the court to consider the matters set out in Section 26 as outlined above.

[3] The Procurator Fiscal, on behalf of the Crown, represents the public interest in investigating, arranging and conducting an Inquiry. An Inquiry is inquisitorial and not adversarial. It is not an Inquiry's purpose to establish civil or criminal liability.

Procedural background

[4] The first notice was lodged on 21 March 2024. The preliminary hearing was held on 17 May 2024. At that stage, the Crown were inviting the court to dispense with evidence and issue a determination based on papers only. It was readily apparent at that stage that the Crown had not properly investigated the issues which were relevant to the Inquiry. In particular, the focus up to that point had been to solely on Mr Murray's apparent failure to secure the load in his trailer. No consideration had been given to the responsibilities of Mr Murray's employer or the loader / consignor who had loaded the pallets onto the trailer. I therefore asked the Crown to investigate these matters as they were potentially relevant to the inquiry determination.

[5] A number of continued preliminary hearings followed whilst the Crown investigations progressed. By 12 September 2024, the Crown were considering a

prosecution of the deceased's employer. That prosecution resulted in a Section 76 diet where guilty pleas were tendered to a single charge with 3 areas of failing, more details of which are outlined below. On 5 December 2025 the employer was fined £120,000.

[6] I acknowledge that, after what might be described as initial failings, the Crown's investigation was extremely thorough and their efforts, along with those representing the next of kin, Mr Murray's employer and the consignor, resulted in an extensive joint minute being lodged when the case called for the evidential hearing on 8 December 2025. Detailed Crown submissions were lodged at the bar at the same time. The submissions were adopted by all of the other parties. They joined in a Crown motion to dispense with evidence and for the court to issue a determination based on the terms of the joint minute. I raised a number of issues which required clarification, and I adjourned until later in the day to allow those matters to be considered. Following the lodging of supplementary written submissions and further discussion in court, I was satisfied that all matters had been addressed and I could dispense with parole evidence. A second joint minute was also lodged. I commend parties' efforts in that regard.

Factual background as agreed in the first joint minute (paragraphs [7] to [117]):

James Murray

[7] James Osbourne Murray (hereinafter referred to as "Mr Murray") was born on 10 October 1967, and at the time of his death was ordinarily resident in West Lothian.

[8] Mr Murray lived with his wife, son and step-daughter.

Employment status

[9] Mr Murray was employed by R Drummond (Carriers) Limited (hereinafter referred to as "Drummond Distribution") as a Heavy Goods Vehicle ("HGV") Driver. Mr Murray was driving a Drummond Distribution DAF XF HGV registered mark YX13 ZWG ("the HGV") in the course of his employment at the time of his death.

Health

[10] Mr Murray had no significant medical history of note. He took medication for anxiety. On the day of his death, he had attended at his GP surgery following pains in his abdominal/bowel area, and provided a urine sample.

[11] CP7 is Mr Murray's medical records.

Definitions

[12] The following are definitions of relevant terms:

(i) Curtain-sided – goods vehicles and trailers with enclosed cargo areas typically either have solid sides (these are known as box-siders) or open sides fitted with curtains (these are known as curtain-siders). The curtains of a standard curtain-sider are designed to protect the load from the weather and hide it from view, and they provide no effective load restraint.

(ii) Inner Load Curtain – the green tyre netting, which was found on the HGV is an Inner Load Curtain, which may also be referred to as a Cargo Net. These are commonly used within standard Curtain-Sided trailers, and are

suitable for containing light loads or stacks weighing less then 400kg. These were not suitable to secure the load being transported by Mr Murray at the time of the fatal accident.

(iii) Buckle straps – black in colour, these straps are attached to roof-mounted rails inside a trailer. They are intended for light duty (securing individual items or stacks of items weighing up to 400kg) and are typically rated for 700 decaNewtons (daN), or 0.7 tonnes.

(iv) Positive fit – where the load either fills the trailer entirely, front to back and side to side, or where packing is used to fill any gaps between the load and the trailer body.

(v) Ratchet straps - usually blue or orange in colour, these straps are intended for heavy duty (securing items of stacks of items weighing over 400kg). When used to secure palletised loads, they usually pass over the top of each load item with each end attached to the side rave of the trailer. They are typically rated for 2,500daN, with a breaking force of 5,000daN (5 tonnes). Such straps were available in the HGV involved in the fatal accident (visible in CP59 – 5), but were not used by Mr Murray in securing the load at Interflex prior to the fatal accident.

(vi) XL Curtain-sider – (also referred to herein as "ENXL") - although the sides of a standard curtain-sider cannot be used for load securing, there is a special type of curtain-sider, constructed to the British Standard BS EN 12642,

which features a reinforced structure and curtains that can be used for load securing if the load is in positive fit.

The HGV

[13] The HGV being driven by Mr Murray on the date of the fatal accident was a standard curtain-sider, fitted with Inner Load Curtains and Buckle Straps. It was not an XL Curtain-Sider.

Mr Murray's attendance at Dalkeith

[14] Mr Murray commenced work at Drummond Distribution at around 0730 hours on 23 August 2022. He was driving the HGV in the course of his duties.

[15] CP43 is a VOSA plating Certificate relating to the HGV.

[16] The curtains of the trailer comprising the HGV were not ENXL Rated. The trailer was fitted with Internal Load safety netting, shown in CP42, though the Buckle Straps (which are shown as being in use in that photograph) were not used by Mr Murray in securing the load involved in the fatal accident.

[17] Drummond Distribution did have trailers at that time with ENXL Rated curtains.

[18] In the course of his duties that day, Mr Murray had cause to attend at premises occupied by Interflex, Mayfield Industrial Estate, Dalkeith (hereinafter referred to as "Interflex") with whom Drummond Distribution had a longstanding commercial relationship. Whilst there, a load comprising a mixture of paper and plastic film, made up of around 41 pallets with a total weight of around 24,156 KG was loaded onto his

vehicle and secured. There is a divergence among witnesses as to the precise number of pallets being transported at the time of the fatal accident. Scott Brown (Interflex) estimates that there were 41 pallets (CP24 – 2). Joshua Caunt (Interflex) indicates that there were 42 and itemises these, though the itemised number amounts to 40 (CP57 – 3). Robert Drummond (Drummond Distribution) indicates a figure of 41 (CP23 – 3). The Police Collision Investigators also indicate 41 (para 9.8 CP4 – 40), though it is not clear if they counted the pallets actually contained within the HGV trailer after the fatal accident. Nina Day (an HSE official who will be referred to in more detail below) comments (CP64 – 32) that "the exact number is not particularly relevant to the incident: the more important issue is the heavy pallets and stacks weighing well over 400kg and therefore inadequately secured by the internal nets."

[19] The precise number of pallets involved does not require to be resolved for the purposes of the Inquiry.

[20] On 23 August 2022 at 1150 hours, Interflex sent an email to Drummond Distribution with a stock sheet attached to give advance notice of the details of the load: CP40. The stock sheet listed 41 pallets which were to be transported and specified the size and weight of each. CP41 contains details of the trips undertaken by Mr Murray in the HGV up to the time of the fatal accident.

[21] The trailer of the HGV had space for 52 pallets in total (comprising 26 pallets, double stacked), and as such was not full.

The loading of the pallets and securing of the load at Dalkeith

[22] An Interflex employee, Scott Brown, loaded the trailer at Interflex's Dalkeith premises.

[23] The HGV was empty when it arrived. Mr Murray was well known to Scott Brown, as Mr Murray had been coming to Interflex's Dalkeith premises for a number of years. Scott Brown raised the ramp at the rear of the HGV and used a forklift truck to drive onto the trailer of the HGV and place pallets thereon.

[24] Once the pallets had been loaded onto the trailer of the HGV, Scott Brown was of the opinion that all of the pallets were stable, and nothing was bulging. The Inner Load Curtain was secured along each side of the trailer of the HGV by Mr Murray. Mr Murray did not ask Scott Brown to put any straps onto the load. Mr Brown proceeded on the basis that securing the load was the driver's responsibility and so his involvement was restricted to placing the pallets on the trailer bed.

[25] Joshua Caunt, Warehouse and Transport Supervisor at Interflex's Dalkeith premises had no direct involvement in the events of 23 August 2022. He provided a statement to Police Scotland in which he explained that in general heavier pallets (those weighing – he said – 904kg and 711kg) would occupy the bottom spaces, and lighter pallets would be placed on top. 26 pallets would occupy the bottom layer, with remaining pallets making up an upper layer. If there were around 41 pallets, this means not every layer would have had a lower and an upper layer. Joshua Caunt further explained that drivers would normally ask for the heavier pallets to be placed near the headboard of the trailer. He further stated that once placed, the pallets would all be

touching so there would not be much room left for the load to move. As and when there was enough material to be picked up, a list specifying the load would be sent to Drummond Distribution (as occurred on 23 August 2022 in terms of CP40).

[26] At the point at which the HGV left the premises occupied by Interflex at Dalkeith, the load was secured by use of the Inner Load Curtain, and the Standard Curtain-Sides. These were not a suitable means of securing a load of this type.

The fatal accident

[27] At approximately 1600 hours that day, Mr Murray was driving the HGV and negotiating the left-hand bend from the Hermiston Gait Roundabout onto the M8 motorway, this being Junction 1 of the M8 Westbound, Edinburgh. In negotiating this corner, the HGV overturned and came to rest on its offside.

[28] The locus of the fatal accident is more fully described in the Collision Investigation Report (CP4).

[29] Various drivers in the vicinity stopped their vehicles and sought to go to Mr Murray's aid. At this time, Mr Murray was seen to be in the driver's seat of the HGV. He was not moving with his hands by his chest. He was wearing his seat belt and appeared to be breathing but unconscious.

[30] The first police officer to attend, Chief Inspector Harris, Area Commander for Road Policing East, arrived at the locus at approximately 1610 hours. Members of the public had smashed the windscreen of the HGV to gain access to the cab. Chief

Inspector Harris noted that Mr Murray was unconscious but breathing. He requested further assistance, and other officers were deployed.

[31] When other police officers arrived, efforts were made to extract Mr Murray from the vehicle. It was noted his head was trapped beneath a metal structure which appeared to be the door frame. Efforts were made to release him using a crowbar found by a member of the public, but these efforts were not successful. Entry to the cabin was gained through the front window. At this time, Mr Murray was unresponsive and was not breathing.

[32] Personnel from the Scottish Fire and Rescue Service attended and assisted with the extraction of Mr Murray from the HGV. He was freed from under the door frame and placed onto the ground whereby cardiopulmonary resuscitation ("CPR") commenced. It was noted that Mr Murray had a head injury to the upper right forehead area.

[33] Personnel from the Scottish Ambulance Service ("SAS") attended at approximately 1630 hours, as did MEDIC 1 at approximately 1655 hours, which contained Dr Lyle Moncur, a Consultant in Emergency Medicine.

[34] On arrival Dr Moncur was advised that when SAS personnel arrived Mr Murray was found to be in traumatic cardiac arrest and was asystole.

[35] On being extracted from the HGV, SAS personnel placed Mr Murray in a pelvic binder, inserted an I-gel supraglottic airway and commenced CPR. During this, bilateral thoracostomies had been performed, IV access had been established and Mr Murray had been administered with two litres of fluid and four units of adrenaline.

[36] Dr Moncur examined Mr Murray and his Glasgow Coma Scale was recorded at 3, his lungs were inflated however his pupils were fixed. He had the following obvious injuries: - Right sided rib fractures with surgical emphysema. Large laceration to right scalp. Large haematoma to scalp with obvious underlying skull fracture.

[37] At the time of Doctor Moncur's examination, Mr Murray was still asystole on the monitor and due to the prolonged downtime of around thirty minutes a decision was made to cease resuscitation efforts. However, on carrying out a final pulse check Mr Murray was found to have a return of spontaneous circulation. Due to this he was administered with 1mg of IV adrenalin and one unit of packed red blood cells.

[38] At 1708 hours, Mr Murray suffered a further pulseless electrical activity cardiac arrest. A further 1mg of adrenaline was administered and CPR was recommenced which resulted in a further return in spontaneous circulation. Mr Murray was moved onto a stretcher for transfer.

[39] At 1717 hours Mr Murray suffered a further pulseless electrical activity cardiac arrest. At this point it was agreed between all medical staff present to terminate resuscitation efforts as there was no reasonable chance of survival due to Mr Murray's head injury and likely traumatic asphyxia whilst within his vehicle.

[40] CP8 are handwritten notes made by Dr Moncur in respect of Mr Murray's injuries, treatment, and noting when life was pronounced extinct.

[41] Mr Murray's body was thereafter taken by road ambulance, under Police escort, to the Edinburgh City Mortuary.

The post mortem examination and cause of death

[42] On 31 August 2022 a postmortem examination was carried out by Consultant Forensic Pathologist Dr Ralph BouHaidar at Edinburgh City Mortuary on the instruction of the Procurator Fiscal. Samples were also instructed to be taken for toxicology.

[43] The cause of Mr Murray's death was initially recorded as 1a. Head injury pending laboratory studies.

[44] Dr BouHaidar thereafter produced CP2 Final Post Mortem Report authored by him, dated 20 October 2022. In CP2 Mr Murray's cause of death was amended to 1a. Head and chest injuries and 1b. Road traffic incident (driver). At pages 5 and 6 of CP2 Dr BouHaidar provided the following commentary:

> "I was informed that this man had no past medical history of note with the exception of recent abdominal pain and the possibility of a urinary tract infection. He reportedly was witnessed driving his truck when this toppled. He was initially unconscious and shortly afterwards stopped breathing. There were no reported suspicious circumstances. At autopsy there were numerous injuries predominantly on the right side of the body in keeping with the history provided. These were of blunt force nature associated with skull fracture and brain injury in keeping with being caused during the incident. There were multiple rib fractures, particularly on the right, mostly in keeping with being caused during the incident. Further rib fractures on the left were noted in keeping with resuscitation. The heart was minimally enlarged with evidence of marked coronary artery disease. There were no identifiable acute events. Histological examination of the main organs confirmed the presence of head injury and identified minor scarring in the heart associated with marked coronary artery disease. No acute events were noted. The remaining organs showed no major pathology with the exception of hepatic steatosis. Toxicology showed traces of alcohol in the blood likely to be the result of postmortem production. There was a therapeutic level of citalopram also in the blood, known to have been prescribed to the deceased. It would appear as such that the death of this man was the result of marked head and chest injuries in keeping with being caused during a road traffic incident. There was pre-existing cardiac disease that could well increase the risk of cardiac dysrhythmic events arguably and potentially playing a role in the events noted albeit this could not be

demonstrated or fully excluded. The cause of death should therefore be amended to: 1a Head and chest injuries 1b Road traffic incident (driver)"

The collision investigation and vehicle examinations

[45] At around 5.53pm on 23rd August 2022, Police Constable John Lang attended the locus. Having been appraised of the circumstances, Police Constables John Lang and Thomas Aitken carried out a full collision investigation at the locus. CP4 contains their Collision Investigation Report and the contents and conclusions thereof are agreed.

[46] Crown Label 1 contains their electronic reconstruction of the scene.

[47] The HGV which had been driven by Mr Murray was recovered from the locus to a secure storage facility.

[48] Between 26 September 2022 and 10 November 2022 vehicle examiner Gordon Montgomery appointed by the Secretary of State for Transport under Section 66A of the Road Traffic Act 1988 carried out an examination of the aforesaid HGV and trailer at the request of the Police Service of Scotland. The examination was carried out at the premises of 911 Recovery, Loanhead, Midlothian. He was assisted, where necessary, by Police Constable John Lang.

[49] Mr Montgomery carried out a limited examination of the vehicle and trailer assessing all fixed and moving parts in relation to the roadworthiness of the combination where possible. A measured brake performance check was carried out using a calibrated piece of equipment. During his examination, vehicle examiner Gordon Montgomery noted no mechanical defects present which would have caused or contributed to the collision.

[50] On 30 August 2022 traffic examiner Kevin Syme appointed by the Secretary of State for Transport under Section 66A of the Road Traffic Act 1988 met Police Constable John Lang at the DVSA Offices, Livingston where the tachograph unit relating to heavy good vehicle registration mark YX13ZWG was produced. The digital driver card from the tachograph unit was ejected and it was established that the card pertained to Mr James Osbourne Murray, date of birth 10 October 1967.

[51] The digital driver card was valid between 18 October 2019 and 17 October 2024. Mr Syme then completed a download of the vehicle tachograph unit and digital driver card of Mr Murray. Upon completion of the downloads the tachograph unit and digital driver card were retained by Police Constable John Lang. The downloaded data was then uploaded into DVSA approved analysing software known as Tachoscan.

[52] From reviewing the speed trace data, lodged as CP6, it can be seen that minutes prior to the last recorded speed, the vehicle speed was accelerating and decelerating and appears to be flowing with traffic. From the last minute of recorded travel, it can be seen that at 16.03 hours and 0 second the vehicle was travelling at 50 kilometres per hour (kmph) (approximately 31 miles per hour (mph)) up until 1603 hours and 20 seconds, when at 1603 hours and 21 second the vehicle was recorded travelling at 49 kmph, up until 1603 hours and 38 seconds. At 1603 hours and 39 seconds the vehicle is recorded as travelling at 41 kmph, then a second later at 1603 hours 40 second vehicle speed was recorded at 5kmph. The final speed recording is at 1603 hours and 41 seconds, when 1 kmph is recorded. At 1603 hours and 42 seconds the vehicle records 0 kmph and is therefore stationary.

[53] The collision investigators were of the opinion that a speed of between 25mph and 31mph was considered to be an appropriate speed for an HGV to negotiate the left-hand bend at the locus, and that speed was therefore not considered to be a causal factor in the fatal accident.

[54] In relation to weekly rest requirements relative to EC Drivers hours Regulations, analysis of the data showed that Mr Murray was fully compliant for EC regulations in respect of his weekly rest period.

[55] In relation to daily rest requirements relative to EC Drivers hours Regulations, analysis of the data showed that Mr Murray was fully compliant for EC regulations in respect of his daily rest period.

[56] In relation to driving break periods relative to EC Drivers hours Regulations, analysis of the data showed that Mr Murray was fully compliant for EC regulations in respect of his daily driving break period.

[57] A full analysis of heavy goods vehicle registration mark YX13ZWG tachograph vehicle unit and digital driver card of Mr Murray revealed no breaches or driving infringements of the EC driver Regulations.

[58] In light of the foregoing, the Collision Investigators did not consider driver fatigue to be a factor in the fatal accident.

[59] The Collision Investigators' conclusions were in the following terms:

> "9.1 The collision occurred during daylight hours on a left-hand bend when the weather was reported to be dry, clear and the road surface was dry. There were no factors present to restrict visibility, or suggestion of any obstructions in the carriageway.

9.2 No defects or surface contaminations were found on the carriageway at the locus which, in the opinion of the Collision Investigators, could have caused or be considered to have been a contributory factor in this collision.

9.3 The approach to the locus is down a slight decline which leads into the left-hand bend which forms part of Hermiston Gait Roundabout. Drivers approaching are given ample warning of the hazards ahead.

9.4 The permitted speed limit for the carriageway, on approach to the roundabout for the vehicle involved in this collision, is 50mph, with a suggested maximum speed of 40mph to negotiate the roundabout safely.

9.5 Examination of the tachograph revealed the DAF XF HGV registration mark YX13ZWG was travelling within the speed limit in the journey to the locus, and had decreased its speed to approximately 31mph immediately prior to the locus, with a further deceleration to 25mph as it negotiated the left-hand bend.

9.6 Examination of the tachograph also showed the driver, Mr Murray, who was the only occupant, had complied with all legal requirements with regards to drivers' hours and rest, therefore driver fatigue is not considered to be a factor in this collision.

9.7 The mechanical examination of the HGV involved in this collision revealed no mechanical defects that could have caused or contributed to this collision.

9.8 The load contained within the trailer comprised of 41 pallets of industrial paper rolls which were stacked two high and weighed 24.156 tonnes.

9.9 The load was surrounded by a green tyre net which was not sufficient to restrain this type of load within the trailer. The trailer was fitted with load restraining straps which should have been secured to the load by Mr Murray prior to the vehicle moving off, but these had not been utilised.

9.10 Tyre marks at the locus evidenced that the vehicle entered the left-hand bend at the locus in lane 2 and was being steered to the nearside to join the M8 westbound carriageway.

9.11 The tyre marks evidence that the offside wheels became subject to increased loading, as the load within the trailer shifted to the offside.

9.12 This shifting of the load has caused the centre of gravity of the trailer to move significantly to the offside, which has led to the trailer falling over onto its offside.

> 9.13 The toppling trailer has then caused the tractor unit to fall over onto its offside, with the whole vehicle sliding into the concrete central reserve barrier before coming to rest.
>
> 9.14 Throughout this, the tyre marks evidence that Mr Murray has continued to steer to the nearside, evidencing he was conscious, in control of the steering wheel, and was attempting to prevent the vehicle from falling over.
>
> 9.15 Having considered the circumstances, it is the opinion of the Collision Investigators that this collision occurred due to the following factor: - the load within the trailer was not properly secured prior to the vehicle moving off which has then shifted during transit, causing the vehicle to fall over onto its offside while negotiating the left hand bend at Hermiston Gait Roundabout."

[60] The collision investigators' comments at para 9.9 quoted in the preceding paragraph should be read in the context of further comments below in respect of the duties on various parties in respect of load security.

Mr Murray's qualifications

[61] Mr Murray first applied for a driving licence on 25 November 1985. He passed a HGV driving test on 12 December 2014. He had a HGV driving licence issued on 18th March 2015. Mr Murray's HGV driving licence was renewed on 12 December 2019. (CP10)

[62] Mr Murray achieved Driver Certificate of Professional Competence, ("CPC") accreditation (a certification process approved and overseen by the Driver and Vehicle Standards Agency, ("DVSA")) in the category "LORRY" on 10 September 2009 which was valid for a period of 5 years and in respect of which load security was a compulsory module. Mr Murray underwent further CPC training in order that his accreditation

could be maintained, such certification being renewed on 17 October 2014 and 17 October 2019. Accordingly, at the time of his death his CPC record was up to date expiring on 16 October 2024. (CP9)

[63] Mr Murray completed manual handling training on 11 September 2017. (CP11)

[64] On 11 September 2017 Mr Murray signed a Tail Lift check list and operating guidelines confirming that he fully understood them and understood that failure to comply with them may lead to a breach of the Health and Safety at Work Regulations. He also acknowledged receipt of the notes. (CP12)

[65] Mr Murray passed a DVSA driver assessment on 13 September 2017. (CP13)

[66] Mr Murray attended Manual Handling/ Safe loading training on 28 May 2019. He successfully passed said training. (CP14).

[67] Mr Murray passed a driving and theory assessment on 28 May 2019. (CP15).

Drummond Distribution – company details and systems of work

[68] Drummond Distribution was established as a business in 1927. The current limited company (Company number SC084702) was incorporated in 1983.

[69] Drummond Distribution had, at the time of the fatal accident, around 180 trucks and trailers. It transported a variety of loads, the most common of which were car tyres and pallets. At the time of the fatal accident the company had no previous convictions, had never been the subject of any form of enforcement proceedings by the Health and Safety Executive and had consistently been independently assessed by the DVSA as being a "low risk" operator under its Operator Compliance Risk Score, ("OCRS"), a

scoring system developed by the DVSA to evaluate and monitor the safety and compliance performance of road transport operators.

[70] Drummond Distribution had various documentation relating to systems of work and load security. These are lodged as Crown Productions 48 and 49.

[71] CP48 provided various advice to drivers, which included the following, at paragraph 1.1 thereof: "You are responsible for the securing of your load, whether you loaded it or not." No further guidance was contained therein in respect of the securing of loads. CP49 identified various risks associated with load distribution and security, and relied on control measures including checking that straps were in good condition and checked regularly, and that drivers were trained in their use.

[72] No specific loading plans or instructions have been provided by Drummond Distribution. Reference is made to the agreed comments of Nina Day below.

[73] Drummond Distribution was a member of Palletline Plc, known as the Pallet Network. CP44 is a share certificate relating thereto. Crown Productions 45 and 46 details any Pallet Network deliveries or collections being undertaken by Drummond Distribution on the day of the fatal accident. The load being carried by the HGV at the time of the fatal accident was not being carried as a part of the Pallet Network.

[74] CP47 details training provided to Drummond Distribution staff in 2022 and 2023. The information in respect of the training syllabus provided includes the following:

ASOT

AC02283 - Association of Trainers (ASOT) Ltd

Safe Loading LGV (011) Course outline – 2021 renewal (content unchanged)

Location - Classroom - Maximum 20 delegates – LGV ONLY

Aims:-To reduce the risk of accidents from insecure loads caused by drivers' lack of compliance with regard to the roadworthiness of the vehicle, the lack of pre-shift check, vehicle and load security,

Objectives:- To discuss and improve drivers' compliance with the legal obligations with regard to, The roadworthiness of the vehicle, The importance of the driver's pre-shift check Vehicle and load security.

Session	Time	Title & Content	Delivery Method	Resources	Location	Reference to Syllabus
1 Either intro or feedback	15	Course welcome, introduction and objectives of the course, fair processing notice, day's activities including course timetable, and ground rules. H&S briefing.	Explanation	• PowerPoint	Classroom	
2	30	**Explanation of Codes of Practice** • Construction and Use and Road Safety • Regulations and potential penalties.	Interactive discussion and Question and Answer Sessions	• PowerPoint • whiteboard • Video clips:- Load securing roles and responsibilities (4 min 3 secs) • Load Securing Vehicles - video 2 of 7 (4 min 48 secs) • Load security consequences of poor load security (5 min 59 secs)	Classroom	1.4 2.1 2.2
3	65	• **Discuss with delegates** • Types of load, restraint and load movement. • Explanation of Centres of Gravity, diminishing loads and reloading.	Interactive discussion and Question and Answer Sessions	• PowerPoint, whiteboard. • Video clips:- Dolly Knot and Driver CPC (14 mins 30 secs) • HSE Load Safety advice (10 mins) • Load Securing Drivers - video 6 of 7 in series(3 mins 50 secs) • Load Securing Equipment - video 5 of 7 in series (4 mins 18 secs) • Load securing good practice (4 mins 9 secs) • Load Securing Methods - video 4 of 7 (4 mins 50 secs) • Load Securing Principles - video 3 of 7 (3 mins 50 secs)	Classroom	1.4 3.1
Break						
4	45	• Understanding the height of loads • load markers and the use of escorts for abnormal loads.	Interactive discussion and Question and Answer Sessions	PowerPoint, whiteboard. Video clips	Classroom	1.4
5	30	• Explanation of weight limits and axle weights and showing delegates how to read VIN plates.	Interactive discussion and Question and Answer Sessions	PowerPoint, whiteboard. Video clips	Classroom	1.4
6	25	• Explaining consequences of not adhering to the regulations. • Graduated Fixed Penalties explained.	Interactive discussion and Question and Answer Sessions	PowerPoint, whiteboard. Video clip:- Load security how DVSA enforces the rules (4 mins 23 secs)	Classroom	1.4
7 Either intro or feedback	15	**Summary and feedback**	Recap on the days training and topics covered. Questions, Trainer to provide the opportunity for group to ask questions Feedback forms to be completed and returned.	Feedback Forms	Classroom	

Total 225 Minutes – (Minus) 15 Mins, depending on if used at start or end of day.

[75] Robert Drummond, Managing Director of Drummond Distribution, gave a statement (CP23) in which he stated:

> "When James picks a load up he wouldn't be responsible for putting the items on the trailer, the company providing the items would have their own forklifts to place the items on. James would then be responsible for securing the load. In the trailer he used he would have had tyre netting around the trailer, it had centre hanging straps to wrap around the items and he would have additional straps in the cab to use for securing the load. General guidance from us that the driver must secure the load and if they needed any extra kit or things fixed the driver would report any defects before or at the end of the journey."

[76] Drivers employed by Drummond Distribution gave voluntary statements in respect of working arrangements relating to load security. Those statements are Crown Productions 36 – 39 and regard may be had to them in determining the issues before the Inquiry. In these statements, the drivers described the following arrangements:

(i) Ratchet straps were kept in HGVs for use on heavier loads and were hence readily available for drivers to use (CP36-3, CP37-3, CP38-3 and CP39-3);

(ii) Drivers would decide how to secure a load, (CP36-5, 37-5, 38-5 and 39-5) or would use positive fit (CP38-5);

(iii) Drivers would call upon their CPC training in deciding how to secure a load (CP26-5 and CP39-5);

(iv) Drivers did not work to a loading plan provided by Drummond Distribution (CP37-5 and CP38-5);

(v) Drivers were not audited on load security (CP37-5, CP38-5 and CP39-5).

Drummond Distribution: response to incident

[77] The investigation of the incident by Drummond Distribution following its referral to the Crown Office Health and Safety Investigation Unit was comprehensive and resulted in a number of important improvements including, consistent with best practice:

(a) the undertaking of a root and branch review of all risk assessments and improvements being made where necessary;

(b) the introduction of a bespoke risk assessment/method statement for the securing and strapping of loads; and

(c) a new induction programme whereby all drivers required to demonstrate to the organisation's health and safety trainer their ability to secure loads safely before engaging in any loading activity. In addition, the organisation introduced a traffic light system in relation to all its training provision to ensure that all training and refreshers were up to date at all times; these included one-to-one Safe Loading refresher courses. All of these measures have been overseen by a newly appointed health and safety adviser, Mr David Duncan and all steps which have been taken are to be the subject of independent audit and review by the external health and safety adviser of Palletline.

Straps contained within storage cabins of the HGV

[78] CP50 contains a photographic record of a voluntary search of the HGV in January 2025, showing, in particular, items recovered from storage cabins at the nearside and offside of the tractor unit of the HGV. Various ratchet straps, recovered from the aforesaid cabins, can be seen in said photographs, such ratchet straps having been within those cabins at the time of the fatal accident.

[79] CP51 contains detailed photographs of various ratchet straps referred to in the preceding paragraph, listing Straps 1 – 9 and specifying details in respect of these.

HSE involvement in the investigation

[80] As a general proposition, the HSE does not investigate incidents which occur on the open road. The policy reasoning underlying this stance is that load security is covered by road traffic legislation and regulations, which are enforced by the Police.

[81] That stance does not imply that HSE would suggest that the provisions of the 1974 Act do not apply to activities on the open road, but rather that it focuses its resources primarily on enforcement where there is not another competent regulator which HSE considers would be better suited to carry out the investigation.

The relevant regulatory framework

[82] The work activity from which the death of Mr Murray arose is covered by road traffic and health and safety legislation. This legislative framework is summarised at CP64 – 8 – 12.

DfT Code of Practice (now superseded):

[83] Department of Transport Guidance: At the time of the fatal accident, the UK Government Department for Transport ("DfT") had published a Code of Practice on Safety of Loads on Vehicles. This had been first published in 1972, and the (then) current 3rd Edition was published in 2002 (CP62).

[84] The Code of Practice was the recognised means of demonstrating compliance with UK legislation on load security at the time of the (fatal) incident (CP64-9).

[85] The Code of Practice stated, inter alia:

> "2.3 Friction alone cannot be relied upon to keep a load in place (…)
>
> 2.4 (…) It is essential therefore that the load is restrained in such a way that movement of the load on the vehicle is prevented.
>
> 2.5 The basic principle upon which this Code of Practice is based is that the combined strength of the load restraint system must be sufficient to withstand a force not less than the total weight of the load forward (…) and half of the weight of the load backwards and sideways (…) The principles should therefore be regarded as minimum requirements." (CP62-15-16
>
> "3.1 It is the vehicle operator's responsibility to provide suitable vehicles and securing equipment for each load carried and to ensure that drivers and loading staff are competent and have received sufficient instruction in its use. It is the driver's duty to check and ensure that the load is adequately secured at all times, not just at the start of the journey." (CP62-17)

[86] Section 11.6 notes a common issue for palletised loads, whereby movement of the load relative to the pallet it is transported on causes failure of the restraint method (CP62-69).

[87] The DfT guidance says, in relation to curtain-sided vehicles:

> "16.1 (…) As a general rule, goods carried within curtain-sided vehicles should be secured as if they were being carried on an open, flatbed vehicle.
>
> 16.3 Unless they are purposely designed for a specific load, the curtains of curtain-sided vehicles MUST NOT be considered as part of the load restraint system (…) Similarly, where vertical inner curtains are fitted and they are not purposely designed for a specific load, they also MUST NOT be considered as part of the load restraint system.
>
> 16.4 A curtain is a thin, flexible sheet and even when reinforced with full height webbing strapping, it can only resist sideways load movement if it deflects or bulges outwards. If this load shift occurs when the vehicle is moving it could make the vehicle unstable and cause an accident." (CP62-103-104)

[88] The Code of Practice was silent as to the position of consignors, other than consignors of dangerous goods, which did not apply to Interflex.

[89] Appendix D of the Code of Practice (CP62-119) sets out areas to be considered in risk assessing transport operations, and makes reference to HSG136.

HSE Guidance:

[90] HSG136 (CP63) states inter alia:

> "33 Where two or more employers (or the self-employed) share a workplace (whether temporarily or permanently), they need to:
>
> - co-operate with the other employers so they can meet their health and safety duties;
> - take all reasonable steps to co-ordinate the measures they take to meet their legal duties with those taken by other employers;
> - take all reasonable steps to tell the other employers about risks to their employees' health and safety as a result of their work activities.
>
> 34. Normally, the site operator or a main employer controls the site and they should take responsibility for co-ordinating health and safety measures by:
>
> - discussion with the smaller employers;
> - asking other employers to agree to site-wide arrangements;
> - liaison with other employers to help ensure they take responsibility and co-operate.
>
> 35. Where employers enter a different workplace (for example, to make a delivery or collect goods), consider that workplace as shared.
>
> 36. Vehicles on which employees of more than one company are working are also considered shared workplaces, even if it is only for a brief period (for example, during loading and unloading). Both employers are responsible for the safety of their own employees and those of other companies. Those involved in managing this work should agree, preferably in writing, the safety arrangements before work starts."

[91] Dealing specifically with loading and unloading, HSG 136 states:

"119 Loading and unloading are among the most hazardous transport activities in the workplace. People can be hit by objects falling from vehicles, struck by lift trucks, or fall from vehicles.

120 Good communication, co-operation and planning are crucial for safe deliveries and collections because there are usually several people involved, often working for different employers and sometimes speaking different languages. Where possible, agree safety arrangements when the order is placed. These should be confirmed in writing, making it clear who has responsibility for what during loading and unloading. Include details of the load being transported.

121 It is important to remember that drivers are not the only people responsible for the safety of the vehicle and the load. The consignor (the person or company who actually places the load onto the vehicle) and those in control of sites must ensure the loading is carried out safely and that the load will remain in a safe and stable condition until it reaches its destination. Those in control of sites where unloading takes place must also ensure unloading is carried out safely. Hauliers are responsible for ensuring the correct equipment and vehicles are used and their drivers are properly trained and monitored.

122 Drivers are often injured during deliveries and collections. Their employer must ensure they are given adequate safety information beforehand. Simple delivery safety checklists may help them decide whether there are sufficient precautions in place, and to establish criteria for when they can reasonably refuse to continue with a particular delivery or collection. Drivers (including agency staff) should be made aware that they are authorised to refuse or stop loading or unloading for safety reasons. This should be confirmed with the recipient when organising the delivery or collection.

123 When organising deliveries and collections, employers and site operators should also make sure:

- drivers know what to expect when they arrive at a site, for example any restrictions on vehicle size or type, or when goods should be delivered or collected;

- there is a safe system of work for deliveries and collections;

- there is a safe place for drivers to wait during loading and unloading;

- suitable equipment is available to allow safe loading and unloading, for example for drivers delivering at retail outlets;

- there is enough time allowed for drivers to check loads are secure and sheeted properly;

- instructions (in writing) are provided for all those involved."

[92] Specific guidance therein in respect of pallets states:

"145 When loads are placed on pallets, the driver or consignor will need to check that:

- pallets are serviceable and of the correct rating;

- load is shrink-wrapped or properly secured to the pallets in another way;

- pallets are securely attached to the vehicle, for example by webbing lashings."

DVSA guidance:

[93] The aforesaid Code of Practice (paragraphs [83] – [89] above) has been superseded by guidance published by the DVSA (and co-authored by Nina Day) (CP70).

[94] CP70 is a web-based publication, originally published on 20 July 2023 (therefore post-dating the accident). The most recent update was applied on 9 December 2024. A list of the updates, prepared by Nina Day, is CP61.

[95] DVSA's Categorisation of Vehicle Defects, referred to at CP64-8, is CP60.

[96] CP 70 provides guidance in respect of risk assessment, and specifies the duties of operators, drivers, and consignors as follows:

"Risk assessments: Employers and self-employed people must:

- assess the risks to both their own employees and anyone else who could be hurt by their work activities

- take appropriate steps to control those risks

- give drivers and loaders the information, training, and equipment they need to do their jobs safely

- do everything 'reasonably practicable' to protect people from harm. Doing this will help keep your employees and the public safe and reduce the risk of damage to your loads and vehicles. If you do not follow this guide, you must be able to show that you have achieved an equivalent level of safety." (CP70-7-8)

[97] Operator responsibilities:

"If you're a vehicle operator, you must manage risk in your business. You must make sure vehicles are:

- suitable for the intended purpose
- safe to drive (roadworthy)
- driven by people who are qualified, trained and competent

If your drivers secure loads, you must provide them with:

- training
- equipment
- instructions

You must support drivers who raise concerns about the way goods are loaded or secured. You must not pressure them to take out a vehicle if they think it's unsafe." (CP70-10)

[98] Driver responsibilities:

"If you load vehicles:

If you're a driver who loads vehicles, you must make sure any equipment you use is:

- in a usable condition
- strong enough to prevent the load from moving
- appropriate for the type of load it is securing.

If you do not load vehicles:

If you can, you should check that the load is secure before you set off. You can ask for a copy of the load plan from the load consignor (the person or company putting the load on the vehicle) if one is available. Report concerns about loading or load securing to your employer or load consignor. You should not proceed with a load if you have any doubts about its security."

[99] During the journey:

"You should check load restraints regularly during the journey. This is particularly important:

- when using lashing straps and chains – these may lose tension over time
- when transporting loads that are likely to settle – for example, sand or aggregate
- after any harsh braking or having to swerve to avoid something" (CP70-10-11)

[100] Consignor responsibilities:

"The load consignor is the person or company who puts the load onto the vehicle. The load consignor's legal duties and responsibilities do not finish when a vehicle leaves the site. They must:

- make sure that the load is in a suitable condition for transport and packaged in a way that means it can be secured to the vehicle
- make sure the load is stable before it's loaded onto a vehicle
- load the vehicle safely
- make sure that the load is safe throughout the journey, especially during multi-drop deliveries
- communicate with any third-party operator to manage safety in the transport operation."

[101] If on-site loaders secure loads, you must provide:

- training
- equipment

- instructions"

[102] If the driver is not involved in loading the vehicle, you must:

- find them a safe place to wait
- make them aware of how the load has been loaded and secured. You may find a load plan helpful so everyone knows how the load has been loaded.

What to include in the load plan:

The load plan could include:

- the weight of the load
- where the load has been placed on the load bed, if the vehicle is a closed body
- how the load has been secured
- any special instructions for unloading
- precautions to take when unloading
- a photo of the secured load, including a date and time taken.

Agree a system with the vehicle operator to keep the load secure:

You must agree on a system with the operator to make sure the load is secure throughout its journey." (CP70 – 11 – 13)

Nina Day's reports

[103] Nina Day provided specialist support to the investigation into Mr Murray's death, notwithstanding HSE's aforesaid position in respect of such matters. Those reports are lodged individually as CP 52 – 56 inclusive, and CP59. Photographs taken

by Nina Day are lodged as CP59. A consolidated version of the foregoing, arranged in the correct date order is lodged as CP64.

[104] Nina Day's qualifications and experience are as stated therein. (CP64-7)

[105] Within the aforesaid reports, Nina Day expressed various opinions in respect of the working arrangements and facts and circumstances leading to the death of Mr Murray. The Court was invited to have regard to the following excerpts from CP64 in determining the issues before the Inquiry

> "It is a common misconception that the driver is the only responsible party for the load, or that the responsibility of the load consignor and vehicle operator ends at the point the driver takes the vehicle onto the public highway. The Road Traffic Act is clear that responsibility is shared between the driver and anyone who causes or permits the vehicle to be on the road. At the same time, employers and the self-employed whose work activities affect others have duties under the Health and Safety at Work Act to take reasonably practicable steps to ensure the safety of employees and others who might be harmed. There is a specific duty under the Management of Health and Safety at Work Regulations for employers to cooperate and communicate in situations where a shared workplace exists, for example when a vehicle operated by one company is being loaded at a site belonging to a second. The risks of load movements are well known, and guidance has been in place to assist employers since the early 1970s. It is not enough to rely on the weight of the load and inertia to hold it in place: the load must be secured to the vehicle. Vehicle operators must assess the risks in their operation and take reasonably practicable steps to protect both their own employees and others. If drivers are expected to secure loads on vehicles, the employer should devise a suitable securing scheme and communicate this to the driver, providing them with appropriate and comprehensible instructions, training, and equipment as set out in the Provision and Use of Work Equipment Regulations. There is no single best practice means of securing loads, and employers must select suitable equipment for the loads they carry and the vehicles they operate. Advice and guidance can be obtained from the regulatory bodies, or from trade associations such as Logistics UK or the Road Haulage Association. Sector-specific groups, such as the Association of Pallet Networks, allow the sharing of good practice between members."(CP64-14)

[106] Nina Day's comments on risk assessment relevant to Mr Murray's accident:

"a. Risk assessment is an important part of establishing a safe system and the risk assessment I have been provided with (CP49) does cover many of the main risks associated with loading and unloading vehicles. However, in my opinion there are a number of areas that lack detail, particularly around the activity category of "check pallets. For safe transport and unloading, it is very important to ensure that palletised loads are fundamentally stable on the pallets and that they are connected securely to the pallets by adequate shrink-wrap or banding. This is particularly important if pallets are going to be stacked, since the lower layer must provide a stable base to the upper layer. In my opinion these sections lack detail, particularly when compared to the sections dealing with falls from height, which are very detailed. I would also expect to see an assessment of the differences in risks between the standard trailers and the XL trailers, which does not appear to be present. This is concerning, as the mode of use is very different between these two types of trailers, and it is very important to ensure that they are loaded and secured appropriately.

b. In my opinion, a recurring theme through the risk assessment is a lack of supervision, which is consistent with the drivers' statements that they are not audited on load security. If drivers are going to be asked to make decisions about loading and securing, then in my opinion there needs to be a system of supervision and checking to make sure that this is being done consistently in line with good practice. This does not have to be every load: many employers use a "random sample" system to check that loading and securing are being carried out safely. It is not clear to me from the risk assessment provided to me who is supposed to be carrying out the actions listed, as that column is blank. The risk assessment does not appear to consider the risk of the load moving during the journey, so that either something happens during the journey itself or the load falls from the vehicle when the driver opens the curtain for unloading or the load has collapsed to the extent that it cannot be unloaded by mechanical handling equipment. These are very common issues within the road haulage industry and can often result in serious incidents if the risk is not identified and controlled through appropriate safe systems of work in advance."(CP64-38)

Comments on drivers' statements:

[107] Nina day commented on the statements provided by drivers as follows:

"a. In my opinion, the statements provided by the drivers are consistent with what I would expect from class 1 HGV drivers of their age and experience. There are some minor misunderstandings in relation to load security, but in my experience these are very common misunderstandings in the wider industry. The exception is Mr Marks, who demonstrates a very detailed knowledge of the

requirements for loading XL-rated trailers that I would consider to be well above the standard of knowledge I would expect of a driver in this regard.

b. In my opinion, the statements demonstrate why it is important not to leave decisions about loading and securing purely to drivers without adequate information, instruction, and supervision. Levels of knowledge and understanding can vary widely, and it is important that employers who load vehicles and/or operate vehicles take steps to ensure that vehicles are consistently going onto the public highway in a safe condition. This could take the form of, for example, toolbox talks about the correct use of ratchet straps, ensuring positive fit in XL trailers, and at what point the internal buckle straps are no longer appropriate to secure a load. This could be reinforced by a system of auditing loads so that any issues can be rapidly identified and corrected.

c. I note that, while the drivers did demonstrate a knowledge of the limitations of the internal buckle straps - correct value or not - it was not clear from the statements whether they understood that the 400kg limit applies either to individual items if single-layer or the total stack weight if one pallet is stacked on top of another. For example, two 300kg pallets stacked on top of each other would require strapping with ratchet straps as the total weight would be 600kg." (CP64-50)

[108] Ms Day made the following overall comments in respect of the accident:

"Having reviewed the evidence to date, my opinion has not changed that the circumstances and location of the incident are entirely consistent with a load shift, which typically occur at the exit of roundabouts due to the combination of changing speed and direction in quick succession. I note the downhill gradient on the approach to the roundabout – where the load would have tended to shift forward due to both the gradient and the braking of the vehicle – followed by the turn into the roundabout and acceleration towards the exit, which would tend to shift the load both rearwards and to the offside. In my experience, load shifts can happen extremely quickly and at low speed under normal driving conditions, and drivers often have little to no warning that the load is moving. I consider it very unlikely Mr Murray could have done anything to rescue the situation once the load started to move. In my opinion, the load was not adequately secured at the time of the incident. I would not expect Mr Murray to have recognised that, or to have understood the danger the load presented to him and other road users due to the inadequate securing. In my opinion, it is for the load consignor and vehicle operator to devise a suitable securing scheme based on an assessment of the risks involved in transporting goods by road, provide suitable training, equipment, and information to drivers and/or loading staff as appropriate, and then provide appropriate supervision and review to

> ensure that loads are secured consistently and that any problems with the securing method/s are identified at an early stage. Securing methods should also be reviewed when using different types of trailer and when transporting different types of loads." (CP64-50-51)

Related criminal proceedings

[109] CP65 is an indictment served in terms of section 76 of the Criminal Procedure (Scotland) Act 1995.

[110] On 20 November 2025, Drummond Distribution pled guilty to the aforementioned indictment at Edinburgh Sheriff Court. CP66 is a Crown narration which was read to the Court on that date. Sentence was deferred until 5 December 2025.

[111] CP67 is an addendum to the aforesaid Crown narration, which was read to the Court on 5 December 2025.

[112] CP68 is an outline Plea in Mitigation which was lodged with the Court in respect of those Section 76 proceedings.

[113] On 5 December 2025, a fine of £120,000 was imposed on Drummond Distribution. CP69 is an extract conviction in respect of the foregoing Section 76 proceedings.

[114] Regard may be had to the aforesaid Crown Productions in determining the issues before this Fatal Accident Inquiry.

[115] In particular, the Court was invited to take note of the wider work of the HSE and other agencies in the area of load security, referred to in the penultimate and final page of CP66 (CP66-21-22)

[116] Save to the extent that evidence to the contrary has been heard or it is otherwise agreed, it is presumed that:

a. All Productions and label Productions are what they bear to be;

b. All documents bearing a date were prepared on or about the date they bear;

c. All typewritten witness statements are to be treated as the equivalent of signed manuscript statements;

d. All letters or other written communications addressed to or intended for another person or persons were sent by the person by who they bear to have been sent, to the person or persons to whom they are addressed, on or about the date they bear;

e. Documentary evidence shall be admitted into evidence without the need for it to be spoken to by its author; and

f. Any document which is a copy shall be treated as the equivalent of the original thereof.

[117] Crown Productions are given the abbreviation CP, Crown Labels the abbreviation CL.

Factual Background as agreed in the Second Joint Minute (paragraphs [118] to [125])

[118] "Positive fit" applies only to trailers or vehicle bodies which are strong enough to withstand the forces likely to be exerted on it during a journey, usually a vehicle constructed to BS EN 12642 XL standard. The sides of an XL Curtain-sided trailer, which features reinforced structure and curtains, can be used for load securing provided

the load is in "Positive fit". A load is in "Positive fit" where either it fills the load area entirely, front to back and side to side, or where packing is used to fill any gaps between the load and the vehicle body. For a load to be in "Positive fit" it must be (a) against or within 30cm of the headboard (the front of the trailer or vehicle load area), (b) loaded tightly along the length without a gap or cumulative gaps of more than 30cm, (c) within 30cm of the rear doors and (d) within 8cm of either side.

[119] A load which is in "Positive fit" on an XL Curtain-Sided vehicle need not be strapped in place as the superstructure of the vehicle is the primary means of load restraint.

[120] DAF XF HGV registered mark YX13 ZWG ("the HGV") was a standard curtain-sided articulated tractor and trailer unit. "Positive fit" is not a recognised means of load security in standard curtain-sided vehicles. The superstructure of a standard curtain-sided vehicle cannot be used for load security even where the distribution of the load would be considered to meet the requirements of a "Positive fit". The curtains of a standard curtain-sided vehicle have no significant strength; their primary purpose is simply to protect the load from the elements.

[121] For palletised loads, paragraph 11.7 (d) of CP62 states that where the load space is not fully utilised and where weight distribution is a problem, pallets should if possible be placed along the longitudinal (front to back) centre line of the vehicle and 'closed up' to one another. CP70 as now in force states that pallets should be loaded 'as close to each other as possible along the longitudinal (front to back) centre line of the vehicle if the load space is not fully utilised and weight distribution is a concern'.

[122] The Health and Safety Executive accepts that it is common practice within the road haulage industry for palletised loads on standard curtain-sided vehicles to not be in "Positive fit", there being no requirement for this. In standard curtain-sided trailers it is considered desirable to secure more of the load towards the front of the trailer with a view to ensuring there is sufficient weight over the 'fifth wheel' (the large plate on the tractor unit into which the kingpin of the trailer unit locks, thus providing articulation between the two units).

[123] The load involved in the accident was not in "Positive fit". There was no requirement for it to have been so. The load was placed on the trailer front to back with each pallet close to the next. Although there was no requirement for the load to be within 8cm of the curtain at either side its dimensions were such that it is likely to have been so. The pallets shifted during the collision and again during the vehicle recovery process. There is no evidence available as to the measurement of the gaps, if any, between pallets longitudinally prior to the horizontal shift and subsequent accident.

[124] The accident occurred when the load on the trailer of the HGV shifting horizontally. If the load had been correctly secured with ratchet straps the horizontal shift would not have occurred and the accident would have been avoided.

[125] There were 41 pallets on the trailer, each of equal area (though not weight). A "Positive fit" on the bottom layer of pallets would have required 26 pallets (2 rows of 13 pallets, front to back). Where pallets required to be stacked, it was Interflex Scotland Limited's usual practice to place the heavier pallets on the lower layer with

lighter pallets above[1]. There is no evidence that this usual practice was departed from on 23 August 2022, although the pallets were not individually weighed post-collision. Crown Production 40-4 shows that the 26 heaviest pallets weighed 18601kg (18.6 tonnes) in total; the remaining pallets weighted 5547kg (5.5 tonnes) in total. On the hypothesis of fact that the 26 heaviest pallets were placed on the lower layer with the remaining 15 pallets forming a partial upper layer, with none strapped, all the pallets would have remained insecure and liable to horizontal shift, unrestrained by the trailer superstructure. Even if a lower layer of 26 pallets had met the requirements of a "Positive fit", as none of the pallets had been correctly secured by ratchet straps within a standard curtain-sided trailer, all the pallets would have remained at risk of horizontal shift such that the accident would still likely have occurred.

Conviction of R Drummond (Carriers) Limited:

[126] The criminal proceedings mentioned above resulted in Mr Murray's employer being indicted to a Section 76 diet and pleading guilty to a contravention of Sections 2(1) and 33(1)(a) of the Health and Safety at Work etc. Act 1974. In short, they accepted that there had been a failure to ensure the health, safety and welfare of their employees, so far as reasonably practicable by a) failing to conduct a suitable and sufficient assessment of the risks associated with the transportation of loads on their vehicles, b) failing to devise, implement and maintain adequate arrangements for the proper securing of loads

being transported on their vehicles and c) failing to provide adequate information, instruction and training to their employees in relation to the proper securing of loads being transported on their vehicles, and in consequence thereof the fatal accident occurred. A fine of £120,000 was imposed.

Discussion

[127] Given the terms of the joint minutes whereby the cause of, and the circumstances surrounding, the accident have been agreed, the focus for the court is primarily on whether

a. any reasonable precautions could reasonably have been taken which would realistically have avoided the accident;

b. there were any defects in work systems which have contributed to Mr Murray's death; and

c. whether any recommendations should be made.

[128] There first two issues can be dealt with together. There is no doubt that the fatal accident occurred as a result of the load in Mr Murray's trailer shifting to the offside, causing, firstly, the trailer, and then the tractor unit, to topple onto their offside. The load had not been secured in any meaningful or effective way. The only load security in place were internal curtains which hang from the roof of the trailer down to the floor. These are sometimes referred to as cargo nets but, for the avoidance of doubt, do not drape over the actual pallets. The palletised load ought to have been secured by ratchet straps which had been supplied by Drummond Distribution and were in storage areas

within the vehicle. These were the only suitable method of securing the load in question, having regard to the weight of the load. Buckle straps and the curtains on the trailer in question did not provide the means necessary to stop the load from shifting and prevent the HGV from toppling onto its side.

[129] Drummond Distribution had issued very basic guidance to drivers saying it was their responsibility to secure their load, whether they loaded it or not. Some training had been provided to Mr Murray. It is a reasonable inference to draw in all the circumstances that he would have known the ratchet straps were available for him to use. Yet, for some reason they were not used. There is no direct evidence to explain why. The evidence in relation to his standard of driving all points to him being a diligent and careful driver who was fully compliant with driving regulations in terms of speed and rest periods. He had held an HGV driving licence for more than 8 years prior to the accident. He had various relevant qualifications as set out above. He was therefore an experienced HGV driver.

[130] Notwithstanding, Nina Day, who is clearly suitably qualified and experienced to provide skilled person evidence on Health and Safety issues relating to the haulage industry, would not have expected Mr Murray to have recognised that the load was inadequately secured, nor to have understood the danger which the load presented to him. Her unchallenged opinion is reflected in the joint minute. I sought further clarification of that opinion prior to agreeing to dispense with parole evidence. Ms Day stated in a written response that her opinion is based on her experience in dealing with hundreds of HGV drivers over many years. The load in question is not one that would

generally be considered to be a difficult one in terms of stability, compared to, for example, a load of roll cages. She considers that from Mr Murray's perspective, it would appear to be entirely reasonable for a uniform stacked load to be adequately secured for transport by the curtains and inner curtains (cargo nets) of his trailer. Based on her experience, she does not consider that to be indicative of carelessness or disregard for his own safety or that of others. I infer from this that Mr Murray did not have the means available to him, in terms of a working knowledge of the relevant risks, to appreciate that the way the load had been stacked posed a serious danger to him if ratchet straps were not used.

[131] It is clear from the evidence available that there were significant shortcomings in the system of work which Mr Murray was expected to operate by. These can be summarised as:

- No load plan was in place covering the matters outlined in paragraph [102] above;
- Inadequate risk assessments had been prepared, and reasonable steps had not been taken, to mitigate the risks which those risk assessments ought to have identified in relation to load instability during transit;
- No communication took place between the employer and consignor in relation to implementation of the HSE Guidance (HSG136) (i) to reflect who required to do what in relation to securing the load; and (ii) for the purpose of monitoring compliance of the driver and loader to ensure the load remained in a safe and stable condition until it reached its destination.

- Lack of reinforcement of training to ensure drivers, and employees of consignors, were aware of, and clearly understood, when dangers could potentially arise with load shifting, depending on the nature and weight of the load, how it was stacked and the securing methods deployed.
- Lack of independent auditing.

[132] These issues were clearly identified by Nina Day who, having reviewed Drummond Distribution's risk assessment, considered that there was a recurring theme of failing to address supervision and a lack of auditing on load security compliance. Nothing is said in the risk assessment regarding the hazard of the load moving during transit. The Drummond Distribution drivers who had been interviewed as part of the investigation showed a varied understanding, and, on occasion a misunderstanding, of load security requirements. Ms Day states this is not unusual and indeed is widespread throughout the haulage industry.

[133] Further, she highlights the dangers posed by changing speed and direction in quick succession. There is no direct evidence, one way or the other, as to whether Mr Murray was cognisant of those dangers. I find it inconceivable that he would have taken the bend onto the M8 motorway knowing that there was a real risk that the load was going to shift so I proceed on the basis that he was oblivious to that risk.

[134] In Ms Day's opinion

> "it is for the load consignor and vehicle operator to devise a suitable securing scheme based on an assessment of the risks involved in transporting goods by road, provide suitable training, equipment and information to drivers and/or loading staff as appropriate, and then provide appropriate supervision and

review to ensure that loads are secured consistently and that any problems with the securing method/s are identified at an early stage".

[135] The issues can be addressed by holding regular toolbox talks about the correct straps to use and providing drivers and loaders with all relevant health and safety information including how those straps should be used, ensuring positive fit in XL trailers where possible, supplemented by effective supervision and auditing. That said, positive fit would not have prevented this accident due to the weight of the load and lack of use of ratchet straps.

[136] I note at this point that paragraph 121 of HSG136 states the consignor and those in control of sites must ensure the loading is carried out safely and that the load will remain in a safe and stable condition until it reaches its destination. But paragraph 145 states when loads are placed on pallets, "the driver or consignor will need to check that…. pallets are securely attached to the vehicle, for example by webbing lashings." Whenever guidance fails to make clear who actually has the ultimate responsibility for doing something, misunderstandings are likely to arise. On the one hand, paragraph 121 places a positive requirement on the consignor, Interflex, to ensure the loading will remain in a safe and stable condition, yet, in relation to pallet loads, that requirement is diluted by paragraph 145, with either the driver **or** consignor having to check pallets are securely attached.

[137] Neither Drummond Distribution nor Interflex contacted the other to agree the specific requirements of the loader and driver. Interflex tasked one of their employees, Mr Brown, with the loading operation when he had no knowledge of the HSE guidance.

It was suggested in submissions that guidance is simply that, it is not a legislative requirement. Whilst that may be a relevant argument in reparation proceedings, it has no bearing on an FAI determination. The guidance had been issued and was readily accessible to any employer with responsibilities for the health, safety and welfare of employees involved in loading operations. The guidance should be followed unless there is some cogent reason not to. And even then, alternative effective methods of protecting the health, safety and welfare of the employees need to be in place. But neither Drummond Distribution nor Interflex followed the guidance. They proceeded on the basis that Mr Murray had sole responsibility to secure the load and that Interflex had no responsibility to do anything in that regard.

[138] The matters listed in para [123] above were defects in the work systems of both Drummond Distribution and Interflex.

[139] Since the accident, Drummond Distribution have fully addressed the defects in work systems by the appointment of a new HSE adviser who has carried out the necessary risk assessments and put all necessary procedures in place in terms of mitigating the risk involved in a loading operation. These include appropriate supervision of drivers' compliance with their training and appropriate auditing practices.

[140] It is important to note that the Department for Transport Code of Practice on Safety of Loads on Vehicles (but not the HSE guidance) referred to in paragraphs [83] to [89] above has been superseded by guidance published by the Driver and Vehicles Standards Agency, originally published on 20 July 2023, with is current version dating

from 9 December 2024. This was co-authored by Ms Day and clearly sets out the responsibilities of the employer, consignor and driver at all stages of the loading and transportation of goods.

Recommendations

[141] There are two recommendations which I wish to make.

[142] Firstly, I have seen nothing to suggest that Interflex have reviewed their health and safety procedures in the same way that Drummond Distribution have. If that has not been carried out by Interflex, I recommend they do so immediately. They should review existing (or prepare new) risk assessments, identify the hazards in a loading operation, put practices in place to ensure the HSE and DVSA guidance along with their obligations under the Road Traffic Act 1998, Health and Safety at Work etc Act 1974 and The Provision and Use of Work Equipment Regulations 1998 are complied with, including the provision of all necessary training and health and safety information to their employees on their responsibilities for the loading and transportation of goods. Further, they should ensure sufficiently robust supervision and auditing practices are put in place to pick up on non-compliance so that those issues are addressed at the earliest opportunity.

[143] Secondly, given the comments made by Nina Day that ignorance of i. loading responsibilities and ii. when a load requires the application of ratchet strapping, is widespread amongst HGV drivers, drivers' employers and consignors, the mere existence of the legislation and guidance, and a hope that drivers, their employers and

consignors fulfil their obligations, is insufficient to ensure that the risks associated with load stability are reduced to the lowest level possible. The diligent employer will do what is required. But, clearly, that is far from a universal position, and this widespread ignorance, or potentially deliberate flouting, of legal obligations, has potentially fatal consequences.

[144] There have been two targeted roadside campaigns, one in 2011 and one in 2015 performed by DVSA which was the subject of an article in *Transport Engineer* published in January 2018. Half of the vehicles stopped in 2011 had inadequate load securing with a quarter having no load securing at all. In 2015, a quarter of lorries stopped had inadequate load securing. One in ten had an unstable load. Ms Day devised and oversaw those campaigns. In 2022, she developed Operation Eventide, a multi-agency enforcement and education operation to address load security issues with the Association of Pallet Networks, of which Drummond Distribution is a member, and provided technical support to its running in 2023 and 2024. DVSA and HSE work together to help commercial training providers access up-to-date supporting materials. Much work has therefore been done to provide information to the road haulage industry on what is expected of them to mitigate the risks associated with load security.

[145] The Road Traffic Act 1988, The Health and Safety at Work etc Act 1974 and the Provision and Use of Work Equipment Regulations 1998 place obligations, and indeed criminal responsibility, on a number of different parties to ensure that loading is undertaken safely and that the load is adequately secured.

[146] As such, the necessary statutory and regulatory framework and guidance already exists, setting out the requirements of each person or organisation involved in a loading operation. However, unless there are adequate auditing and enforcement measures in place across the haulage industry, there is frequent non-compliance by haulage operators, consignors and drivers, culminating in failures to ensure that a load is secure and remains so in transit.

[147] My second recommendation, therefore, is to for DVSA and HSE to jointly consider how best to improve compliance. I acknowledge that DVSA and HSE were not represented at the Inquiry and have not had the opportunity of putting forward their views on this issue. It was a matter of agreement that since the accident Drummond Distribution have fully reviewed their procedures in relation to compliance and are now independently audited. A system of independent auditing across the haulage industry would be highly desirable, but no evidence was led as to whether it is feasible. I therefore stop short of recommending that such a scheme is put in place. I confine the recommendation to considering what can be done to improve compliance with the existing legal requirements for load security. Many professional bodies and businesses utilise peer review and independent auditing to ensure compliance with rules and regulations with appropriate sanctions for non-compliance. It is clear from the material submitted to the Inquiry that some haulage operators are utilising the services of compliance auditors. However, there is a widespread problem where the risks associated with insecure loads still exist despite the extensive work undertaken by Ms Day, and others, in disseminating information to the haulage industry. She herself

recognises that many drivers still fail to appreciate the risks. Many employers and consignors appear to be failing to comply with their legal obligations.

[148] The practical detail of how such a scheme could reasonably operate is something which is beyond the scope of this determination but it is within judicial knowledge that such schemes often involve the creation of a list of auditing criteria which is circulated to those to be assessed so there is a clear understanding of what the auditors will be assessing, how each criteria will be scored, what would constitute a fail and what the implications would be for such failure. Suitably qualified quality assurance peer reviewers are appointed and tasked with undertaking desk-top reviews of the relevant documentation and, if necessary, can undertake on-site reviews. Additional targeted roadside campaigns could be undertaken. There would clearly be a cost implication and consideration would have to be given to how such a scheme would be funded. These are simply observations for consideration in any feasibility study which is undertaken.

[149] It is of note that Drummond Distribution were convicted of contraventions of the Health and Safety at Work etc Act 1974 but that only arose as a result of the death of Mr Murray, and were it not for this Fatal Accident Inquiry it is likely no such convictions would have resulted. An audit of the type described above may well have highlighted, in advance, the various defects in the systems of work which could have been rectified prior to the accident.

[150] The purpose of these recommendations is to minimise the risk of any similar death arising in the future.

[151] I wish to conclude this determination by offering my heartfelt sympathies to Mr Murray's family. I can only imagine how difficult it has been for them to have to deal with the sudden and tragic death of a loved one and then have to cope with the lengthy process of a Fatal Accident Inquiry. I hope that the family feel that the accident has been adequately investigated and that this determination gives them adequate explanations of the issues which led to Mr Murray's death.