

INQUIRY UNDER THE FATAL ACCIDENTS AND INQUIRIES (SCOTLAND) ACT INTO THE SUDDEN DEATH OF IAN SAMUEL JOHNSTON GILMOUR

SHERIFFDOM OF LOTHIAN AND BORDERS AT EDINBURGH

DETERMINATION

by

**SHERIFF FIONA LENNOX REITH, Queens Counsel, Sheriff of Lothian and
Borders at Edinburgh**

**in Inquiry into the circumstances of
the death of**

IAN SAMUEL JOHNSTON GILMOUR, lately of 6 St Joans Crescent, Kilwinning

**in terms of section 6 of the Fatal Accidents and Sudden Deaths Inquiry
(Scotland) Act 1976**

EDINBURGH 25th May 2007

The sheriff, having considered all the evidence adduced and submissions thereon at the inquiry under the Fatal Accidents and Sudden Deaths Inquiry (Scotland) Act 1976, FINDS IN FACT:

1. Ian Samuel Johnston Gilmour ("the deceased") was born on 1 April 1959. He lived at 6 St Joans Crescent, Kilwinning. As at 5 April 2005 ("said date") he was fit and healthy and had no known worries which may have preoccupied him. He was single with no dependants. He was considering buying his council house. As at said date, he was employed by Scotweld Employment Services Limited ("Scotweld") of 270 Petershill Road, Glasgow, and had been so employed for some 5 or 6 years.
2. At about the end of March and beginning of April 2005 Network Rail Infrastructure Limited ("Network Rail") were planning and undertaking track inspections for a programme of track renewal. These inspections required to be undertaken whilst trains were using the line. This was known as working in "Red Zone" conditions. The track renewals engineer for Network Rail, Mr Keith Simmonds, planned inspections of track at sites in the area of Haymarket Station, Edinburgh and towards the Newbridge junction for Tuesday 5 April 2005. This was on the Edinburgh to Glasgow main line railway.
3. To plan for this proposed work, Mr Simmonds utilised various sources of information including a Sectional Appendix, the local Hazard Directory and a computerised system known as "OMNICOM". This provides video footage of the track concerned taken from a train running up and down the route. Mr Simmonds

planned for a three man track survey work party from Network Rail. From the sources of information accessed by him, Mr Simmonds decided that the level of protection required for his survey team was a controller of site safety (a "COSS") and two lookouts. The safety staff comprising the COSS and two lookouts were hired by Network Rail from Scotweld, an outside contractor, rather than in-house from another division in Network Rail.

4. The said safety staff were ordered by Network Rail by telephone from Scotweld on 1 April 2005. The only information provided to Scotweld by Network Rail at that point was as follows: the dates upon which the safety staff were required, the meeting point, the meeting time and a contact number for Mr Simmonds.

5. Network Rail did not provide Scotweld with a RIMINI (Risk Minimisation) Pack for the job. It is best practice to provide a contractor such as Scotweld with such a RIMINI Pack in sufficient time to enable a contractor to understand the information contained in it. A RIMINI Pack would, at a minimum, have included the relevant Sectional Appendix, hazard directory and a partially completed COSS Record of Arrangements and Briefing Form. Such a Record of Arrangements and Briefing Form includes the name of the COSS, the date, nature and time of the work concerned, the location and lines affected, how to contact the signaller in an emergency, details of the lines concerned (including the direction of travel and speed of the line), access and egress arrangements to and from the working area, hazards associated with access and egress, hazards associated with the site, limits of the working area and how these were defined, details of any permit to work arrangements if appropriate, details of the safe system of work involved, details of how warnings are to be given, locations of positions of safety and details of lookouts appointed for the work.

6. All members of the Network Rail track survey work party had PTS (Personal Track Safety) and IWA (Individual Working Alone) certificates. These certificates are issued by Network Rail to staff who undertake and pass the relevant examinations.

7. The meeting point for the work involved on said date was Haymarket West junction. The meeting time was 9.00 am. The track survey work party from Network Rail comprised Mr Simmonds, Mr Euan Greenoak and Mr David Norris. Mr Greenoak was a graduate trainee with Network Rail at the material time. He is now an assistant structures management strategy engineer for Network Rail. Mr Norris is and was said date a structural renewals engineer with Network Rail.

8. The safety team from Scotweld comprised Mr Warren Ferguson, Mr William Hunter and the deceased. Mr Ferguson was the COSS. Mr Hunter was the "distant" or "advance" lookout and the deceased was the "site" lookout. A distant lookout is a qualified lookout who is positioned some distance from the track survey work party. Such a distant lookout communicates warning of approaching trains to the site lookout by means of a horn and/or the use of a blue and white flag. A site lookout is a competent lookout who remains close to the track survey work party and who watches for and gives warning of trains approaching such a work party by means of a horn. Both Mr Hunter and the deceased were competent and experienced lookouts.

9. Mr Ferguson, the COSS, had only worked on this area of track once before. Because of the short notice of the job, he had not had time to look at the site before the job started. A COSS can be required to work anywhere in Scotland. Mr Ferguson prefers to work on lines with which he is familiar.

10. The two teams met up as arranged at Haymarket West junction at about 9.00 am on 5 April 2005. The members of the Scotweld safety team had started out from Ayrshire at about 6.30 that morning.

11. In the absence of a RIMINI Pack provided by Network Rail, Mr Ferguson had to prepare his own COSS Briefing Forms for the work that day using information he had with him in his van. This included a Sectional Appendix. Production number 13 includes the relevant part of the Sectional Appendix for Haymarket West junction and Newbridge junction. This covered the running lines and speed restrictions for the lines at those junctions. Production number 3 comprises the "COSS Record of Arrangements and Briefing Form" completed by Mr Ferguson in connection with the survey on the morning of said date. Production number 4 comprises the "COSS Record of Arrangements and Briefing Form" completed by him in connection with the survey for the afternoon on said date. Mr Ferguson had thought that he had had sufficient information at that time and that he did not require to invoke Scotweld's "refusal to work" policy. If Mr Ferguson had felt that the information available to him was insufficient he would have been entitled to invoke this policy.

12. Mr Ferguson then gave a safety briefing to both the members of the track survey work party and the two lookouts for the work that morning. All present at the briefing signed the Briefing Form, production number 3, to acknowledge that they had been given the briefing.

13. The work in the morning in the area of Haymarket West junction progressed without incident. However, at one point, the deceased called out to Mr Hunter to cover a branch line which joined the main Edinburgh to Glasgow line approximately opposite Murrayfield Stadium, Edinburgh. Mr Hunter accordingly moved his position in order to do that. This had involved having to cross the main line tracks. Until then the two lookouts, as well as the COSS and members of the track survey work party, had been in positions of safety in the "cess" beside the "up" line. The "up" line is the railway line running from Glasgow towards Edinburgh. The cess is the space between the lower edge of the ballast shoulder for the track and either the toe of a cutting slope, the top of an embankment slope, or the edge of unexcavated ground where the track is at natural ground level. The position of safety specified by the COSS for each of the lookouts, in addition to members of the track survey work party and the COSS, was the said cess. This change in position of one of the lookouts, Mr Hunter, was not discussed with Mr Ferguson. Mr Ferguson was unaware that Mr Hunter had changed his position by moving across the main line tracks.

14. After completion of the morning's work the members of the track survey work party met up with the safety team at a petrol station at Newbridge. There was some difficulty in finding an access site for the area of track towards the Newbridge junction to be surveyed in the afternoon. Mr Norris was instructed to find an appropriate egress point for the team to make their way to upon completion of the work planned for the afternoon. He found an appropriate egress point. He did not

rejoin the survey team. Mr Simmonds had intended the work to finish at the Newbridge junction. However, he had not been specific to Mr Ferguson as to where the end point for the work was to be. Mr Ferguson was not made aware of the exact start and end points of the survey. He was merely told that the track survey work party would be walking towards the Newbridge junction. He was not told whether the work party would be walking past the junction. Mr Ferguson therefore told Mr Hunter and the deceased that the work party was walking towards the Newbridge junction. In addition, Mr Ferguson was not informed by the track renewals engineer about two potential hazards, namely a disused platform at Ratho and the Newbridge junction itself. He was therefore unaware that the Newbridge junction might affect the job. As a result, these two potential further hazards were not noted by him in the COSS Record of Arrangements and Briefing Form for the afternoon, production number 4.

15. Prior to the commencement of the work in the afternoon towards the Newbridge junction, Mr Ferguson gave the track survey work party and the safety team a safety briefing on the basis of the information contained in production number 4. The briefing was similar to the briefing given that morning, except that the teams were told that there were two lines rather than four lines and that the line speed was higher. No mention was made of the Newbridge junction.

16. The afternoon work commenced at about 12.30 pm. The track survey work party were to be inspecting the "up" line. The deceased as the site lookout was in the cess for the "up" line about 50 metres ahead of the track survey work party and was walking in the direction of Glasgow. Mr Hunter was a considerable distance further ahead of the deceased in the same cess and walking in the same direction. They were looking ahead for trains coming from Glasgow. Mr Ferguson was with the track survey work party. As the survey work was proceeding both lookouts gave sufficient warnings of trains. The line was very busy with passing trains. Those in the work party were also aware of trains going towards Glasgow on the "down" line (namely the line on which trains travelled in a direction away from Edinburgh). All of the workers in both the track survey work party and the safety team were in the cess adjacent to the "up" line. During the course of the afternoon's work, Mr Ferguson was helping the track survey work party by holding the end of the measuring tape for Mr Simmonds.

17. The distant lookout, Mr Hunter, would give warning of an oncoming train by blowing a horn and waving a large blue and white checkered flag. Once warned, the members of the track survey work party would move to a position of safety to allow any train to pass. When a train approaches, all employees walking on or near a railway line are immediately to move to a position of safety clear of any line on which trains may approach, acknowledge any audible signal given by the train driver (by raising one arm above the head) to show the driver that the warning has been heard and look to make sure which line the train was approaching on (Rule 6.6 of Module G2 of the Rule Book entitled "Personal safety when walking on or near the line, or when on the lineside"). It is particularly important to look to see where a train is coming from in relation to bi-directional lines. The branch line to Bathgate at the Newbridge junction is bi-directional.

18. As the track survey progressed, the distant lookout, Mr Hunter, continued on past the Newbridge junction. He was looking towards Glasgow for approaching trains and

was also glancing back to make sure that he could still see the deceased and the track survey work party. Mr Hunter did not feel tired. He was working correctly.

19. On glancing back that afternoon Mr Hunter became aware that the deceased had left the cess for the "up" line and was crossing both the main "up" line and the main "down" line. He was then aware of the deceased walking beside some sidings on the far side of the "down" line and then being in the "V" between the main "down" line and the branch line to Bathgate. The junction of the Bathgate line from the main Edinburgh to Glasgow "down" line is known as the Newbridge junction.

20. Neither Mr Ferguson nor any members of the track survey work party were aware that the deceased had crossed the tracks. Mr Hunter, the distant lookout, was not concerned about this because he assumed that the deceased had moved across the tracks in order to get a better view of trains coming off the branch line from Bathgate towards Edinburgh. If Mr Hunter had been concerned, he would have blown his horn in order to attract the attention of Mr Ferguson.

21. In the meantime, Mr John Strang, a driver employed by First ScotRail, had attended for duty at Waverley Station, Edinburgh. He was an experienced and competent driver. His first duty on said date was to drive the 14.18 hours Edinburgh to Bathgate train, Headcode No. 2B09. The train was a class 1582 car diesel unit. The train was working correctly. It was fitted with a data recording device known as OTMR.

22. The Edinburgh to Bathgate service departed from Edinburgh Waverley Station on time. As Mr Strang passed signal EN567 shortly before the Newbridge junction, he was signalled to proceed onto the branch line to Bathgate. He was travelling at a speed appropriate to the track concerned and within the speed limit. Mr Strang noticed the presence of the track survey work party on the opposite running line (the "up" line). The members of the work party were all wearing high visibility orange reflective clothing. He sounded a horn to warn them of the approach of the train. They all acknowledged the warning and moved to the far side of the "up" line. It was at this point that Mr Ferguson became aware for the first time that the deceased had moved across the mainline tracks and was in the "V" between the main "down" line and the branch line to Bathgate.

23. Mr Strang then saw the deceased ahead. The deceased was on the said branch line to Bathgate. He was standing on the right hand side of one of the sleepers of the said branch line. He was not standing clear of the line. He was therefore in the path of the train. He had his back to the train. On seeing the deceased, Mr Strang sounded the horn of the train. It was a 2-tone horn sounding an alternate high tone and low tone. The deceased raised his right hand to acknowledge that he had heard the horn. However, he did not look to see where the train was coming from and did not move to a position of safety. He remained where he was. Mr Strang sounded the horn a second time. The deceased again raised his right hand to acknowledge that he had heard the horn. However, he again did not look to see where the train was coming from or move to a position of safety. On seeing that the deceased was still not moving out of the path of the train Mr Strang applied the emergency brakes for the train and sounded the horn for a third time. However, the deceased still did not move out of the way of the train. Mr Strang was unable to avoid a collision with the

deceased. The said collision occurred at about 14.37 hours on said date. The deceased was pronounced dead at the scene.

24. On 7 April 2005 Professor Anthony Busuttil and Professor Gerhard Kernbach-Wighton, both forensic pathologists at Edinburgh University, carried out a postmortem examination of the deceased. Their report is production number 9. They established the medical cause of death and certified it to be: 1(a) Multiple Injuries, (b) Railway Collision. The pathologists also commented that: "This man died of multiple injuries consistent with having occurred as a consequence of a collision with a moving train. There are severe injuries to the chest, with extensive internal injury, and also of the pelvis. As the aorta was torn asunder, death is likely to have been instantaneous." The pathologists forwarded samples for analysis to the forensic science laboratory of Lothian and Borders Police.

25. On 7 April 2005 Sunella Brahma, forensic scientist of Lothian and Borders Police, Edinburgh, examined the samples taken from the deceased and analysed them for drugs and alcohol. All the samples tested negative for drugs and alcohol.

26. It is more likely than not that the deceased crossed the main line tracks to a position in the "V" between the main "down" line and the branch line to Bathgate in order to get a better view of trains coming from Bathgate.

27. Such a decision would not have been an unreasonable one. However, the deceased and all others at the COSS briefings had been told that the position of safety was the cess beside the "up" line. A decision to cross main line tracks such as occurred on said date would have represented a material change to the established safe system of working previously discussed with Mr Ferguson. However, it is not proved whether a requirement to discuss any proposed material change or variation in the safe system of working was explicitly covered in either of the briefings given by Mr Ferguson on said date. Mr Ferguson was not aware that there had been a change in the safe system of working in the morning when the distant lookout, Mr Hunter, had crossed over the tracks to the branch line opposite Murrayfield Stadium.

28. Mr David Hunter, driving standards manager for First ScotRail Limited, carried out an internal investigation into the circumstances of the said collision. His report comprises production number 5. The said train was found to be working properly, with the exception of one minor matter, namely that the speedometer of the train was reading 4 miles per hour higher than the actual train speed. In addition, the data recorder time was set, in accordance with usual practice, to Greenwich Mean Time (GMT) rather than to British Standard Time (BST) and therefore read approximately 1 hour and 4 minutes earlier than the actual incident time.

29. Following the said accident the Rail Safety and Standards Board (RSSB) appointed an inquiry panel to conduct a formal inquiry into the said accident. Production number 20 comprises the Final Report dated 29 September 2005 following said inquiry. This report included six recommendations to address the issues raised in the inquiry. The objective given for each recommendation was to prevent a similar accident.

30. Recommendation 1 was to the effect that a thorough review of work planning activity should be undertaken in Network Rail Scotland Territory Track Engineering to ensure that (1) staff with work planning roles and responsibilities are properly trained and equipped for the task and (2) only staff with appropriate training and competence are to undertake work planning activities. It was recommended that a remedial action plan should be produced, identifying appropriate resources, deliverables and timescales. Responsibility for implementation of this Recommendation was said to be that of Network Rail, Scotland Territory within a timescale of three months.

31. Recommendation 2 was to the effect that a review of the Network Rail business process entitled "Safety of people working on or near the line" should be undertaken to ensure sufficient clarity in regard to (1) roles and responsibilities of staff planning work in accord with the Business Process, and the COSS in maintaining the safe system of work, (2) standards of advance information and documentation, and the process for information transfer between the parties, and (3) the definition and mandatory components of a safe system of work, including their practical applicability. These were all to ensure that the COSS has adequate information and guidance with which to establish a safe system of work. Responsibility for implementation of this Recommendation was said to be that of Network Rail HQ, and the timescale specified was to be within six months.

32. Recommendation 3 was to the effect that a research study should be undertaken to review the impact which lack of local geographic knowledge has on the ability to plan effectively and carry out work safely. The study was to assess the extent to which local knowledge is important, the impact of local knowledge or decision making when planning in a variety of different circumstances, and the effectiveness, applicability and currency of data in the systems, processes and procedures which are used to mitigate the position on local knowledge. Responsibility for implementation of this Recommendation was said to be that of the RSSB and the timescale given was within twelve months.

33. Recommendation 4 was to the effect that the requirement that any change or variation to an established safe system of work be discussed with the COSS in advance should be explicitly covered in pre-work COSS briefings. Responsibility for implementation of this Recommendation was said to be that of Network Rail HQ, Territories and Contractors. The timescale given was within three months.

34. Recommendation 5 was to the effect that there should be a review of relevant rules and standards for Red Zone working to assess their adequacy and applicability to moving or "rolling" sites (such as was the position at the material time on said date). It was recommended that this review should consider particularly the communication needs of a moving team, both routinely and in abnormal circumstances, and the roles and responsibilities of both the work team leader and the COSS in maintaining the safe system of work at all times. The timescale given was within six months.

35. Recommendation 6 was to the effect that provisions in the Rule Book concerning the sounding of the horn as a warning and the precise meaning of the terms used should be clarified in all relevant sections of the Rule Book. It was also

recommended that the techniques associated with certain warnings should be defined and specified for incorporation into driver training, refresher training and practical briefing opportunities. Responsibility for implementation of this Recommendation was said to be that of the RSSB. The timescale given was within six months.

36. The first four recommendations were accepted by those with responsibility for implementing them. They have now been acted upon. As a result, the various deficiencies identified in the final report by the inquiry panel have been addressed and real improvements have now been made. The Office of the Rail Regulator ("ORR") through Her Majesty's Rail Inspectorate (HMRI) is actively monitoring the implementation in the practices and procedures recommended.

37. Recommendations 5 and 6 have been considered by the RSSB but rejected as being unnecessary. The ORR through HMRI has accepted this position.

38. Both Network Rail and Scotweld were prosecuted and pleaded guilty on indictment to contraventions of sections 2 and 33 of the Health and Safety at Work etc Act 1974. Production number 21 is a copy of the indictment, as amended, to which the pleas of guilty were tendered. Network Rail and Scotweld were fined £130,000 and £33,000 respectively.

39. There is a difference in the Driver's Rule Book as to horn codes for "wrong line working" and "urgent warning". However, track workers are expected to act on the sounding of any train horn.

40. The work of a lookout is quite monotonous. It can be difficult to keep attention levels at a sufficiently high level. It is for this reason that lookouts are not permitted to have mobile phones or walkie-talkies whilst working on the tracks.

41. Paragraph 6.6 of Module G2 of the Rule Book (production number 22) provides in relation to track workers such as the deceased:

"6.6 Action to take when a train approaches.

When a train approaches, you must:

- immediately move to a position of safety clear of any line on which trains may approach
- if you are already in a position of safety, stay there
- watch out for other trains that might be approaching that you may not have noticed

When you hear the audible warning given by the driver of an approaching train, you must raise one arm above your head to show the driver you have heard the warning.

If necessary you must put any equipment you are carrying down on the ground clear of the line before the train passes.

You must stay in the position of safety and watch the train until either:

- the train has passed clear, or
- you are certain that you will not be in any danger by that train or any other train

You must not assume that you know which line the train is approaching on. You must always stop, look and make sure."

The sheriff accordingly **DETERMINES** as follows:

1. In terms of **Section 6(1)(a)** of the Fatal Accidents and Sudden Deaths Inquiry (Scotland) Act 1976: that the death of Ian Samuel Johnston Gilmour, born on 1 April 1959, occurred on 5 April 2005 at approximately 14.37 hours on the Edinburgh to Glasgow railway line at the junction with the line to Bathgate, known as Newbridge junction.

2. In terms of **Section 6(1)(b)** of the Fatal Accidents and Sudden Deaths Inquiry (Scotland) Act 1976:

(a) that the medical causes of death of Ian Samuel Johnston Gilmour were (a) Multiple Injuries and (b) Railway Collision.

(b) that the immediate cause of the accident resulting in the death of Ian Samuel Johnston Gilmour was his decision to cross the main railway lines running between Edinburgh and Glasgow to make his way to a location on the Bathgate branch line where he was not in a position of safety. He acknowledged the warnings given by the train driver by horn of the approach of the train, Head Code No. 2B09. However, he did not look to see where the train was coming from and did not move to a position of safety, all as set out in paragraph 6.6 of Module G2 of the Rule Book, production number 22.

4. In terms of **Section 6(1)(e)** of the Fatal Accidents and Sudden Deaths Inquiry (Scotland) Act 1976:

(a) that the steps taken by Network Rail, the Rail Safety and Standards Board and Scotweld, as an outside contractor, since the said accident in accepting and acting upon Recommendations 1, 2, 3 and 4 of the Final Report by the inquiry panel appointed by the Rail Safety and Standards Board, together with monitoring by the Office of the Rail Regulator through Her Majesty's Rail Inspectorate to ensure effective implementation of the Recommendations, represent reasonable precautions whereby a similar accident might be avoided in the future.

(b) that there was poor initial planning by the track renewals engineer of Network Rail of the said work to be carried out on said date.

(c) that Network Rail ordered Scotweld staff at short notice with minimal information and did not provide the controller of site safety (COSS) with a RIMINI Pack in relation to the work to be carried out on said date. As a result, the COSS had to put the information together himself on the morning of the job, and without the benefit of

a site visit prior to commencement of the job. In particular, the COSS was not provided with information relating to the Newbridge junction and how the junction might affect the job to enable him to establish a safe system of work to include the junction in determining a safe system of work.

(d) that Mr Ferguson, the COSS, thought that he had sufficient information to enable him to proceed. He therefore did not invoke the refusal to work policy. He would have been entitled to do so if he had felt that the system of working was unsafe. However, he was unaware that the Newbridge junction might affect the job because he had not been made aware of this by the track renewals engineer, Mr Simmonds. It would have been best practice for Mr Ferguson to have been provided with information about the Newbridge junction. This would have enabled him to have included it in devising a safe system of working and in the briefing to the track survey work party and the lookouts, including the deceased.

(e) that even although the work concerned was to be "Red Zone" working, Scotweld accepted the job from Network Rail without sufficient details having been provided by Network Rail. Since the said accident, Scotweld has instructed employees acting as a COSS that they must be provided with a completed COSS Record of Arrangements and Briefing Form as a minimum.

(f) that Ian Samuel Johnston Gilmour was not made aware of the layout of the branch line to Bathgate at the Newbridge junction, including the fact that it was bi-directional in nature.

(g) that the COSS did not see Ian Samuel Johnston Gilmour cross the main railway tracks just before the said accident. By the time Mr Ferguson became aware that Ian Samuel Johnston Gilmour was on the branch line to Bathgate it was too late for him to be able to attempt to prevent the accident.

(h) that there was nothing else that Mr John Strang, the train driver, could have done to avoid a collision.

NOTE:

[1] The evidence led at the inquiry and submissions thereon extended over 2 days on 30 April and 2 May 2007.

[2] At the conclusion of proceedings in court I indicated, in terms of rule 11(3) of the Fatal Accidents and Sudden Deaths Inquiry Procedure (Scotland) Rules 1977, that I required time to prepare my Determination and that it would be issued in writing.

[3] At the inquiry, Mr John Kirk, procurator fiscal depute, represented the Crown; Mr C G Sanders, Advocate, represented Network Rail Infrastructure Limited on the instructions of Mr Turnbull of MacRoberts, Solicitors, Glasgow, and Miss D Turner of DLA Piper (Scotland) LLP, Glasgow, represented Scotweld Employment Services Limited. Members of the family of the deceased were present at the inquiry. However, they were not legally represented at the inquiry.

[5] The procurator fiscal led evidence from 8 witnesses. A joint minute was entered into by the parties agreeing, first, the evidence of a member of the deceased's family regarding personal details relating to the deceased and, second, evidence of Professor Anthony Busuttil, forensic pathologist. No other evidence was led. There was little dispute about the facts at the inquiry.

[6] In his closing submissions, the procurator fiscal sought formal findings in terms of sections 6(1)(a) and (b) of the 1976 Act. No specific findings were suggested in terms of paragraphs (c) or (d). However, under reference to paragraph (e) of section 6 of the 1976 Act, the procurator fiscal submitted that there were a number of facts relevant to the circumstances of the death of the deceased. However, it was not suggested that the inquiry should make any specific recommendations.

[7] The procurator fiscal's position was that the immediate cause of the accident was the deceased crossing the track, not standing in a position of safety and then, despite acknowledging the warnings from the oncoming train, his failure to look to see where the train was coming from. The procurator fiscal also submitted that there were a number of "contributory causes" of the accident: poor initial planning of the work by the track renewals engineer, the lack of production of a RIMINI Pack, the ordering of the Scotweld staff at short notice and with minimal information, Scotweld's accepting the work without sufficient details and whether the COSS should have invoked a refusal to work policy. The procurator fiscal's initial submission was that these should be recorded under reference to paragraph (b) of section 6 of the 1976 Act. However, the procurator fiscal was equally content that they should be narrated under reference to paragraph (e) of section 6 of the 1976 Act as being: "any other facts which are relevant to the circumstances of the death".

[8] It was a matter of agreement between all parties that following the accident an in-depth inquiry was held by an inquiry panel appointed by the Rail Safety and Standards Board (RSSB). Following this inquiry a Final Report was issued in September 2005 which included six recommendations to address the issues of concern raised at that inquiry. It was a matter of agreement that, of these recommendations, four had been accepted and acted upon and that the remaining two had been rejected by the RSSB as being unnecessary. Mr Ian Skinner of the Office of the Rail Regulator (ORR) confirmed in evidence at this inquiry that the ORR had not challenged the rejection of Recommendations 5 and 6 of the inquiry panel as the ORR was satisfied with explanations given for their having been rejected by the RSSB. In the light of the evidence before me, I can see no reason to conclude that Recommendations 5 and 6 should not have been rejected. There was also evidence from witnesses from both Network Rail and Scotweld to confirm that procedures have since the accident been revised and tightened up considerably. The procurator fiscal submitted that, as a result of this, the various deficiencies identified in the Final Report by the inquiry panel have been addressed and that real improvements have been made. In the light of the evidence led before this inquiry this submission appeared to me to be well-founded.

[9] It was also a matter of agreement that both Network Rail and Scotweld pleaded guilty to contraventions of section 2 of the Health and Safety at Work etc Act 1974 and that both were fined for these breaches. I was also reminded by the procurator fiscal that Mr Skinner of the ORR had confirmed in his evidence that the ORR

through Her Majesty's Rail Inspectorate (HMRI) is now actively monitoring the improvements in practice and procedure put in place following acceptance of the recommendations.

[10] Mr Sanders took issue with only two points made by the procurator fiscal in his submissions. There had also been limited cross examination of any of the witnesses led by the procurator fiscal. He submitted that it was clear that the immediate cause of the accident was that the deceased had failed to comply with paragraph 6.6 of Module G2 of the Rule Book. However, Mr Sanders told me that he took "slight issue" with the procurator fiscal's suggestion that there had been "contributory causes" of the accident. Mr Sanders told me that in the context of the prosecution under the Health and Safety at Work etc Act 1974 it had been agreed with the Crown that the Crown narrative would not assert any causal link between the breaches of the statutory provisions and the accident. Mr Sanders also submitted that to describe the matters referred to by the procurator fiscal as "contributory causes" was in any event to state the matter too highly.

[11] In response to this point, the procurator fiscal reminded me that the context and purpose of a fatal accident inquiry was entirely different from a prosecution under the Health and Safety at Work etc Act 1974.

[12] In my opinion, the procurator fiscal is correct in relation to this issue. The purpose of a fatal accident inquiry is to look back, as at the date of the inquiry, to determine what can now be seen as the reasonable precautions, if any, whereby the accident resulting in death might have been avoided, the defects, if any, in any system of working which contributed to the accident resulting in the death, and any other facts which are relevant to the circumstances of the death. The purpose of any conclusions drawn is to assist those legitimately interested in the circumstances of the death to look to the future. They, armed with the benefit of hindsight, the evidence led at the inquiry, and the determination of the inquiry, may be persuaded to take steps to prevent any recurrence of such an accident in the future. What may or may not have been agreed as being appropriate for the Crown narrative in relation to a criminal prosecution under the Health and Safety at Work etc Act 1974 cannot prevent a sheriff at a fatal accident inquiry from reaching conclusions which are relevant and appropriate in the context of the Fatal Accidents and Sudden Deaths Inquiry (Scotland) Act 1976, section 6.

[13] Miss Turner submitted that the "direct" cause of deceased's death was his failure to comply with paragraph 6.6 of Module G2 of the Rule Book. As regards the other factors referred to by the procurator fiscal as being "contributory causes", there was she submitted no "direct" link between these deficiencies and the death itself. All members of the safety team and the work party had been told by Mr Ferguson that their position of safety was in the "up" line cess. I was also reminded by Miss Turner that all parties involved had now accepted and acted upon the relevant recommendations. The deficiencies identified have therefore now been addressed and their implementation is to be monitored by HMRI for the ORR.

[14] Having considered the submissions in relation to this issue, I took the view that the matters referred to by the procurator fiscal as being "contributory causes" were contributory in relation to the accident which resulted in the death of the deceased in

the sense that the facts concerned were really facts relevant to the circumstances of the death. That being so, I took the view that they fell more appropriately under section 6(1)(e) than section 6(1)(b) of the 1976 Act. In view of the fact that all parties have now accepted and acted upon Recommendations 1, 2, 3 and 4 of the inquiry panel, and that their effective implementation is to be monitored by HMRI, I am satisfied that it is appropriate to make a finding in terms of section 6(1)(e) to the effect that as a result a similar accident might be avoided in the future.

[15] The second point with which Mr Sanders took issue was a submission by the procurator fiscal to the effect that Mr Ferguson had indicated that he had felt that his role would have been easier if he was working on tracks he knew rather than anywhere in Scotland. I was reminded of evidence from Mr Ferguson to the effect that, although that was his position in general terms, in relation to the particular job, he had felt that he had had sufficient information to go on to the line on the day in question to act as a COSS. If he had felt that he had had insufficient information, he could have refused to work. Mr Sanders accepted that he had not cross-examined Mr Skinner of the ORR in relation to evidence given by him to a contrary effect, namely that the COSS had not been provided with sufficient information..

[16] Mr Skinner is one of Her Majesty's Inspectors of Railways. He gave evidence to the effect that he had in the past been a COSS himself. His evidence was to the effect that a COSS is at liberty to invoke a refusal to work policy if he is of the view that a safety plan is unsafe. He told the court that the best practice is for a COSS to be provided by the client, in this case Network Rail, with a RIMINI Pack in sufficient time to allow him to understand the information contained in it. Preferably, this should not be left to the day of the job itself. Mr Skinner's opinion was that the information provided to the COSS in this case by Network Rail was insufficient. It did not include information about the Newbridge junction or the access and egress points for the work. When he was asked if the COSS could have invoked the refusal to work policy, he replied to the effect that the problem for the COSS in this case was that he did not know that the presence of the Newbridge junction was close enough to affect his work. Because the COSS did not have this information, he did not know to ask for it. If the COSS had had information about the junction, he could have briefed the lookouts, including the deceased, about it. The problem was that the COSS did not have information about how the junction could affect the job. Mr Skinner gave evidence to the effect that he would have expected this information to have been provided by the person planning the work, namely Mr Simmonds of Network Rail. Miss Turner on behalf of Scotweld founded on Mr Skinner's evidence to this effect. She submitted that there should be no criticism of Mr Ferguson having thought that there was sufficient information and therefore not invoking the refusal to work policy. She submitted that the problem was that because he did not know about it, he had not known to ask for it.

[17] I had no hesitation in accepting Mr Skinner's evidence. He clearly has substantial experience in the railway industry. He gave his evidence in a careful and measured manner and was a witness in whom I felt I could have complete confidence. In so far as there was any conflict between the evidence of Mr Ferguson and Mr Skinner, I preferred the evidence of Mr Skinner in the light of his more substantial experience in the railway industry than Mr Ferguson.

[18] On that basis, I have not criticised Mr Ferguson for failing to invoke the refusal to work policy. I accepted Miss Turner's submission to the effect that as at 5 April 2005 Mr Ferguson had genuinely thought that he had been sufficient information. However, in the light of Mr Skinner's evidence, I am satisfied that the problem was that he had not in fact been provided with sufficient information by the track renewals engineer, Mr Simmonds. This ought to have included information relating to the Newbridge junction and how the junction might affect the job. This would have enabled Mr Ferguson to establish a safe system of work to include that junction.

[19] It is clear from the evidence that the deceased was an experienced and competent lookout. Except for the fact that he did not discuss it in advance with the COSS, there was no dispute that it would have been a reasonable decision for him to have crossed the main line in order to get a better view of trains coming from Bathgate as well as the main line. In the absence of any other explanation to account for his actions in crossing the line as he did, it seems likely that this was indeed the reason for his movement across the main line.

[20] Mr Skinner also gave evidence to the effect that if a lookout proposed to change his position of safety from that specified by the COSS, he would have expected any such lookout to stop and to communicate with the COSS in order to discuss the position and obtain authorisation by the COSS of the proposed change. Mr Ferguson told the court that he had told the lookout and the work party to stay in the "up" line cess. I accepted his evidence on this. He also agreed with the procurator fiscal that he would have expected any proposed material change in the established system of working (such as crossing over main line tracks) to be discussed with a COSS in advance. However, there was no evidence as to whether in either briefing that day Mr Ferguson explicitly stated to the lookouts that any change or variation in the established system of working should be discussed with him in advance. That being so, there was no evidence that the deceased was actually aware of any requirement to do this. In view of the lack of evidence about this issue I have not made any specific finding beyond that set out in finding in fact 27. This is a matter upon which Recommendation 4 of the Final Report of the inquiry panel was concerned. That recommendation has been accepted and acted upon and, reassuringly, is one of the recommendations the implementation of which is to be monitored by HMRI.

[21] The COSS was unaware that the deceased had crossed the main line until just seconds before the collision. It appears that he had been helping the track survey work party with the tape measure. However, the duties of a COSS in this respect were not explored in evidence. It is therefore not possible for me to reach any firm conclusions about the extent to which it was, or was not, appropriate for Mr Ferguson to helping the track survey work party.

[22] It is clear that the deceased heard the train horn being sounded. This is because he raised his arm to acknowledge it. However, it remains a puzzle as to why he did not look to see where the train was coming from and move to a position of safety. At one point in the course of his evidence, Mr Skinner gave evidence to the effect that the job of a lookout is "quite monotonous" and that it is "difficult to keep attention levels at a sufficiently high level". It may be that that was a problem in the present case. However, this was not a matter which was explored in any great detail in evidence before me. If, as seems likely, the deceased was unaware of the bi-

directional nature of the branch line to Bathgate, he may well simply have assumed that any train would come from Bathgate rather than from behind. However, irrespective of the direction from which the train was coming on the Bathgate branch line, it has to be observed that the deceased was nevertheless not in - and did not move to - a position of safety on hearing the train horn. Even if the train had been travelling from the direction of Bathgate, he was still not in a position of safety. This was therefore truly a tragic situation resulting in the loss of Mr Gilmour's life.