

**SHERIFFDOM OF SOUTH STRATHCLYDE, DUMFRIES AND GALLOWAY  
AT AYR**

**[2016] FAI 22**

B477/15

DETERMINATION

BY

SHERIFF DESMOND J LESLIE, ESQUIRE

UNDER THE FATAL ACCIDENTS AND SUDDEN DEATHS INQUIRIES (SCOTLAND)  
ACT 1976

into the death of

**JAMES IRVINE**

AYR SHERIFF COURT – 15 December 2016

The Sheriff, having resumed consideration of the cause determines:-

In terms of the Fatal Accidents and Sudden Deaths Inquiry (Scotland) Act 1976

Section 6(1)(a) that the death of James Irvine, born 12<sup>th</sup> February 1955, residing formerly in Ayr occurred at North Harbour, Ayr, KA8 0LG died in the course of his work as a self-employed taxi driver shortly after the hour of 00:24 on 23<sup>rd</sup> December 2014 at North Harbour in Ayr.

6(1)(b): That the cause of death was drowning brought about by acute myocardial infarction and coronary artery atheroma.

6(1)(c): That there were reasonable precautions which could have been taken whereby his death might have been avoided in particular the Port entry barrier system with

intercom communication facility to the Pilot House should have been activated to prevent unhindered access to the Port harbour area and to provide directional instruction, and emergency information and procedures to all Port visitors and in particular to Mr James Irvine.

6(1)(e): Other facts which are relevant to the circumstances of the death namely: Signage and road markings in the dock harbour area were inadequate.

The facts relating to the circumstances of the deceased's death were as follows:

- (1) At the time of the death James Irvine was a licensed self-employed taxi driver operating under the aegis of Streamline Taxis Limited and driving a vehicle being a silver Skoda Octavia registration number RK07 UMJ owned and co-leased to him by Mrs Catherine Moran.
- (2) The vehicle RK07 UMJ was well maintained, recently serviced, and had no noted mechanical issues.
- (3) On the evening of 22<sup>nd</sup> December 2014 Mr James Irvine suffered from no health issues either mental or physical.
- (4) At approximately 00:15 hours on 23<sup>rd</sup> December 2014 Mr Irvine received a request to attend at Ayr Harbour to collect Mr Graham Love, a marine operator employed by Ayr Harbour Tug Company. He was to attend at the Pilot House situated within the Port of Ayr at the end of North Harbour Street, Ayr. The intention was to convey Mr Love to Troon Harbour where Mr Love would attend upon an incoming vessel.

(5) The Ayr Harbour/Port is a free access area and vehicular traffic is not subject to any restriction imposed on Port users. A barrier at North Harbour Street to the Port Area operates from 18.00 to 06.00. The barrier has an intercom system which connects to the Pilot House. The barrier operates to provide security to the harbour area. Taxis and vehicles known to the marine operator were allowed free access to the Port.

(6) At 00:19 hours on 23<sup>rd</sup> December 2014 Mr James Irvine entered the Port area to collect Mr Love. In anticipation of Mr Irvine's entry to the harbour Mr Love raised the barrier in response to:

- (a) a text message that the taxi ordered by him had been dispatched and
- (b) the sound of the vehicle approaching the harbour area.

(7) Mr Irvine entered the harbour at speed and at a speed inappropriate to the negotiation of the speed bump encountered within a few metres to the harbour side of the port barrier. Mr Irvine had attended the harbour area on one previous occasion in October 2014.

(8) No discussion took place between the Pilot House and Mr Irvine on Mr Irvine's entry to the harbour area.

(9) The Pilot House is situated at the corner of Berths Four and Five of Ayr Dock. There was a ship docked at Berth Four, the Wilson Gdynia, which displayed full harbour illumination. There was general background noise from that ship's generators. A six metre high deposit of salt lay at Berth Four obstructing the view of the Pilot House from the entry point to the harbour area.

(10) On entry to the harbour area Mr Irvine turned right into Spur Road in the direction of Barrett Steel. He stopped briefly at the junction of Spur Road and Griffin Dock Road before turning left in the general direction of the Port Office.

(11) The Pilot House is normally approached by vehicles entering the harbour by taking a right turn into Spur Road and then diverting left in a direction of the Port Office following road markings. There is a sign to the north of Spur Road directing vehicular and pedestrian traffic southwards to the Port Office and to the Pilot House. There is an alternative unsigned road running alongside Dock Five which would also lead to the Pilot House. Both routes are considered suitable. It was known to Mr Love that there was a history of taxis entering the harbour area becoming disorientated and telephoning the Pilot House for directions.

(12) Weather conditions on the 23<sup>rd</sup> of December were inclement. Wind was averaging 30 knots (33-35 miles per hour). It was raining. The tide was running high at 7.8 metres above chart datum. There were white tops on the harbour water surface. High tide normally averages 7.4 metres.

(13) At approximately 00:23 hours Mr Love became curious as to the non-arrival of the taxi at the Pilot House. He had made no visual or aural observation of the taxi beyond hearing its initial approach and in consequence raising the port harbour barrier to facilitate entry.

(14) At 00:25 hours Mr Love telephoned the taxi controller for Streamline Taxis, Mr Colin Dempsey, to enquire of the whereabouts of Mr Irvine and to request he be contacted. Mr Dempsey could not make contact with Mr Irvine. Meantime Mr Love

carried out a cursory search of the harbour area to see if he could locate Mr Irvine. He was unsuccessful.

(15) Between 00:37 hours and 00:39 hours a second taxi sent by Streamline Taxis arrived at the port and collected Mr Love from a point adjacent to Ailsa Craig Terminal and conveyed Mr Love to Troon Harbour.

(16) On his departure from the harbour Mr Love retained the port harbour barrier in an upward position to allow free access and egress to the harbour in his absence.

(17) On his return to Ayr Harbour shortly before 02:00 hours Mr Love changed his outer wet clothing. He replaced the barrier. He was then contacted by the taxi driver from the vehicle which had taken him to Troon and returned him to Ayr Harbour to the effect that the driver had become disorientated and that he sought directions to the exit from the harbour.

(18) Mr Love then checked CCTV recordings of the harbour area to satisfy himself of all activity in the harbour area occurring in his absence. He noted there was no record of Mr Irvine's taxi leaving the harbour area.

(19) Mr Love then made an extensive search of the harbour area but could not locate Mr Irvine's taxi. When the search proved negative he contacted the controller of Streamline Taxis to determine if any contact had been made with Mr Irvine. He considered the situation to be serious and merited calling the police and the Ayr Harbour Master.

(20) The police arrived at 03:17 hours. The police initially treated the incident as a “missing person” inquiry. The coastguard arrived shortly afterwards. All enquiries and searches to find Mr Irvine were negative.

(21) The pilot boat was drafted in to search the harbour area in the vicinity of Docks Five, Eight and Nine working west to east across the harbour basin. A lead line was deployed to gauge depth and harbour bed impediments. This search was carried out at daylight at approximately 07:30 hours. The search again proved negative.

(22) On 26<sup>th</sup> December 2014 a diver from Police Scotland located a Skoda Octavia motor vehicle RK07 UMK to the east side of Dock Five at a depth of between three and four metres. The body of Mr Irvine was situated within the driver’s seat of the vehicle with his seatbelt unclipped. The vehicle lay at an angle of 45 degrees and was embedded in silt. The front offside window was broken.

(23) Scuff marks on the harbour basin perimeter kerb at Dock Five were identified adjacent to where the vehicle RK07 UMJ was recovered. These marks coincided with abrasions which were subsequently noted to the underside heat shield of the vehicle.

(24) For the vehicle to have entered the harbour at Dock Five it had to have been driven between two heavy operational mechanical vehicles positioned approximately two car widths apart and parked by the dock perimeter kerbing. To negotiate between the two mechanical vehicles a driver would have had to exercise considerable care.

(25) A post-mortem examination of Mr Irvine concluded that Mr Irvine died of (1) drowning, (b) acute myocardial infarction; (2) coronary atheroma. No pre-mortem

injuries were evident on the upper limbs or body of Mr Irvine which would have been consistent with efforts by Mr Irvine to free himself from his vehicle.

(26) Medical records of Mr Irvine disclosed a history of high blood pressure but no current medical or heart condition requiring medication.

(27) On the west side of Dock Five opposite to the point where Mr Irvine's vehicle entered the water is a canteen building illuminated by low wattage security lighting. Vehicular access to this building would require circumnavigation at the harbour basin following its perimeter from Spur Road by Griffin Dock Road. The area in which this building is situated is lit by three floodlights.

(28) The Harbour Port Estate is illuminated throughout to a satisfactory standard. There are no problems encountered by vehicular traffic caused by "glare". Any glare likely to be encountered is limited and does not provide an obstruction to drivers. The area around Berth Five is illuminated by a tower providing high intensity lighting. The lighting in the area of where Mr Irvine entered the water is acceptable and adequate in its intensity.

(29) Signage from the port entry barrier to the Pilot House is inadequate and misleading. There are two potential routes from the junction of Spur Road and Griffin Dock Road to the Pilot House which are not differentiated by signage. The sign directing traffic to the Pilot House points southwards. There is a no entry road marking outside the port office prohibiting access to the Pilot House. A vehicle is therefore required to turn back on itself and take an alternative route right which leads alongside Berth Five. This forms a recognised and second orthodox route to the Pilot House.

NOTE.

(30) I heard evidence in this case over a number of days. Written submissions were provided by all parties to the Inquiry after an exchange between parties to consider respective submissions and to answer any relevant suggestive findings. The Inquiry was led by Miss Arias for the Crown. Associated British Ports were represented by Mr Grant Hutchison, Advocate; Mr Graham Love, a marine operative with Ayr Harbour Tug Company, was represented by Mr Honeyman, solicitor; and the family of the deceased Mr James Irvine were represented by Mr Thomson, solicitor. I am obliged to all parties for their detailed and thoughtful submissions and presentations. I am also grateful to Associated British Ports who own and run Ayr Harbour for facilitating access by the Court to the Ayr Harbour estate and replicating, so far as possible, the features of the estate which were present on the morning of the 23<sup>rd</sup> December 2014.

(31) Evidence was taken from the following witnesses:-

Graham Alexander Frew, taxi driver.

Graham Love, Marine Operator at Ayr Harbour Tug Company.

Colin Dempsey, Taxi Controller Streamline Taxis Limited.

Catherine Moran, owner of taxi Skoda Octavia RK07 UMJ.

George Wilkie, owner Streamline Taxis.

PC Ian Pittams, Investigation Police Officer, Police Scotland.

Doctor Thomas Hunter, General Practitioner.

PC Ewan Alexander, Police Diver, Police Scotland.

PC Ross Neilson, Dive Supervisor, Police Scotland.

Trevor Boyes, Operations and Safety Manager, Associated British Ports.

Daniel Rigg, engineer Associated British Ports.

Mark Carroll, Health and Safety Inspector, HSE.

Michael Thomson, Chartered Civil Engineer, HSE.

Stuart Cresswell, Port Manager, Ayr Associated British Ports.

Affidavit: Dr Alison Gilchrist, Pathologist.

## DISCUSSION

[1] The deceased is Mr James Irvine who was 59 at the time of his death. He was a taxi driver sharing a taxi with Graham Alexander Frew. This was a Skoda Octavia registration number RK07 UMJ. Both men worked alternate shifts. The taxi was leased to them by Mrs Catherine Moran and operated through the radio control of Streamline Taxis. On the 22<sup>nd</sup> going into the 23<sup>rd</sup> December 2014 the taxi had no known mechanical faults, was well serviced and was fit for purpose. Mr Irvine had been working the evening and early morning shifts. This would take him from 6:00pm on the 22<sup>nd</sup> December through to 6:00am on the 23<sup>rd</sup> of December. As this was near Christmas taxi bookings were in demand. Mr Irvine had picked up his co-driver, Mr Frew, at Mr Frew's request somewhere between 11:00pm and midnight on the 22<sup>nd</sup> of December in order to take Mr Frew home after a night out. Mr Frew noted there was nothing untoward about Mr Irvine or his demeanour or attitude or anything suggestive of any

preoccupation mental or physical. Mr Frew had been using this vehicle earlier in the day and had no concerns regarding the vehicle's roadworthiness.

[2] At around 00:19 hours on the 23<sup>rd</sup> December 2014 Mr Graham Love, a marine operative with Ayr Harbour Tug Company, telephoned Streamline Taxis for a taxi to take him to Troon Harbour where he had to attend upon an incoming vessel expected at that Port. A marine operative assists in the mooring operation. Shortly after making the call a standard text was received by Mr Love telling him that a taxi had been dispatched to the harbour area. He awaited arrival of the taxi from within the Pilot House. The taxi was anticipated to arrive within minutes.

[3] The weather was foul with intermittent heavy rain. The Pilot House is situated to the west of the harbour and to the west of Dock 14. A ship, the "Wilson Gydnia", was berthed at Dock 14 and was displaying its full harbour illumination. A cargo of salt was deposited on the dockside adjacent to the "Wilson Gydnia" rising some 20 feet. This would have the effect of obscuring the view from the Pilot House to the harbour entrance. At the harbour entrance at the end of North Harbour Street there is a controlled entry system or barrier which allows access to the harbour area. On hearing an approach from a vehicle Mr Love's reaction was to open the barrier to allow the vehicle entry. There is an intercom communication system at the point of entry with the Pilot House. However since the barrier was lifted at the sound of the approaching vehicle there was no enquiry made of the driver of the vehicle as to his knowledge of the Harbour area. Mr Love guessed that the sound of the vehicle heralded the arrival of his taxi. It was not an uncommon practice to allow a taxi entry without making enquiry. A

subsequent viewing of the CCTV recording covering the harbour area showed that a taxi had entered the harbour area as had been anticipated by Mr Love. The taxi was a Skoda Octavia registration number RK07 UMJ and was driven by Mr James Irvine. The taxi did not appear to enter the harbour area at a speed appropriate to the hazards likely to be encountered. There is a speed bump positioned some metres west of the barrier. The vehicle was seen to approach that at a speed inappropriate for negotiating the impediment and suggested that the vehicle had been driven at some speed possibly without knowledge that there was a speed bump positioned beyond the barrier. The Skoda Octavia was then seen to turn right into Spur Road and was last identified by a CCTV recording (now no longer available) recovered from Barret Steel Ltd, stationary at the head of Spur Road having turned left in a direction of the Port Office. The vehicle was not seen again until its recovery from the harbour basin at Dock Five.

[4] Mr Love had become increasingly concerned that the taxi had failed to attend at the Pilot House and being pressed to attend Troon Harbour assumed there had been a change of plan either by the Taxi operator or by the taxi driver and ordered a second taxi to convey him to Troon. A second taxi was dispatched and was met by Mr Love at or around the entrance to the harbour.

[5] Mr Love returned to Ayr Harbour shortly before 2:00am in the morning. He had previous experience of drivers entering the harbour area becoming disorientated. He therefore decided that he should carry out a search of the entire harbour area covering all potential points of egress to determine whether the Skoda Octavia he had seen enter the harbour area remained within the harbour area.

[6] Mr Love on leaving the harbour area to attend at Troon had left the harbour barrier open. On his return to Ayr Harbour from Troon he reviewed CCTV recording of the entrance and exit from the harbour. There was no footage of the Skoda Octavia exiting the harbour. As his concerns increased he contacted the taxi controller, Mr Dempsey, who was making his own enquiries as to the whereabouts of the Skoda Octavia by trying to hail Mr Irvine on his radio and secondly by contacting Mr Irvine's family to see whether or not they had any information as to whether or not Mr Irvine had in fact returned home or been in contact with them. All efforts to find the Skoda Octavia and Mr Irvine proved futile.

[7] Shortly after three o'clock in the morning the police were contacted as was the coastguard. The police initially treated the matter as a missing person inquiry.

[8] A search of the harbour estate was conducted with negative results. At daybreak at approximately 7:30am the pilot boat was deployed to trawl the harbour basin using a lead line suspended from the boat. The boat reversed a grid across the basin. The use of the lead line in an experienced hand might identify an irregularity on the sea floor. This search also proved negative. It was not until the 26<sup>th</sup> of December that police divers were deployed in the harbour basin. The Skoda Octavia was identified as lying at an angle of 45 degrees some metres west of Berth Five. The front offside window was open or smashed. Mr Irvine was in the vehicle in the driver's seat and on the evidence of PC Alexander was unsecured by a clipped seatbelt. The vehicle was removed from the water and subsequent examination disclosed no mechanical malfunction. Scuff marks or scratches to the underside of the heat shield of the vehicle were forensically consistent

with abrasions identified on the dockside kerb adjacent to where the vehicle entered the water.

[9] A post-mortem examination was carried out on Mr Irvine who was found to have sustained a myocardial infarction and coronary artery atheroma and drowned. A post-mortem examination could not determine whether the myocardial infarction contributed to or caused the accident which resulted in Mr Irvine's death or whether it was a consequence of the accident.

[10] It cannot be said with any certainty what train of circumstances developed or combined in a way which precipitated Mr Irvine's death. Ayr Harbour estate had no history of health and safety deficit nor had there been a fatality there for 33 years. That fatality occurred for very different reasons. There was a presumption that it was an inherently safe place within which to work or traverse and that there were systems in place to guard against the potential dangers inherent in a functioning harbour with an unguarded waterfront, an industrial complex, the presence of heavy machinery and the deposit of cargo. There was considerable activity associated with the embarking and disembarking of crew and their families, the movement of goods onto and from ships and the general vehicular and pedestrian activity arising from general harbour activity.

[11] Much of this Inquiry focused on the familiarity visitors or work personnel would have had with the port layout and the clarity of signage. It was accepted by all parties that Mr Irvine had attended the harbour area on one previous occasion. However it was not determined what the circumstances of that visit were nor the time of day, the prevailing weather conditions, nor the exact location he had attended upon. It could not

therefore be assumed that he had sufficient knowledge of the harbour area procedures for entry or for directions he should follow to attend upon the Pilot House.

[12] It is a mystery as to why Mr Irvine plunged into the harbour at the site of Berth Five. The Inquiry explored two particular possibilities namely that he had suffered a heart attack and that his reaction to that event had caused disorientation and inadvertent driving into the harbour basin and secondly that he had become disorientated by the harbour lay out and signage and had misconstrued lights emanating from a building on the opposite side of the harbour basin to where he was driving as being from the Pilot House to which he was heading.

[13] I will deal with the first of these possibilities. Access to the harbour edge adjacent to Berth Five was not straight forward. To tip his vehicle over the side Mr Irvine would have required to exercise extensive care to drive between the two heavy mechanical vehicles parked by the berth side. These vehicles were considered to have been approximately one and a half to two car widths apart. A manoeuvre between these industrial vehicles could not have been random or reckless. It would have required a 90 degree right turn by Mr Irvine from the track he was taking to direct his vehicle between these two larger vehicles. It is unlikely, in my view, and in the balance of probabilities, that that manoeuvre would have been conducted in the throes of a heart attack or been in consequence of a heart attack for the reasons which were advanced by Dr Hunter namely that someone experiencing such a heart attack would be undergoing not only anxiety but dizziness, chest pain and perspiration and that a more consistent reaction to such symptoms evident in the onset of a heart attack would be to stop the vehicle in an

effort to recover some physical equilibrium. This would be quite the opposite to a reaction of a highly orientated change of direction and careful manoeuvring between two vehicles. It cannot be said forensically that a myocardial infarction occurred before or after Mr Irvine entered the water but the former is the least likely event. There may be some additional support for the possibility that the heart attack occurred on the vehicle striking the water and its subsequent submergence from the testimony of PC Ewan Alexander, the police officer who discovered the vehicle, who stated that Mr Irvine's seatbelt was unclipped. This observation was made by PC Alexander on his discovery of the vehicle and in my view would be consistent within an attempt, if very limited, to escape the ingress of water. It was also noted that Mr Irvine's fear of water spoken to by Dr Hunter combined with a history of hypertension and historical cardiovascular complaint could have contributed to the myocardial infarction which ultimately resulted in drowning. It was also recognised by Dr Hunter that there may have been a vagal reflex reaction from hitting cold water bringing about an immediate heart attack. I am not therefore drawn to the conclusion that Mr Irvine ended up in the water as a result of having a heart attack. It is more likely than not that the heart attack occurred upon his entering his water and subsequent confusion.

[14] In my view the totality of the evidence is highly suggestive of the second scenario that Mr Irvine was disorientated and unclear as to the location of the Pilot House and misidentified the building on the opposite side of the harbour and opposite Berth Five as being the Pilot House. It was noted that the weather conditions were inhospitable, the tide was running high, that the lighting within the entire port was

coming from a number of angles and locations, that there were obstacles to be negotiated, there was signage to be made sense of and there was a general unfamiliarity on the part of Mr Irvine as to the index of routes to the Pilot House. The wind was running at 30 knots and there was a high tide causing the River Ayr to back up into the harbour with a consequence higher level of water in the harbour basin. The surface of the water was choppy. There was also heavy rain. I consider it something of a contradiction that Mr Love considered that the visibility was good. I heard no specific evidence that there was any refraction of light from puddles forming within the general port compound but it would be a reasonable inference that that would have been evident in what appeared to be fairly stormy conditions. No issue was taken by any party as to the standard of illumination within the port. The Health and Safety Executive report (No. 5 of process) did not identify any issue of concern. Nor was any glare from the illumination considered to be a distraction to harbour users. Mr Love reported anecdotally that drivers who frequented other ports other than Ayr considered Ayr to be a well-lit port. This assertion was not challenged by the Health and Safety Executive. However it is clear that lights were evident from a number of locations around the harbour basin which to someone unfamiliar with the Port may not have been from an identifiable or decipherable location. There were lights to the south-west of the basin and to the north of the basin which gave adequate illumination and some, but not distracting, glare – by that I mean reflection from other surfaces. The outbuilding on the west side of the harbour opposite Berth Five is known as the Canteen. That was illuminated only by security lighting and therefore would have displayed limited

illumination. Berth 14 lay to the south of the compound adjacent to the harbour basin and was situated on the River Ayr itself. The “Wilson Gydna” was situated at Berth 14 and displayed full harbour lighting fore aft and amidships. For anyone travelling in a southwards direction along the compound adjacent to Berth Five the Pilot House may have been in the slipstream of the lights of the berthed “Wilson Gydna”. In inclement conditions and from within a vehicle travelling southwards alongside the harbour basin the Pilot House lights may have been obscured or made indistinguishable by the larger range of lights from behind from the “Wilson Gydna”. This cannot be said with any certainty however. It is a possibility that Mr Irvine whilst driving southwards on the compound alongside considered that the only observable building displaying lights was the canteen on the opposite side of the harbour and to the west of the harbour basin and concluded that outbuilding must have been the Pilot House and had driven towards that, with some care, to tragic effect. Mr Irvine would thus have made a very simple error of judgement by turning right from his direction of travel passing very deliberately between two heavy vehicles positioned by the berth side and, mistaking the basin surface as part of the harbour compound, drove over the side of the harbour kerb with fatal consequences. There is no evidence to suggest that such a manoeuvre was conducted at speed. In my view there is sufficient circumstantial evidence to suggest a general disorientation on the part of Mr Irvine. This stands in contrast to either the suggestion that he may have taken his own life or that his driving into the harbour was a reaction to him having suffered a heart attack. There was no history of depression nor evidence of any temperamental upset on the night Mr Irvine was working and I

therefore, for the avoidance of doubt, discount any suggestion that he may have taken his own life. For reasons I have already stated I consider it highly unlikely that Mr Irvine's entry into the harbour basin was in consequence of suffering a heart attack. On the balance of probabilities I consider that his entry to the harbour was as a result of disorientation and a mistaken understanding of where he was and to where he was headed.

[15] As I previously noted it is fortuitous Ayr Harbour has been accident free for at least 33 years and that record is commendable. It is a testament to the health and safety awareness of the management of Associated British Ports. It is however of some concern that there had been instances previously where drivers had been "lost" within the port. Mr Love was alert to that possibility when he was unable to track the whereabouts of Mr Irvine. He also recounted that there had been previous instances of drivers being lost within the Harbour area. The experience of the taxi driver who collected and returned Mr Love from and to Ayr Harbour on the morning of the 23<sup>rd</sup> December was in itself evidence that within the harbour area there was a propensity for drivers unfamiliar with the harbour layout to become lost. Night-time and poor weather are factors which lower the threshold for that occurrence. I consider it more likely than not that Mr Irvine's death was in consequence of such disorientation. Disorientation or loss of way within the Harbour area as might be experienced by a driver or visitor was a reasonably foreseeable event.

[16] Crown production No. 8 is the Health and Safety Executive guideline SIP001 which provides:

*“5.1. All terminals must have risk assessments carried out and safe systems of work in place. These should be communicated to all relevant parties including terminal staff, visitors, visiting hauliers and drivers, ships’ crew, agents, ships’ deliveries, emergency services, contractors and those who have business on the port or terminal.”*

*[...]*

*“5.11 In addition to port and terminal staff there will be a significant number of visitors who need to be provided with appropriate information to ensure their own and other port and terminal user’s safety. Visitors to operational areas need to be given information appropriate to the risk such as traffic routes/flows, emergency and reporting procedures. This may be provided by means of a map and basic written instructions or pictograms to allow for the fact some visitors may have a limited understanding of English.”*

Associated British Ports Workplace Transport Safety Policy and Procedure, production

No. 9, recognising the HSE Guideline SIP001 provides:-

*18) Where appropriate a safe system of work should be developed for control of vehicles and pedestrians.*

*[...]*

*20) ABP will provide appropriate training to all ABP drivers and appropriate information to all site personnel and visitors regarding safe passage through the premises.*

*[...]*

*26) To ensure, so far as reasonably practicable, the safety of visitors to the premises appropriate information will be issued or displayed and adequate supervision maintained.*

[17] The system in place at Ayr Harbour was simple and ought to have been functional: a barrier with an intercom facility linked to the Pilot House was operational. A vehicle stopped by the barrier ought to be provided with “appropriate information... regarding safe passage through the premises”. That would assume that someone about to enter the harbour area would have an identified purpose on attending the harbour and would be provided with geographic knowledge of where they were heading. That assurance was not provided to Mr Irvine. The barrier was opened by Mr Love in anticipation that the taxi he had ordered and driven by Mr Irvine would have not only

unimpeded access to the harbour area but would have knowledge of where they were heading. The CCTV recording from the camera at the entrance to the harbour area identified the approaching Skoda Octavia driven by Mr Irvine. There was some support that he was driving at speed and therefore unaware of the speed bump on the road positioned a few metres beyond the barrier. At the relevant time of entry to the harbour area it was not known whether Mr Irvine had any familiarity with the harbour or whether he knew of the location of the Pilot House and the designated route to that destination. If a system to identify incoming vehicles and make enquiry of them is *in situ* then it should have been deployed on the night in question. In particular if there was a likelihood that an incoming vehicle might not have knowledge of the harbour layout then it would have been imperative in line with ABP Harbour Transport Safety Policy and Procedure and in compliance of HSE Guideline SIP001 to make enquiry of the driver of that vehicle to establish if he knew where he was going and, if he was unsure, to provide specific instruction as to the route he should take. If such a procedure had been given effect then the HSE guideline SIP001 and the ABP's Workplace Transport Safety Policy and Procedure would have been satisfied to the extent that "appropriate information [would have been given] to all site personnel and visitors regarding safe passage through the premises". ABP guidelines which follow the HSE guideline SIP001 if implemented would have significantly reduced any risk to Mr Irvine. It is foreseeable that at night and in particular inclement conditions a "visitor" to the harbour area could become disorientated or lost. The only person to provide assistance, having regard to the time of morning when Mr Irvine entered the harbour area, was the person

occupying the Pilot House. There was no reason why the entry barrier with its communication facility to the Pilot House should have been made redundant. The fact that a taxi driver may be able to obtain some directional advice from a taxi controller does not displace the obligation and clear duty on ABP to satisfy their own safety policy as outlined in their Workplace Transport Safety Policy and Procedure document. It is incumbent upon ABP to secure the safety of all visitors to the harbour and no assumption should be made that all visitors to the harbour are equally familiar or conversant with the road network within the harbour area. Streamline Taxis now have a blanket policy whereby they do not enter the harbour area beyond the entry barrier. This policy is exclusive to Streamline Taxis and does not apply universally to all taxis. A leaflet entitled "ABP Drivers Safety Information Sheet" (Crown Production No. 12) has been distributed to all relevant taxi companies with a view to educating drivers on procedure and practice. While that approach is commendable it does not, in my view, obviate any obligation on the part of ABP to make diligent and proper enquiry of those entering the harbour area as to the individual's knowledge as to where they are going and provide to them appropriate directional instruction. In my view it is a critical consideration for admission to the harbour area that persons are aware of their direction of travel and, if unaware of precisely where they are heading, to be provided with appropriate directions and emergency and reporting procedures.

[18] I therefore consider that in terms of Section 6(1)(c) of the Act had diligent enquiry been made of Mr Irvine as to where he was headed and the appropriate directional safety information provided by the communication means available, which was fully

functional, the risk to Mr Irvine would have been significantly diminished and his death may have been avoided.

[19] Directions, however, must follow clear signage and routing. It is clear from the evidence given to the Inquiry that Ayr Harbour is accessed by a wide variety of individuals with varying knowledge of the port's geography. Regular lorry driving visitors will present different and possibly lower categories of risk from intermittent visitors and from first time visitors. Visiting in darkness will present additional risks and visiting in darkness in poor weather conditions will present additional hazards. The road layout and road markings within the harbour area follow normal highway road markings. There is also signage by the entrance to the port indicating the direction of the buildings housing the port's administration namely the Port Office and the Pilot House. These signings should be clear and unambiguous; all road markings should also be clear and unambiguous. The HSE investigation (Production No. 5) details that:

*"On 7<sup>th</sup> of January 2015 [the] ABP site [was] visited by [the reporting officer Mark Carroll] accompanied by Mr Mike Thomson. They reviewed the arrangements in place for direction of drivers for the entrance and layout of the entrance road and the areas around which Mr Irvine's car was believed to have gone into the water. ABP also provided workplace transport risk assessment relating to the organisation of the routes of the site. No concerns were noted within this which could be linked to Mr Irvine's death. Hazards discussed in the Port Safety and Skills Guidance were addressed in these assessments. There is evidence of relevant controls being recorded and applied during site visits.*

*Aside from some minor repainting work required it is obvious that routing through the site was considered. Lined roadways lead to the Pilot House. It appears that Mr Irvine either drove past and around the entrance to the Pilot House or drove straight across the open area before the Pilot House towards Berth Five. The routing and signage was considered sufficient for the operations there".*

Mr Carroll reached this conclusion on the basis of a walk around the harbour area following the existing signage. He was satisfied that if the signage was followed from the entrance of the harbour a visitor would terminate their journey at the Pilot House. In my view Mr Carroll's assessment is fundamentally flawed. In his evidence he accepted that there were in fact two potential routes to the Pilot House, one which was marked by signs and road markings and one which was unmarked by either. He considered that both routes were equally valid. On entrance to the harbour a vehicle would turn right or north into Spur Road and that at the head of Spur Road would meet signage directing it to the Pilot House and the Port Office. Following normal road markings this would take a vehicle leftwards or slightly westwards and then southwards between two buildings. The building to the left of the southwards heading vehicle would be the Port Office and to the right an industrial building which divides the marked route from the harbour basin compound and the unmarked route. At or beyond the Port Office however a vehicle would then encounter a "NO ENTRY" road marking prohibiting further travel in that direction. If this road marking is observed a vehicle would require to turn back on itself and head northwards to the point where the road divides as it encounters the industrial building just at the head of Spur Road. The potential route thereafter to the Pilot House would be to veer right then southwards in the direction of the Pilot House along the compound adjacent to the harbour and Berth Five. Ironically if the sign to the Pilot House is followed and the road markings are religiously observed then the Pilot House could never be reached by the identified route. The signage is therefore inadequate. It would appear from the evidence given by Mr

Carroll that the convention is to ignore the “NO ENTRY” road marking and follow the route to the Pilot House. The signage therefore is in conflict with the road marking and that, potentially, is hazardous and creates risk to a careful driver with no knowledge of the port geography. If following the appropriate signage in combination with the road markings, then a visitor negotiating their way in a vehicle to the Pilot House more likely than not would end up in the car park of the Port Office. The alternative unsigned and unmarked route is to traverse the compound adjacent to the harbour basin southwards; this would lead to the Pilot House. Mr Irvine’s vehicle is not further seen on any CCTV recording once he has turned from the head of Spur Road. It cannot be said with any certainty or indeed on the balance of probabilities that he followed the normal marked route to the Pilot House by the road to the Port Office and confronted the “NO ENTRY” sign. It cannot be said with certainty whether he did take this route and turned back on himself and chose an alternative route. Simply stated such obfuscation and contradiction between signage and road markings would not have been of assistance to him in locating the Pilot House. Had he initially chosen to follow the road markings but thereafter confronted the “NO ENTRY” road marking and turned back on himself towards Spur road but thereafter veered to the right of the industrial building to traverse the compound adjacent to the harbour basin in the direction of the Pilot House it is more probable than not that he was completely disorientated and took a direction along the harbour compound which ended with him fatally driving into the harbour. That alternative route is accepted as an orthodox route although unsigned and unmarked. If it is officially recognised then there ought to be an expectation that it is

identified by adequate signage and road markings to define direction and to avoid foreseeable potential danger.

[20] I am satisfied that there can be no finding made under Section 6(1)(c) of the Act in relation to the Port signage and road markings as it is unclear and unknown what bearing the ambiguity and contradictions presented by the signage to Mr Irvine. That would be to speculate. Equally I cannot say that the inadequacy of signage satisfies the requirements of Section 6(1)(d) of the Act. However I am satisfied that the inadequacy of the signage and road markings within the Port area particularly with reference to the location of the Pilot House were factors relevant to the circumstances of the death of Mr Irvine and accordingly make such a finding in terms of Section 6(1)(e) of the Act.

[21] I recognise this is a sensitive time for Mr Irvine's family and friends and offer my personal and sincere condolences to them together with the sympathies of all those who participated in the Inquiry.