

SHERIFFDOM OF NORTH STRATHCLYDE AT PAISLEY

[2016] FAI 14

B684/15

DETERMINATION

BY

SHERIFF COLIN WILLIAM PETTIGREW

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

into the death of

DOUGLAS BRIAN GORDON

Paisley, 2016

The Sheriff, having heard and considered all of the evidence adduced and the parties' submissions, DETERMINES:

1. In terms of Section 6(1)(a) of the Fatal Accidents and Sudden Deaths Inquiry (Scotland) Act 1976 that:
 - (i) Douglas Brian Gordon, born 24 May 1956 and who resided in Glasgow died at the Southern General Hospital, Govan Road, Glasgow on 2 July 2014 at 13.15 hrs. His life was pronounced formally extinct at the hospital at that time.
 - (ii) The accident resulting in Mr Gordon's death occurred around 11:30am on 2 July 2014 in the eastbound carriageway on Sanderling Road, Paisley, approximately 36 metres west of the roundabout junction with White Cart Road, Paisley.
2. In terms of Section 6(1)(b) of the Act that:
 - (i) the cause of Mr Gordon's death was

1(a) Chest Injury due to

1(b) Road Traffic Accident (minibus driver); and

- (ii) The cause of the accident resulting in Mr Gordon's death was his negotiation of the roundabout in the course of his employment whilst driving the Ford Transit van registration number SJ13 JYU at excessive speed, his loss of control of the Ford Transit van resulting in it crossing into the path of a large oncoming white coloured MAN TGX26:440 Articulated LGV registration number T40 STS operated by Saints Transport Limited and being driven by their employee Denis Gallacher, and colliding with same.

The reason or reasons why Mr Gordon drove at excessive speed and lost control of the Ford Transit Van cannot be established.

3. In terms of Section 6(1)(c) of the Act the death of Mr Douglas Brian Gordon and the accident resulting in his death might have been avoided:

- (i) if he had not driven the Ford Transit van through the roundabout at the junction with White Cart Road, Paisley at excessive speed and lost control of the vehicle;
- (ii) if, whilst driving the Ford Transit van in a westerly direction, he had not entered the eastbound carriageway of Sanderling Road, Paisley as he exited the roundabout whereby the Ford Transit van collided with the LGV being driven in the opposite direction by Mr Denis Gallacher;
- (iii) if, the Drivers and Vehicle Licensing Agency (DVLA) when assessing the Application by Mr Douglas Brian Gordon for a vocational (Group 2) licence (Crown Production No. 15) accompanied by the completed and signed D4 Medical

Examination Report dated 22 November 2013 (Crown Production No. 16) had contacted his General Practitioner to obtain sight of Mr Gordon's GP Records relative to his anti-hypertensive treatment and blood pressure readings, authority for the release of which medical information relevant to his fitness to drive to the Secretary of State's medical advisor having been given by Mr Gordon in signing Section 12 - Consent and Declaration - of the D4 Medical Examination Report.

4. In terms of Section 6(1)(d) of the Act it is not established that a defect in any system of work contributed to the accident resulting in Mr Gordon's death.
5. In terms of Section 6(1)(e) of the Act that the following facts are relevant to the circumstances of Mr Gordon's death:-
 - (i) Airlink Management Limited did not at the time of interviewing Mr Gordon for the position of the driver seek references or any specific medical information from interviewees, other than to ask the interviewee a general question relating to whether or not he had any medical issues
 - (ii) Nevertheless it was reasonable for Airlink Management Limited to employ Mr Gordon as a driver. Approximately six months before his employment commenced, Mr Gordon had undergone a D4 Medical Examination and had then been issued in December 2013 by the DVLA with a vocational (Group 2) driving licence. This entitled him to drive Group 2 vehicles until December 2018. At interview Mr Gordon produced a copy of his Certificated Professional Competence form GTG confirming he had undergone thirty five hours of CPC earlier in 2014.

- (iii) There was no reason why Airlink Management Limited should not have relied upon the issue of a five year vocational licence in December 2013 by the DVLA and on the Certificate of Professional Competence documentation as proof of Mr Gordon's fitness to drive and competence for the driving job he was employed to do.
- (iv) Appropriate training was provided to Mr Gordon by Airlink Management Limited.
- (v) There were no pre-collision defects in the Ford Transit van (minibus) or the luggage trailer which it was towing that could have led to a loss of control of the vehicle or trailer or increased the severity of the collision. The mechanical condition of the vehicle and trailer were not contributing factors in the collision.
- (vi) There were no pre-collision defects in the white MAN TGX26:440 LGV tractor unit or the SD semi-trailer attached thereto that could have led to a loss of control of the vehicle or the trailer or increased the severity of the collision. The mechanical condition of the vehicle or the trailer was not a contributing factor in the collision.
- (vii) The DVLA's "At a Glance" guide to the current medical standards of fitness to drive for medical practitioners is for use as guidance only. Whilst it provides some idea of the anticipated outcome of the medical inquiry the guide provides that the specific features of each case will be considered before an individual licencing decision is reached.
- (viii) It is the duty of the licence applicant to notify DVLA of any medical condition which may affect safe driving. On occasions, however, there are circumstances in

which the licence holder cannot, or will not do so. In such circumstances the General Medical Council has issued clear guidelines to the medical profession.

- (ix) In the section entitled “Cardiovascular Disorder” under “Hypertension” in the 2013 edition of the DVLA’s At a Glance guide to the current medical standards of fitness to drive for medical practitioners, in force November 2013, dealing with entitlement to the Group 2 licence, it provides that a person is disqualified “from driving if resting BP consistently 180mm Hg systolic or more and/or 100mm Hg diastolic or more”.
- (x) In November, 2013 the DVLA’s operational instructions re section 4G blood pressure of the D4 medical examination report provided that if a single blood pressure reading taken on the day of the examination was below the threshold of 180/100 the DVLA would proceed to grant the application for a vocational (Group 2) driving licence.
- (xi) On 11 March 2016 the DVLA published its latest guidance “Assessing fitness to drive” a guide for medical professionals.” In the section dealing with hypertension the DVLA guidance now states in relation to Group 2 licence holders (bus and lorry) that they must not drive and must notify the DVLA if resting BP is consistently: 180mm Hg or higher systolic and/or 100mm Hg or more diastolic.
- (xii) The current DVLA’s operational instructions re section 4g blood pressure of the current version of the D4 Medical Examination Report require the best blood pressure reading taken on the day of the D4 medical examination to be recorded.

This single reading is then assessed against the threshold of 180/100. If found to be above the application for a vocational (Group 2) licence is refused.

- (xiii) The DVLA's At a Glance guide to current medical standards of fitness to drive for medical practitioners in use in November 2013 and the guidance currently in use (as from 11 March, 2016) was and is not uniform in its approach to the assessment to blood pressure when compared with the DVLA's operational instructions in relation to assessing the high blood pressure readings in the D4 Medical Examination Report. There is a lack of clarity in the DVLA's position.
- (xiv) No definition of the meaning of the word "consistently" is given by the DVLA in their At a Glance guide. It is capable of different interpretations by medical professionals leading to the potential for the giving of differing advice on the same facts and circumstances.
- (xv) In their booklet INF4D entitled "Medical Examination Report for a Group 2 (Lorry or Bus) Licence D4", which is for applicants and medical professionals alike, the DVLA adopt the word "persistently" when providing that an applicant is likely to be refused a Group 2 licence if he/she cannot meet the recommended medical guidelines for inter alia hypertension where the blood pressure is "persistently" 180mm Hg systolic or more and/or 100mm Hg diastolic or more. That word was capable of different interpretations from the meaning of the words "resting consistently" in the DVLA's At a Glance guide in force in November 2013 and is also capable of different interpretations from the meaning of the words "resting BP is consistently" in the latest DVLA guidance "Assessing fitness to drive: a guide for medical professionals".

- (xvi) Notwithstanding that Mr Gordon was correctly noted in question number 2 in section 4G blood pressure of the D4 medical examination report dated 22 November 2013 as being on anti-hypertensive treatment, the three blood pressure readings with dates requested were not recorded by Dr Lesley Anne Somerville the registered medical practitioner who prepared said report as they were not available to her, she having no access to Mr Gordon's medical notes. Dr Somerville recorded the second blood pressure reading she took on the day of the examination, after the lapse of about 5/10 minutes which blood pressure reading was below the threshold of 180mm Hg systolic and/or 100mm Hg diastolic.
- (xvii) On the basis of the medical information contained in the D4 medical examination Report completed by Dr Somerville on 22 November 2013 Mr Douglas Brian Gordon met the standards of the DVLA's operating instructions for the implementation of section 4G blood pressure part of that Report on that date leading to the approval of his application for and the issuing of his vocational (Group 2) licence in December, 2013. The DVLA's operating instructions provided that if information in the D4 medical report disclosed on the day of the examination a blood pressure reading for the licence applicant below the threshold of 180mm Hg systolic and/or 100mm Hg diastolic, his blood pressure was considered to be "under control" at that point in time and the DVLA would proceed to grant the application for a vocational (Group 2) licence irrespective of whether or not the D4 medical examination report contained any other blood pressure readings above the threshold and/or did not provide the

three previous blood pressure readings requested in the event of the licence applicant being on anti-hypertensive treatment.

- (xviii) It has not been proved on the balance of probabilities that Mr Gordon did not meet the DVLA standards for fitness to drive at the date of the accident on 2 July, 2014. His last blood pressure reading for which there is a record namely that taken on 1 May 2014 by his general practitioner was recorded as 160/90, below the DVLA threshold.
- (xix) The D4 Medical Examination Report can be completed by a medical practitioner licensed to practice in the UK or in the EU who has no prior knowledge of the licence applicant and no access to the licence applicant's medical records, in particular his/her general practitioner records. In the absence of the licence applicant's medical records, in particular his/her general practitioner records, the DVLA's approach to the D4 Medical Examination Report relies upon the licence applicant's knowledge, understanding and honesty in relation to declaring his/her medical history to the examining medical practitioner.
- (xx) On the advice of the Secretary Of State for Transport's Honorary Medical Advisory Panel on driving and disorders of the cardiovascular system, the DVLA have updated the form of the D4 Medical Examination Report, medical assessment since November 2013. In relation to section 4g blood pressure the report requests the licensed medical practitioner, if the licence applicant's blood pressure is 180/100mm Hg systolic or more and/or 100mm Hg diastolic or more to take a further two readings at least 5 minutes apart and record the best of the three readings in the box provided. Box 1 now therefore asks the medical

practitioner to record today's best blood pressure reading (my emphasis). Notwithstanding that alteration in the wording of section 4g of the current version of the D4 medical examination report from the wording of Section 4 of the report completed by Dr Somerville in respect of Mr Gordon on 22 November 2013 the other parts of section 4g of the current version of the report are identical. If the licence applicant is on anti-hypertensive treatment the registered medical practitioner continues to be asked to provide three blood pressure readings with dates if available.

- (xxi) On the advice of the Secretary of State for Transport's Honorary Medical Advisory Panel on Neurology, the DVLA have expanded and redesigned question 7 in section 5 General of the D4 Medical Examination Report since November, 2013. Although specific reference continues to be made to obstructive sleep apnoea syndrome or any other medical condition causing excessive sleepiness, the Report now seeks information on the diagnosis, treatment and control of ALL sleep conditions (which should include obstructive sleep apnoea although it is not specifically mentioned).

In view of findings (xvi), (xix) and (xx) the Sheriff respectfully recommends that consideration be given by the Secretary of State for Transport's Honorary Medical Advisory Panel on driving and disorders of the cardiovascular system and by the DVLA to instituting a review of the wording of the DVLA's latest guidance "Assessing fitness to drive: a guide for medical professionals", their booklet INF4D entitled "Medical Examination Report" for a Group 2 (lorry or bus) licence D4" and of section 4g

blood pressure of the D4 Medical Examination Report to assist doctors and other health professionals when advising their patients, to endeavour to achieve uniformity in the provision of such advice by doctors and other health professionals.

In view of findings (xvi), (xix) and (xx) the Sheriff recommends that, when a licence applicant answers affirmatively question 2 in section 4g blood pressure of the D4 Medical Examination Report confirming he is on anti-hypertensive treatment, when none of the 3 previous blood pressure readings is provided or when any of the 3 previous blood pressure readings is above the threshold of 180mm Hg systolic and/or 100mm Hg diastolic consideration be given by the DVLA, in consultation with the Secretary of State for Transport's Honorary Medical Advisory Panel on Cardiovascular disease to instituting a procedure whereby, in such circumstances, prior to the approval of any licence application, the DVLA is required to contact the licence applicant's general practitioner, in accordance with the Consent and Declaration signed by the licence applicant, to obtain further information relative to the licence applicant's blood pressure history.

In view of finding (xxi) the Sheriff recommends that consideration be given by the DVLA, in consultation with The Secretary of State for Transport's Honorary Medical Advisory Panel on Neurology, to amending question 7 in section 5 General of the D4 medical report to include a specific reference to obstructive sleep apnoea.

Matters for consideration:-

- (1) In view of finding (xix) as, to a large extent, the DVLA's current approach to the D4 Medical Examination Report is reliant upon the licence applicant's knowledge, understanding and honesty in relation to declaring his/her medical history to the examining medical practitioner, the Secretary of State for Transport should instigate a consultation on how best to ensure the completeness and accuracy of the information available to the DVLA in making fitness to drive licensing decisions and whether or not legislative change is required.
- (2) Those involved in the system of assessing licence applicants' fitness to drive should give consideration to the institution of procedures whereby, following the obtaining of the licence applicant's consent, the registered medical practitioner performing the D4 medical assessment can obtain access to the licence applicant's general practitioner records and any consequent legislative change necessary to give effect thereto.

Sheriff

NOTE

Introduction

1. This Fatal Accident Inquiry was held in terms of Section 1(1)(a)(i) of the Fatal Accidents and Sudden Deaths Inquiry (Scotland) Act 1976 into the circumstances of the death of Douglas Brian Gordon who died on 2 July 2014 as a consequence of injuries sustained by him in a road traffic accident which occurred on an unclassified road on the periphery of Glasgow Airport, namely, Sanderling Road, Paisley, approximately 36 metres west of the roundabout junction with White Cart Road, Paisley.

Application to hold the Inquiry and Preliminary Hearings

2. An Application was made by the Procurator Fiscal to hold this Inquiry. I considered the Application and appointed this Inquiry to be held on 8 February 2016 when the hearing of evidence commenced.
3. There were three preliminary hearings on 25 September and 11 December 2015 and 12 January 2016. It was initially proposed that the family of Mr Douglas Brian Gordon be represented at the Inquiry. In the event their application for legal aid was unsuccessful and they were not separately represented at the Inquiry. All three preliminary hearings were conducted by myself. At the first the Crown, through the Procurator Fiscal Depute, Ms Arias, intimated that the Inquiry may last 10 days although it was hoped it would be of shorter duration. At the second preliminary hearing the Crown informed me that following further inquiries it was felt that *"fitness to drive" issues and the*

involvement of the DVLA would require to be explored. I was told it was then likely that all 10 days which had been reserved in the Court Programme for the hearing of evidence would be required. The possibility of additional dates was canvassed with parties' representatives.

4. At the second preliminary hearing I enquired of the Crown if intimation of the Application had been made upon Mr Douglas Brian Gordon's general practitioner and the registered medical practitioner (Dr Lesley Anne Somerville) who had carried out the D4 Medical Examination and Assessment of him on 22 November 2013. Upon being informed that no intimation had yet been made upon Dr Somerville I ordered that to be done.
5. At the final preliminary hearing on 12 January 2016 the Crown confirmed that no criminal proceedings were to be taken against Mr Denis Gallacher of Saints Transport Limited, the driver of the articulated LGV with tractor unit MAN TGX26:440 registration number T40 STS with which the Ford Transit van of Airlink Management Limited, registration number SH13 JYU, being driven by Mr Douglas Brian Gordon, had collided.

Length of the inquiry

6. This Inquiry lasted some thirteen days. When it became apparent that the Operating Instructions of the DVLA *vis a vis* assessment of the content of the D4 Medical Assessment as regards blood pressure (Crown Productions 47 and 48) were relevant to the circumstances of Mr Gordon's death, efforts were made to obtain evidence from a senior administrator and arrangements made for her evidence to be taken by video link.

I arranged for parties to lodge written submissions. These are reprinted as Appendices number 11 to 16. An oral Hearing on Submissions was subsequently held.

I wish to assure all parties that I have carefully considered their written and oral submissions even where there may be no significant reference to them in any part of this Determination.

Representation

7. The Crown were represented by Ms Arias, Procurator Fiscal Depute. Mr Meehan, Advocate, appeared for Airlink Management Limited, Ms. O'Donnell, Solicitor appeared for Saints Transport Limited and their driver, Mr Denis Gallacher. Drs David Taylor and Lesley Anne Somerville were represented by Mr Reid, Advocate. Mr O'Reilly, Solicitor appeared for the Greater Glasgow Health Board. Mr Olson, Advocate appeared for the Driver and Vehicle Licence Authority (DVLA).

8. Witnesses

1. Ms Mary Kelly, Mr Gordon's ex-partner.
2. Mr Richard Clifford, TOA Taxi Driver, eye witness to the accident.
3. Mr Malcom Newlands, eye witness to the accident
4. Mr Denis Gallacher, driver of MAN TGX 226:440 LEV (operated by Saints Transport Limited).
5. PC Scott Simpson, collision investigator.
6. Ms Rhianna Carr, Operations Manager, Airline Management Limited (Mr Gordon's employer).

7. Mr Brian Rice, driver, Airlink Management Limited.
8. Dr Daniel Taylor, Mr Gordon's General Practitioner.
9. Dr Lesley-Anne Somerville, Registered Medical Practitioner, who carried out the D4 Medical Examination of Mr Gordon on 22 November 2013 in relation to his application for a Group 2 Driving Licence.
10. Dr Jesse Dawson, Consultant Physician, with responsibility for Glasgow Blood Pressure Clinic on Wednesdays from August 2011 to the end of 2014.
11. Dr Stephen Banham, Retired Consultant, former Head of Sleep Clinic, Gartnavel General Hospital.
12. Mr Duncan Macfarlane, Physiologist, Sleep Clinic, Gartnavel General Hospital.
13. Dr Christopher M. Carlin, Consultant Physician in Respiratory Medicine, Head of Sleep Clinic, Gartnavel General Hospital, Glasgow since July 2012.
14. Dr Wyn Parry, Senior Medical Advisor to the DVLA, Swansea.
15. Ms. Carol A. Tamplin, Medical Executive officer, DVLA, Drivers' Medical Division, Swansea.

Mr Douglas Brian Gordon and the loss suffered by his family as a result of his death

9. At the commencement of the Inquiry all present stood to mark respect for the life of Mr Douglas Brian Gordon with a minute's silence. That was entirely appropriate.
10. It is clearly established from the evidence of Ms. Mary Kelly, his ex-partner, that Douglas Brian Gordon was a warm-hearted individual who had cared for his late wife when she fell ill. He was said to be a very good father to his children. Mr Gordon actively looked for work following the death of his late wife.

11. Mr Gordon's sudden and unexpected death has left a void in each of the lives of his family and friends which will continue. All the evidence led at this Inquiry from witnesses who worked for his employers including Ms Rhianna Carr, the then Operations Manager of Airlink Management Limited, MacDowall Street, Paisley was that Mr Gordon, notwithstanding his short period of employment with the company, was a lovely man, very friendly with a nice manner. He had been well liked and was popular with his colleagues, someone who left an impression with them. The Operations Manager agreed that Mr Gordon possessed the ideal attributes of an employee especially in the area of customer service.
12. Mr Gordon's death has had a profound effect upon his family and friends. Their love and respect for him was demonstrated by their attendance throughout the Inquiry. I expressed my condolences to them at the end of the Inquiry, as did the Procurator Fiscal Depute and the lawyers for each of the represented parties. I repeat my expressions of sympathy to them.

A Synopsis of the Evidence Led at the Inquiry

The events of the morning of 2 July 2014

13. Much of the evidence as to what occurred on 2 July 2014 was not in dispute. Mr Gordon was working in the course of his employment as a minibus driver with Airlink Management Limited ferrying passengers and their luggage between the Park and Fly car park at MacDowell Street, Paisley operated by Airlink Management Limited and Glasgow Airport.

14. I heard evidence from Mr Richard Clifford, a TOA taxi driver who testified that at about 11:25am on 2 July 2014, as he was proceeding onto the roundabout at the junction with White Cart Road, Paisley intending to turn right in a westerly direction he observed the Ford Transit van with trailer being driven by Mr Gordon. Mr Clifford described the Ford Transit van as “flying along the road” in the inside lane. He said that, despite having the right of way, he was forced to “stop abruptly” in his taxi to avoid the Ford Transit van colliding with the taxi and to permit the Ford Transit van to “carry on in front of him” in a westerly direction. Mr Crawford said the trailer at the rear of the Ford Transit van was “unstable” due to the speed being employed. He said “it was bouncing all over the place at the back.” Mr Crawford informed the Inquiry that Mr Gordon had looked at him as he proceeded through the roundabout. He described Mr Gordon as “sitting up at the wheel in a normal manner.” He testified that Mr Gordon, in the Ford Transit van, changed lane whilst on the roundabout. As he, Mr Clifford, followed the Ford Transit van around the roundabout, he observed the Ford Transit van being driven by Mr Gordon “drift into the oncoming carriageway on Sanderling Road.”

I found Mr Clifford to be a credible and reliable witness.

15. The Procurator Fiscal informed me that she intended to call as a witness Mr Denis Gallacher, an HGV driver employed by Saints Transport Limited who had been driving the white coloured MAN TGX26:440 Articulated LGV registration number T40 STS at the material time on the morning of 2 July 2014. I was aware from information imparted at the final preliminary hearing that the Crown was not taking criminal proceedings against Mr Gallacher arising out of the circumstances of the death of Mr

Gordon. It was not, therefore, necessary for me to give Mr Gallacher any warning as regards self-incrimination and none was given.

16. Mr Gallacher's evidence was relatively unchallenged. I am in no doubt that he was a credible witness trying to tell the truth as he remembered it.

Mr Gallacher informed the Inquiry that when he first saw the Ford Transit van being driven by Mr Gordon "it had just come off the roundabout" onto Sanderling Road. Mr Gallacher described seeing Mr Gordon's trunk "*lying across the two passenger seats*" of the van with his face down such that he, i.e., Mr Gallacher "could only see the back of his head." Mr Gallacher testified that Mr Gordon had his right hand on the steering wheel of the van at the 12 o'clock position. He stated that from a point 6 to 7 metres short of his articulated vehicle Mr Gallacher heard "a loud rev from the engine (of the Ford Transit van) whereupon it started to come over to my side of the road." Mr Gallacher said that shortly before the impact of the two vehicles, on the eastbound carriageway of Sanderling Road, Mr Gordon had looked up and in Mr Gallacher's opinion "tried to steer the Ford Transit van to the left with his right hand on the wheel."

17. Despite Mr Gallacher applying the brakes on the articulated vehicle prior to impact, the front of the Ford Transit van collided with the offside front of the articulated vehicle. Mr Gallacher telephoned his employers and asked them to contact the emergency services. He then reversed his articulated vehicle from its resultant position following impact, so that the emergency services could gain access. Mr Gallacher went to Mr Gordon's aid and told him the emergency services were on their way. At this time Mr Gordon was breathing. His speech was garbled. Mr Gallacher was joined by Mr

Clifford, the taxi driver, once he had parked his taxi out of the way and by two other workmen close by.

18. Mr Gallacher's evidence about Mr Gordon's attempts to steer left at the last minute is not evidence I can rely upon. There is no physical evidence to support that part of his testimony. PC Simpson testified and I accept that the principal direction of force is indicative of the Ford Transit van travelling towards the articulated vehicle at an angle. There is no physical evidence to support Mr Gallacher's view that at the last minute Mr Gordon turned the wheel of the Ford Transit van to the left.
19. Mr Malcolm Newlands was the next witness led at the Inquiry. He had been driving a Ford Transit van in the course of his employment eastwards on Sanderling Road, Paisley towards the roundabout at the junction with White Cart Road. While I am satisfied that Mr Newlands endeavoured to advise the Inquiry of what he remembered occurring on the morning of 2 July 2014 I cannot rely upon the whole of his evidence. His evidence that the Ford Transit van being driven by Mr Gordon exited the roundabout at the junction with White Cart Road, Paisley into Sanderling Road having come round the roundabout in the wrong direction is at odds with the evidence of Mr Gallacher, Mr Clifford, Police Constable Simpson and the Crash Investigation Report to which I shall return shortly. I prefer their evidence. I believe Mr Newlands is simply mistaken. In cross-examination by Ms O'Donnell for Mr Gallacher and Saints Transport Limited, Mr Newlands clarified that all he saw was "the front corner of the transit van appearing in front of the lorry" [in the eastbound carriageway of Sanderling Road] whereupon he heard a loud bang and saw smoke emanating from the collision. In my opinion Mr Newlands, perhaps understandably, given what he saw and the passage of

time has assumed that the Ford Transit van being in the correct lane of Sanderling Road for vehicles travelling westwards had in error come round the roundabout the wrong way. That is an incorrect assumption on his part. By his own testimony he did not actually see the Ford Transit van travel around the roundabout. When it was put to him that his recall regarding the braking of the articulated vehicle was at odds with the content of his statement to the police, Mr Newlands could not remember saying to the police that the articulated vehicle braked in advance of impact. Nevertheless he told the Inquiry the content of his statement was “probably” more accurate.

Crash Investigation Report

20. Crown Productions 4 and 5 comprise a Crash Investigation Report prepared by PC Scott Simpson corroborated by PC Ewan Thomson. PC Simpson was called to give evidence at the Inquiry. Although he was subject to appropriate cross-examination by some of the parties at the Inquiry his evidence was in the main unchallenged and was plainly credible and reliable. The Crash Investigation Report prepared by the two police officers is a thorough piece of work which has assisted me greatly in reaching my determination. Its conclusion is that the accident occurred as the result of the Ford Transit van being driven by Mr Gordon negotiating the roundabout at the junction with White Cart Road, Paisley at excessive speed, Mr Gordon then losing control of the van and the van entering the eastbound carriageway of Sanderling Road as it exited the roundabout where the van collided with the articulated LGV being driven by Mr Denis Gallacher at a point some 36 metres west of the roundabout.

21. Large parts of the Crash Investigation Report were agreed by the parties to the Inquiry. They form paragraphs 1, 40-66 of the second Joint Minute of Agreement, which I have reproduced as part of Appendices 1 and 4 and Appendices 5 and 6 to this Determination.
22. PC Simpson testified that he found a nearside tyre mark of the articulated vehicle and also a tyre scuff mark extending towards the front offside tyre of the Ford Transit van. He explained that the scuff mark was post-impact and created by the front offside tyre of the van as it slid towards its resultant position. As regards braking, PC Simpson informed the Inquiry that there was no physical evidence that Mr Gordon had applied the brakes on the Ford Transit van prior to impact. The physical evidence did, however, disclose that Mr Gallacher had reacted and locked the front nearside brake of the articulated vehicle prior to impact. PC Simpson described the physical evidence of the damage to the vehicles as being consistent with "a more gradual move" by the Ford Transit van into the eastbound carriageway of Sanderling Road, Paisley and the path of the articulate LGV rather than "a sharp deviation."
23. While there was insufficient evidence to calculate the speed of the van (minibus) at the time of the collision PC Simpson testified that the damage to the van was more extensive than to be expected from a crash happening within the 30 mile per hour limit.
24. PC Simpson said the damage to the respective vehicles indicated that the Ford Transit van had come into the articulated LGV "at an angle." He explained this was evidenced by the pattern of damage to both vehicles. He said on the van there was a vertical impact on the roof extending down to the windscreen and front panel which tied in with the front offside of the lorry. He described the direction of force of impact by the

Ford Transit van “going from the offside towards the front nearside” of the articulated LGV, the collision having caused the Ford Transit van to rotate.

25. PC Simpson assisted the Inquiry by indicating that Crown Production No.10, photographs nos. 10, 29 and 30, being some of a number of photographs taken by the Crime Scene Examiner, as referred to in paragraph 19 of the Joint Minute of Agreement between parties which is repeated as Appendix 2 to this Determination, show the impact position of the collision between the two vehicles and confirm the conclusions he and his colleague reached, namely that the collision was the result of Mr Gordon negotiating the roundabout at excessive speed, losing control of his vehicle and entering the opposing lane of Sanderling Road as he exited the roundabout where he collided with the opposing LGV driven by Mr Denis Gallacher.

Response of the Emergency Services

26. Parties were agreed as to the response of the emergency services as set out in the Joint Minute of Agreement, Appendix 2 to this Determination.
27. On 2 July 2014 at around 11:30am, paramedic William Fleming and Ambulance Care Assistant Desmond Donnelly were on duty and responded to a call to attend a road traffic collision at Sanderling Road, Paisley. Upon arrival, William Fleming examined Mr Gordon. The initial examination revealed a head injury, possible chest injury and lower limb crush injury. Mr Gordon was trapped in the minibus he had been driving. He was conscious and feeling short of breath. William Fleming applied a cervical collar, gave him oxygen and carried out basic observations.

28. A short time later, the police, fire service and Emergency Retrieval Medical Service (hereinafter referred to as “ERMS”) arrived at the scene. ERMS doctors Catheryn Bennett and Neil Dignon attended along with critical care nurse Graham Percival.
29. At around 12:24pm, Mr Gordon was extracted from the vehicle by fire service personnel and ambulance personnel. During the extracting Mr Gordon’s condition deteriorated.
30. Dr Catheryn Bennett, anaesthetic registrar, performed emergency anaesthesia bilateral thoracotomies, traumatic cardiac arrest protocol and gave Mr Gordon three units of blood. He was also administered an intravenous painkiller.
31. Thereafter Mr Gordon was conveyed by ambulance to the Accident and Emergency Department at the Southern General Hospital, Glasgow, utilising a police escort to facilitate the transfer.
32. Upon arrival at the Southern General Hospital, Mr Gordon was in cardiac arrest. He was given three further units of blood and 1 mg of adrenalin. After consultation between Dr Nicola Littlewood, Accident and Emergency Consultant, and Dr Wotherspoon, Surgical Consultant, it was agreed that surgical intervention was likely to be futile.
33. Douglas Brian Gordon was pronounced dead on 2 July 2014 at 1:15pm at the Southern General Hospital, Govan Road, Glasgow, by Dr Nicola Littlewood.

Post Mortem Results

34. Crown Productions 2 and 3 are the toxicology and post mortem reports relative to Mr Douglas Brian Gordon’s death dated 30 July and 7 August 2014 respectively. Parties

again agreed large tranches of these said Reports as set out in paragraphs 15 to 17 of the said Joint Minute of Agreement, Appendix 2 as follows:-

15. That on 9 July 2014, a post mortem examination was carried out on the deceased by Dr Julia Bell, Forensic Pathologist. The cause of death was found to be 1a) Chest injury due to 1b) Road traffic accident (minibus driver).
16. That Dr Julia Bell, Forensic Pathologist, concluded in the post mortem examination that the deceased "had sustained severe injuries, in keeping with his having been involved in a road traffic accident... Externally, there were various bruises and abrasions on the face, trunk and limbs in addition to a deep laceration on the right knee and a few small lacerations on the face. Deep to this, in the chest, there were multiple fractures of nearly all of the ribs on the right side associated with significant haemorrhage into the right chest cavity and multiple lacerations of the right lung, and there were also a few rib fractures on the left. There was also fracture of the thoracic vertebrae and sternum. In terms of other injuries, there were fractures of the front and back of the pelvis associated with a moderate amount of haemorrhage but there were no significant injuries elsewhere... [I]n terms of natural disease, the heart was enlarged and concentric left ventricular hypertrophy, in keeping with the history of hypertension, and there was also moderate atheromatous narrowing of two of the main coronary arteries. Whilst the chest injuries were considered the main factor in his death, the possibility that underlying natural disease has played a part in the road traffic accident and/or contributed to his death cannot be excluded."

17. That the Toxicology Report confirms that the blood and urine analysis was negative for alcohol, paracetamol, opiates and drugs of abuse. Blood tests were positive for therapeutic levels of ketamine which was administered in hospital post-accident.
35. In an Affidavit Dr Julia Bell further explained her opinion by confirming that the physical cause of Mr Gordon's death were the injuries he sustained in a road traffic accident. She advised that, whilst the chest injuries were considered the main factor in his death, the possibility that underlying natural disease has played a part in the road traffic accident and/or contributed to his death cannot be excluded. She commented further that she "can't exclude the possibility that his underlying natural disease led to the accident, for example, he may have had a "heart attack" prior to the crash that led to a reduced level of consciousness which resulted in the collision." (my emphasis)
36. Dr Bell deferred to a clinician whom she commented would be "in a better position to comment on the likelihood and type of symptoms he [the deceased] would have experienced given the presence of heart disease."
37. Parties further agreed per paragraph 2 of the Fourth Joint Minute of Agreement (Appendix 8) Dr Bell has stated that "while there was evidence of chronic heart disease, she would not necessarily have expected to find any acute changes or pathology if Mr Gordon had had a "heart attack" prior to the collision. Dr Bell also stated that there would be no specific acute pathology to suggest that a sleep apnoeic event had occurred."

Examination of the Ford Transit Minibus and the Articulated Vehicle

38. Parties to the Inquiry agreed that the following facts should be admitted in evidence per paragraphs 23 to 25 of the Joint Minute of Agreement (Appendix 2) viz:-

23. On 7 July 2014, George Scott McIntyre, Vehicle Examiner with the Vehicle and Operator Services Agency, at Karen Yuill Recovery Ltd, Blantyre Industrial Estate, Blantyre, conducted an examination of a white Ford transit sixteen passenger seater public service vehicle bearing registration mark SJ13JYU, which was towing a 750kg luggage trailer bearing identification number 070611, driven by the deceased. At the time of the inspection, there were no pre collision defects noted that could have led to a loss of control of the vehicle or trailer or increased the severity of the collision. The mechanical condition of the vehicle and trailer were not contributory factors in the collision.

24. On 8 July 2014, George Scott McIntyre, Vehicle Examiner with the Vehicle and Operator Services Agency, at Karen Yuill Recovery Ltd., Blantyre Industrial Estate, Blantyre, conducted an examination of a white MAN TGX26:440 HGV tractor unit bearing vehicle registration mark T40STS, driven by Denis Gallacher. At the time of the inspection, there were no pre collision defects noted that could have led to a loss of control of the vehicle or increased the severity of the collision. The mechanical condition of the vehicle was not a contributory factor in the collision.

25. On 7 July 2014, George Scott McIntyre, Vehicle Examiner with the Vehicle and Operator Services Agency, at Karen Yuill Recovery Ltd., Blantyre Industrial Estate, Blantyre, conducted an examination of an SD semi-trailer bearing identification number C068435, attached to the aforesaid tractor being driven by Denis Gallacher.

At the time of the inspection, there were no pre collision defects noted that could have led to a loss of control of the trailer or increased the severity of the collision. The mechanical condition of the trailer was not a contributory factor in the collision.

Evidence of Airlink Management Limited

39. Evidence was led from Ms Rhianna Carr, the Operations Manager of Airlink Management Limited in 2014. She remembered interviewing Mr Gordon for the position of a Passenger Carrying Vehicle (PCV) driver at Airlink Management Limited towards the end of June 2014. She described Mr Gordon as being “very friendly, well presented and with a nice manner.” She agreed with the Procurator Fiscal Depute that Mr Gordon possessed the ideal attributes of an employee particularly in the field of customer service. Having reviewed and considered Mr Gordon’s CV (Crown Production No.36) Ms Carr formed the opinion that he was an experienced driver both as a self-employed taxi driver and as a bus driver with First Bus. Mr Gordon was noted to possess an LGV2 and PVC driving licence and to have a CPC card.
40. In 2014 Airlink Management Limited did not undertake any pre-employment checks by, for example, taking up references. Since May 2015 their practice has altered and Ms Carr has sought references for potential employees in general terms, engaging persons subject to receipt of satisfactory references.
41. Ms Carr testified that, at his interview, she inquired of Mr Gordon if he had any medical or health conditions. He replied “no” or “no issues” and stated he had passed his driver’s medical and had his licence renewed by the DVLA in December 2013, valid for 5 years. Ms Carr did not ask Mr Gordon if he took any regular medication.

42. Airlink Management Limited did not require Mr Gordon to complete any declaration concerning his health nor did they carry out any medical or fitness test prior to employing drivers. Had Mr Gordon informed Ms Carr of any medical condition, such as hypertension or sleep apnoea, Ms Carr informed the Inquiry she would have had to look into the condition and seek advice from the company's insurers.
43. Ms Carr said Mr Gordon received training from Mr Brian Rice, an experienced driver with the company, whose personality and shift pattern enabled him to undertake same. At the time there was no training manual in existence. After Mr Gordon's training was carried out a record was subsequently typed up by Ms Carr and inserted into his file. Crown Production No.19 is a copy of the pro forma record typed up by her following Mr Gordon's training on 30 June 2014 based on the information supplied by Mr Rice. The Inquiry was told that in 2016 a training form had been introduced that is now signed off by both the trainer and the employee and kept for record purposes.
44. Ms Carr did not specifically recall seeing Mr Gordon on the morning of 2 July 2014 although she thought she probably had done so.
45. In cross-examination Ms Carr told the Inquiry that she placed reliance on the DVLA having given someone a licence that they are fit to drive. She raised the issue of a licence by DVLA as an "assurance."
46. Mr Brian Rice who described himself as a bus driver told the Inquiry he worked for "the same company as Rhianna Carr" (even if he did not know the exact name thereof). Conflicting with the evidence of Ms Carr, Mr Rice said he had not been with Airlink Management Limited for two years but had only worked for them for a period of 8

months when he came to train Mr Gordon at the end of June 2014. Mr Rice explained the training given to Mr Gordon, the details of which are not material to this Inquiry.

47. Mr Rice was very complimentary of Mr Gordon. He described him as a “lovely big guy...I can’t say anything too highly about him.” He did not recall any issues with Mr Gordon over the training. Mr Rice stated that he could not recall speaking with Ms Carr about Mr Gordon’s training. He said “the manager takes it for granted I went through everything.”
48. Mr Rice did not think he had seen Mr Gordon on the day of the accident. He was unable to assist the Inquiry further.

Evidence of Mr Gordon’s General Practitioner

49. Dr David Taylor, Mr Gordon’s general practitioner, testified that Mr Gordon’s most notable health issue was hypertension or high blood pressure. He told the Inquiry that blood pressure issues had featured significantly in Mr Gordon’s medical records for a long period of time and that, at the time of his death, Mr Gordon was on four medications, all used in the management of blood pressure.
50. Dr Taylor’s surgery operated a system of computerised notes. Dr Taylor took the Inquiry through his referrals of Mr Gordon to the Blood Pressure Clinic, Western Infirmary/Gartnavel General Hospital, Glasgow commencing in October 2010 (Crown Production No.11 pages 160 et seq). In that referral the doctor recorded Mr Gordon’s blood pressure as 195/110 which he categorised “definitely high” against what he described as the upper limit of normal of 140/90.

51. Mr Gordon's GP records and Blood Pressure Clinic records produced at the Inquiry reveal that for a number of years from 2009 to 2013 his blood pressure was above the upper limit of normal (140/90). Dr Taylor testified that Mr Gordon had a lengthy history of high blood pressure. He said Mr Gordon had very significant high blood pressure problems.

52. Crown Production No.38 gives a chronology of blood pressure readings taken from Mr Gordon's medical records over the years as follows:-

4/12/2009	168/102
16/4/2010	185/90
13/10/2010	195/110
3/11/2010	176/110
16/2/2011	176/104
20/4/2011	177/104
18/5/2011	200/100
27/6/2011	202/100
7/7/2011	193/98
20/7/2011	210/100
27/7/2011	177/102
5/10/2011	142/100
7/22/2011	144/102
8/7/2012	142/100
19/3/2012	191/108
19/7/2012	190/90
24/10/2013	170/90
22/11/2013	176/106
22/11/2013	172/94

53. Dr Taylor said Mr Gordon's obesity was a contributing factor to his high blood pressure.

54. Dr Taylor advised Mr Gordon was accepted by the Blood Pressure Clinic as a patient and attended a number of reviews at the clinic before being discharged at his own request in December 2012. Dr Taylor said that he saw Mr Gordon on 13 February 2013 when the notes reveal (Crown Production No.11, page 126) that Mr Gordon did not

wish any further involvement with the Blood Pressure Clinic, nor did he wish his blood pressure taken that day by his general practitioner, notwithstanding the doctor's advice of the increased risk of cardiovascular disease. Dr Taylor said he could only advise and recommend treatment. If, however, a patient chose to follow a different course, that was a matter for them. Mr Gordon made it clear to Dr Taylor that he preferred to manage his blood pressure alone.

55. Some eight months later, on 24 October 2013, Mr Gordon's blood pressure reading was taken by Dr Taylor and found to be 170/90. Mr Gordon agreed to be re-referred to the Blood Pressure Clinic to measure his blood pressure readings over a 24 hour period. Dr Taylor indicated he was hoping to find out Mr Gordon's blood pressure was artificially raised when attending his surgery (known as white-coat hypertension). Dr Taylor felt white-coat hypertension may have been contributing to the high blood pressure readings. At that time Mr Gordon was wanting to return to work and obtain his Group 2 (HGV licence). Dr Taylor realised that Mr Gordon's blood pressure readings were "too high" to pass the DVLA medical requirements for the issuing of a Group 2 licence. He told the Inquiry he "explained [to Mr Gordon] the DVLA would require a history of his blood pressure readings and his history was not satisfactory."
56. Dr Taylor confirmed receipt of a letter from the Western Infirmary dated 17 January 2014 notifying him that Mr Gordon had informed the Blood Pressure Clinic that he no longer required an appointment with them. Although Mr Gordon had had a D4 Medical Examination Report completed, following his assessment by Dr Lesley Anne Somerville, a registered medical practitioner, on 22 November 2013 in connection with his application for the renewal of his Group 2 licence and subsequently had his

application approved and his Group 2 licence issued by the DVLA in December 2013 (for 5 years), he did not inform Dr Taylor of the renewal of his Group 2 licence, notwithstanding that he attended the medical practice on a number of occasions between January and May 2014 including a consultation with Dr Taylor himself on 1 May 2014.

57. The medical standards applied by the DVLA differ as between Group 1 and Group 2 licence holders. The DVLA – At a Glance to the Current Medical Standards of Fitness to Drive [2013 Edition] (Crown Production No.28) identifies the two groups of licence holders viz:-

- **Licence Groups**

The medical standards refer to Group 1 and Group 2 licence holders.

Group 1 includes motor cars and motor cycles.

Group 2 includes large lorries (category C) and buses (category D). The medical standards for Group 2 drivers are very much higher than those for Group 1 because of the size and weight of the vehicle. This also reflects the higher risk caused by the length of time the driver may spend at the wheel in the course of his/her occupation.

All drivers who obtained entitlement to Group 1, category B (motor car) before 1 January 1997 have additional entitlement to category **C1 and D1**. C1 is a medium size lorry of weight between 3.5 and 7.5 tonne. D1 is a minibus of between 9 and 16 seats, not for hire or reward.

Holders of C1 and D1 entitlement retain the entitlement until their licence expires or it is medically revoked. On subsequent renewal the higher medical standards application to Group 2 will apply.

Under certain circumstances volunteer drivers can drive a minibus of up to 16 seats without having to obtain category D1 entitlement. Individuals should consult DVLA for a detailed fact sheet.

- **Age Limits**

Group 1: Licences are normally issued valid until age 70 years (Till 70 licence) unless restricted to a shorter duration for medical reasons as indicated above. There is no upper limit but after age 70 renewal is necessary every 3 years. All licence applications require a medical self declaration by the applicant.

A person in receipt of the higher rate of the Mobility Component of Disability Living Allowance may apply for a licence (Group 1 category B) from age 16 years, instead of the usual lower age limit of 17 years.

Group 2: Excepting in the armed forces and certain PCV licences, Group 2 licences, lorries (category C) or buses (category D) are normally issued at age 21 years and are valid till age 45 years but may be issued from age 18 where the licence holder has obtained or is undertaking a Certificate of Professional Competence (CPC) initial qualification.

Group 2 licences are renewable thereafter every five years to age 65 years unless restricted to a shorter period for medical reasons.

From age 65 years Group 2 licences are renewable annually without upper age limit. All Group 2 licence applications must be accompanied by a completed medical application form D4.

58. Dr Taylor informed the Inquiry that Mr Gordon's blood pressure readings were such that he did not require to notify DVLA in respect of his driving per se (Group 1). His blood pressure was not at a level to preclude him from driving Group 1 vehicles.
59. Dr Taylor was aware of the DVLA – At a Glance Guide. He referred the Inquiry to Chapter 2 entitled "Cardiovascular Disorder" and the section dealing with Hypertension (Crown Production No.28 page 653) which I repeat below for ease of reference:-

CARDIOVASCULAR DISORDER	GROUP 1 ENTITLEMENT ODL - CAR, M/CYCLE	GROUP 2 ENTITLEMENT BOC - LGV/PCV (LORRY/BUS)
HYPERTENSION	Driving may continue unless treatment causes unacceptable side effects. DVLA need not be notified	Disqualifies from driving if resting BP consistently 180 mm Hg systolic or more and/or 100 mm Hg diastolic or more. Re/licensing may be permitted when controlled provided that treatment does not cause side effects which may

		interfere with driving.
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60. Dr Taylor explained it was his understanding that the phrase *“resting consistently”* required more than one test. He was familiar with the D4 medical examination report to be completed by a registered medical practitioner following upon medical assessment in relation to a licence application seeking a Group 2 licence and the requirement, if the licence applicant is on anti-hypertension treatment (as in Mr Gordon’s case), to provide three previous blood pressure readings with dates if available (Crown Production No.16, page 348). He added that he would “average” the readings and if the average was above 180 systolic or above 100 diastolic that could cause him concerns.
61. Dr Taylor acknowledged that the reading of 170/90 on 24 October 2013 although high was “not excessive for DVLA purposes.” He said it was “one of the better ones” in Mr Gordon’s history of blood pressure readings. Had he been asked by Mr Gordon at that time for an appointment to undertake a D4 medical assessment in conjunction with his application to renew his Group 2 licence, Dr Taylor was clear that he would have told Mr Gordon he could make such an appointment but he did not think Mr Gordon would pass because of his blood pressure history. Had he been asked [by the DVLA] for a note of Mr Gordon’s last three blood pressure readings at the beginning of December 2013 from his GP records (and therefore excluding the findings of the registered medical practitioner during the D4 medical examination on 23 November 2013, of which Dr Taylor was then unaware) Dr Taylor would have responded thus:-

24/10/2013	170/90
19/7/2012	190/90
19/3/2012	191/108

(average of 183.7/96)

62. Dr Taylor observed that the D4 medical assessment undertaken by Dr Lesley Anne Somerville (without access to any medical records) was approximately one month after he had seen Mr Gordon and one week after he had referred him to the Blood Pressure Clinic (my emphasis).
63. Dr Taylor has experience of completing D4 medical examination reports for the DVLA. He emphasised that the decision upon fitness to drive is one for the DVLA. Their "At a Glance Guide" states in relation to the application of the medical standards that **"The Secretary of State in the person of the DVLA's medical advisors alone can make this decision" [the decision to issue or revoke or refuse a licence]**. The guide indicates that any doctor who is asked for an opinion about a patient's fitness to drive should explain the likely outcome by reference to the Guide but refer the licence holder/applicant to the driver's medical group, DVLA for a decision. Dr Taylor advised that in Scotland if a registered medical practitioner, other than the licence applicant's general practitioner, completed the D4 medical examination report, he/she would need to obtain the previous blood pressure readings called for in section 4G of the Report, in the event of the licence applicant being on anti-hypertension treatment, from either the licence applicant himself or by contacting the licence applicant's general practitioner.
64. Dr Taylor also testified on the subject of sleep apnoea. He advised that he had referred Mr Gordon to the Respiratory Medicine Clinic at the Western Infirmary, Gartnavel General Hospital, Glasgow in May 2011 because of his concern that Mr Gordon may be

suffering from Obstructive Sleep Apnoea. The doctor indicated that uncontrolled sleep apnoea can cause hypertension.

65. Dr Taylor explained that Obstructive Sleep Apnoea is a condition where, during sleep, the patient's airways partially collapse leading to an interruption in breathing. He said the patient ceases breathing for a period and then recommences breathing. Obstructive Sleep Apnoea Syndrome which differs from Obstructive Sleep Apnoea arises where during periods of airway closure in patients, the response is variable, the breathing can be aroused from a "deeper sleep pattern" causing fragmentation of sleep which can cause patients to feel not rested when awake and in some cases the patient can fall asleep during waking hours. He explained to the Inquiry that a diagnosis of Obstructive Sleep Apnoea Syndrome is not made in primary care.
66. The Respiratory Medicine Clinic advised Dr Taylor that Mr Gordon's symptoms "could be attributable to Obstructive Sleep Apnoea but with his low Epworth sleepiness score (measurement of sleepiness) it may be that he is simply a primary snorer." They arranged for a sleep study for clarification. Following the sleep study the consultant physician, Dr. Banham, wrote to Dr Taylor in October 2011 (Crown Production No.11, page 184) intimating the data "indicates mild but definite Obstructive Sleep Apnoea." However as Mr Gordon did not have day time hypersomnolesence Dr Barnham opined that he *"should not be regarded as having fully emerged Obstructive Sleep Apnoea Syndrome at this stage. This is a grey area with regard to therapeutic intervention but I note he has hypertension and in view of the cardiovascular risk associated with Obstructive Sleep Apnoea I am forwarding him to our waiting list for a trial of CPAP treatment"* (routine first line

treatment approach due to cardiovascular risk). This treatment involves creating a positive airway pressure to hold open the airways and prevent them collapsing.

67. Dr Taylor was unconcerned regarding the implications for Mr Gordon's driving with mild but definite sleep apnoea. He emphasised it is the diagnosis of Obstructive Sleep Apnoea Syndrome which has implications for driving. Dr Taylor knew of the Position Statement regarding Obstructive Sleep Apnoea and Obstructive Sleep Apnoea Syndrome dated June 2014 issued by the British Thoracic Society (Crown Production No.24). He emphasised the Statement was intended for healthcare professionals working in secondary care as specialists.

Dr Taylor was unaware that Mr Gordon had subsequently discharged himself from the sleep clinic.

68. I found Dr Taylor to be a credible and reliable witness. In an earlier Fatal Accident Inquiry over which I presided I cited with approval the dicta of Sheriff Stephen (now Sheriff Principal of Lothian and Borders) in her Determination in an Inquiry into the death of Lynsey Miles regarding the evidence required before criticism can properly be made of a doctor. I accept the submissions made by Mr Reid, Advocate on Dr Taylor's behalf that no criticism can be made of his care and treatment of and advice to Mr Gordon. As Mr Reid highlighted, the referral by Dr Taylor to the Respiratory Medicine Clinic was described by Dr C. M Carlin, Consultant Physician and Honorary Senior Lecturer in Sleep and Respiratory Medicine, Gartnavel General Hospital, Glasgow, as "very detailed for primary care" and "thorough."

D4 Medical Examination of Mr Gordon on 22 November 2013

69. Dr Lesley Anne Somerville, testified that she had been a locum general practitioner since August 2003. She explained that outwith her role as a general practitioner she has been involved since July 2013 one session per week with Glasgow Training Group as a Registered Medical Practitioner in undertaking D4 medical assessments in connection with applications for issuing/renewal of Group 2 Driving Licences.
70. Dr Somerville identified the D4 Medical Examination Report she completed following her medical assessment of Mr Gordon on 22 November 2013 (Crown Production No. 16 pages 345A and 346-351). She had no memory of Mr Gordon himself and was therefore reliant upon the content of the Report when giving her evidence.
71. Dr Somerville told the Inquiry she was familiar with the Booklet INF 4D issued by the Driver and Vehicle Licensing Authority (DVLA) entitled "Medical Examination Report D4" "Information and Useful Notes" (Crown Production No. 31 is a copy of the April 2013 edition of said booklet current at the time of Mr Gordon's examination). The booklet contains information and advice for the licence applicant and for the doctor. Dr Somerville was referred to Section B "Information for the doctor" (Crown Production No. 31, page 733) wherein the doctor is told *"You must examine the applicant fully and answer section 1-10 of the medical assessment... Please obtain details of the applicant's medical history when you fill in the report. Details of any condition which has not been covered by the report should be given in section 6. You may find it helpful to read DVLA's "At-a-Glance" [guide to the current medical standards of fitness to drive] (Crown Production No. 28 being the then current 2013 edition).* Dr Somerville told the Inquiry she had no access to

the At-a-Glance Guide at Glasgow Training Group. She said she rarely looked at the guide when completing Reports within her own surgery.

72. Dr Somerville explained that “in examining fully” an applicant she normally checked the applicant’s height, weight, blood pressure and listened to his heart and lungs. She said *“I sign the form (D4 Medical Examination Report) based on the information I have given that (at Glasgow Training Group) I don’t have access to the patient’s medical records.”*

73. Dr Somerville was invited to comment upon the section of the INF 4D Booklet – No.4 Other Medical Conditions” (Crown Production No. 31 at page 735 wherein it is provided:- **An applicant or existing licence holder is likely to be refused a Group 2 licence if they cannot meet the recommended medical guidelines for any of the following:-**

Hypertension where the blood pressure is PERSISTENTLY (my emphasis) 180 systolic or more and/or 100 diastolic or more.

She advised that she could not measure an applicant’s blood pressure to assess “persistently” in the process of one day. She said she inserted in the Report the blood pressure readings she obtained during her examination of Mr Gordon. Her completion of the D4 Medical Examination Report was based upon what Mr Gordon, told her at the time of the assessment. She informed the Inquiry that, as a matter of practice, she does not seek verification of what she is told by a patient.

74. Dr Somerville was taken through the D4 Medical Examination Report in detail by the Procurator Fiscal Depute. She explained her methodology which was unchallenged. It was clear that without sight of the patient’s notes (which Dr Somerville clearly noted on

the Report she did not have – cf. section 6 on page 349) she had no independent means of testing the veracity of the patient’s responses to the various questions in the Report.

75. Dr Somerville informed the Inquiry that Mr Gordon had confirmed to her he had had a “resting ECG” which he reported as normal. As the result was not available to her she noted on the Report: “No result available. Reported normal.”
76. I set out Section 4G of the D4 Medical Examination Report entitled “Blood Pressure” as it appears on the completed Report so as to assist with the understanding of Dr Somerville’s evidence thereon *viz*:

4G	Blood Pressure										
1. Please record today’s blood Pressure reading											
										176/106	
										YES	NO
2. Is the applicant on anti-hypertensive treatment?										√	
if YES provide three previous readings with dates											
if available. <i>Not available</i>											
172/94			2	2	1	1	1	3			

Dr Somerville said she took Mr Gordon’s blood pressure reading and recorded it as 176/106. As he advised her he had been previously told he had “white coat hypertension” she completed the rest of the form and after about 5/10 minutes took a second blood pressure reading which she noted as 172/94. In addition, in the further details section of the Report (Section 6), in reliance upon the information provided by

In response to Question 7(a) Mr Gordon said no and Dr Somerville therefore ticked the appropriate box. She completed the whole of Section 5 and in particular question 7 on the basis of the answers provided by Mr Gordon. Had Mr Gordon told her he had been to the Sleep Clinic Dr Somerville said she would have documented that in Section 7 of the Report (it is blank). She explained one of the general questions which she asks of all licence applicants is "Do you attend or have you recently attended any hospital clinic?"

78. Dr Somerville indicated that she noted on every D4 Medical Examination Report she completed at Glasgow Training Group that it was completed by her without access to medical notes. She said there is no system in place whereby when undertaking medical assessments at Glasgow Training Group she can access an applicant's medical notes. Attempts to contact an applicant's GP there and then would delay completion of the Medical Examination Report and require storage of uncompleted Reports to await receipt of the information necessitating that licence applicants return another day. She would be unable to complete the Medical Examination Report on the one day. She does not retain notes or copies of the D4 Medical Examination Reports completed by her at Glasgow Training Group. There are no facilities for storage to maintain confidentiality. It is not her decision on whether or not to grant the licence application. She merely completes the Report and hands it to the applicant for him to forward it to the DVLA for their decision. While the DVLA had reverted to her when, by accident, she had omitted to tick a particular box in answer to a question, the DVLA had never contacted her to enquire about her absence of access to the applicant's medical notes. Dr Somerville is not contacted by DVLA for follow up or informed of the outcome of individual applications.

79. In the hundreds of D4 Medical Examination Reports which she has completed Dr Somerville told the Inquiry she has never been in a position to give three previous blood pressure readings. She has never written to the applicant's GP for that information. She is however aware of the terms of the Consent and Declaration signed by Mr Gordon on page 8 of the Report (Crown Production No. 16, page 351) authorising his doctor and specialists (if requested) to release reports/medical information about his condition relevant to his fitness to drive to the Secretary of State's Medical Advisor.
80. Dr Somerville confirmed she went over the Report and its contents with Mr Gordon and asked him to sign and date it to confirm everything written on the form was correct. She is aware of the last paragraph of the declaration signed by Mr Gordon, *viz "I understand it is a criminal offence if I make a false declaration to obtain a driving licence and can lead to prosecution."*

Evidence of Mr Gordon's Attendance at the Blood Pressure Clinic, Gartnavel General Hospital, Glasgow

81. Evidence was led from Dr J. Dawson, a Consultant Physician, a specialist in cardiovascular disease, who from August 2011 to the end of 2014 had assumed prime responsibility for the Wednesday morning Glasgow Blood Pressure Clinic.
82. Dr Dawson is not a consultant cardiologist and objection was taken to a line of evidence which the Procurator Fiscal Depute sought to adduce from him on the basis that he did not possess and had not been hitherto been set up before the Inquiry as someone with a requisite expertise as a cardiologist to entitle him to give expert testimony on a factual

scenario being presented to him, in which the Crown sought his opinion on whether or not Mr Gordon may have suffered a “cardiovascular event” at the time of the accident. Having heard competing submissions on the issue of Dr Dawson’s experience, on the lack of fair notice and a challenge to the accuracy of the factual scenario being put by the Crown, and under reference to the Supreme Court decision of *Kennedy (Appellant) v Cordia (Services) LLP (Respondent) (Scotland) [2016] UK SC 6* at paragraphs 38 to 61, in particular paragraphs 39 to 44, I sustained the objection as I was not persuaded that Dr Dawson had been set up as possessing the requisite experience in cardiology.

83. Dr Dawson was, however, able to give evidence which was of assistance to the Inquiry.

I found him to be both a credible and reliable witness. He explained that when a patient attends the Blood Pressure Clinic he is asked to rest for five minutes and then his blood pressure reading is taken. This is to acclimatise the patient to the pressure on his arm. There is then a further period of rest and a further two blood pressure readings are taken, the Clinic recording the average of the final two readings. Dr Dawson said hypertension is blood pressure greater than 140/90. He testified that a reading of:

140/160 / 90 to 100 is mild hypertension – stage 1

160/180 / 100 to 110 is moderate hypertension – stage 2

Greater than 180/110 is severe hypertension – stage 3

Dr Dawson said there was a linear relationship between hypertension and cardiovascular risk. Somewhere around 130/70 or 80 the increase in cardiovascular risk began and for each 20 systolic and for each 10 diastolic he advised the cardiovascular risk doubled.

84. Dr Dawson agreed with Dr Taylor that Mr Gordon's reading of 195/110 on 14 October 2010 was indicative of severe or stage 3 hypertension (Crown Production No.13, Blood Pressure Clinic Records, page 305). The Clinic Records (page 317 et seq), he said, disclosed a patient who had, at that time (November 2010), at least moderate or perhaps severe high blood pressure and required treatment to reduce his cardiovascular risk.
85. Dr Dawson was referred to a letter from Professor McInnes, Professor of Clinical Pharmacology from his Blood Pressure Clinic dated December 2010 in which a blood pressure reading of 138/93 was recorded as the average of two readings for Mr Gordon (Crown Production No.13, page 301). He opined that Professor McInnes was suggesting "a degree of white-coat hypertension," which Dr Dawson described as being "the more severe end of what is much more a natural phenomena, in that blood pressure varies".
86. Dr Dawson was taken through the Blood Pressure Clinic records and Mr Gordon's blood pressure readings from 2010 to 2012. On 18 April 2012 when his blood pressure was recorded as being 151/88, Dr Dawson said Mr Gordon was "pretty much on maximum therapy." By this time Mr Gordon was prescribed four medications. If there was "good tolerance" to that medication then according to Dr Dawson "you are probably near where you are going to get." The reduction in his blood pressure equated to between a 50 and 75 percent reduction in cardiovascular risk. Dr Dawson was pleased more that the top number fell than that the bottom number remained reasonably consistent. The reading of 151/88 was "vastly better than that which [he initially] presented with."

87. Dr Dawson advised that as Mr Gordon intimated to the Clinic in late 2013/early 2014 that he no longer wished an appointment, no action was taken by the Clinic in response to Dr Taylor's "second" referral of November 2013.
88. Shown the DVLA At a Glance guidance on hypertension (Crown Production No.28, page 653) Dr Dawson deemed "consistently" as repeated measurements spaced in time over at least one month or more. He said *"Really I mean at least two – a single blood pressure reading does not reflect the patient's blood pressure. We must do more than that."* He was unaware of any definition of what "consistently" meant. He was unaware of any guidance whether from the NHS or DVLA or otherwise to interpret the At a Glance guide although he knew he could contact the DVLA for assistance. Dr Dawson stressed that a diagnosis of hypertension cannot be made or a patient placed in a particular stage of hypertension on the basis of one reading. *"It is the sustained elevation of the readings that is diagnosis."*
89. Dr Dawson said he did not believe Mr Gordon had ever advised him at the Blood Pressure Clinic of his intention to apply for a Group 2 licence. It was inconceivable that he would not have addressed the issue or documented it if he had been made aware of it.

Evidence of Mr Gordon's Attendance at the Sleep Clinic, Gartnavel General Hospital, Glasgow

90. Dr S. Banham, Retired Physician, testified that he was involved from 1990 until his retirement in 2012 in the "emerging speciality" of "sleep breathing difficulties."

Between 2005 and 2012 he was head of the Sleep Clinic, Gartnavel General Hospital, Glasgow.

Dr Banham had never met Mr Gordon. He had had sight of the Sleep Clinic Records and the result of the referral to his fellow consultant, Dr MacGregor. He told the Inquiry his involvement was in pulling together clinical information uploaded by Dr MacGregor and data from sleep investigations and communicating to Mr Gordon's General Practitioner recommendations for treatment and also directing the physiologists to implement that treatment. Dr Banham explained it was Dr MacGregor who regulated the standard home channel sleep study (CPAP trial) whereby Mr Gordon's "respiratory variables" were recorded through the night. He said the study revealed that in 2011 Mr Gordon had a definite element of "sleep disorder breathing" which was categorised as mild, but "definite obstructive sleep apnoea" (Crown Production No.12, page 281).

91. Dr Banham testified that Mr Gordon had responded well to be placed on the CPAP trial such that by 16 February 2012 he had reported to Mr Gordon's general practitioner a marked reduction in his Epworth score and that Mr Gordon would then enter the routine CPAP Clinic review.
92. Dr Banham was of the view Mr Gordon would have been extremely likely to develop Obstructive Sleep Apnoea Syndrome unless he managed to lose many stones in weight. He said that "left untouched it is inevitable that he would have developed Obstructive Sleep Apnoea Syndrome." He described Obstructive Sleep Apnoea Syndrome as slow, evolving, typically thought to be in excess of 10 years to develop. He was, however,

unable to state other than to speculate on the effect upon Mr Gordon of his stopping using the CPAP equipment.

Dr Banham was unable to further assist the Inquiry.

93. Mr Duncan Macfarlane, a Clinical Physiologist explained that it was his function to perform diagnosis on the respiratory investigations, lung function exercise tests and sleep diagnostic tests. He was tasked with initiation and follow up of the patients with sleep breathing disorders. He had no memory of Mr Gordon and his evidence was restricted to commenting upon some of the Sleep Clinic Records (Crown Production No.12)

His evidence while unchallenged did not assist me in reaching my determination.

94. Dr C M. Carlin, whose extensive CV was lodged as Crown Production No.39, is a Consultant Physician, one of eight consultants in Respiratory Medicine in the north west of Glasgow. He operates four clinics per week, a general respiratory clinic, a breathing support clinic and two sleep clinics, one under his supervision although taken by a general practitioner with specialist interest. Consideration of his evidence and his voluminous CV left me in no doubt as to his knowledge and expertise based on his skill, experience, training and education to provide expert factual testimony to the Inquiry. Objection was taken by a number of parties to the Crown's attempt to illicit expert opinion evidence from Dr Carlin. After hearing their objections, the Procurator Fiscal Depute did not insist upon her line of questioning.

Dr Carlin has been the clinician in overall control of the Sleep Clinic at Gartnavel General Hospital, Glasgow since July 2012, having succeeded Dr Banham.

95. Dr Carlin explained that if there was a possible diagnosis of Obstructive Sleep Apnoea Syndrome, Continued Positive Airway Pressure (CPAP) treatment is the standard primary treatment. In Obstructive Sleep Apnoea Syndrome the problem is the repetitive collapsing of the patient's upper airway when sleeping which causes partial or complete apnoea. CPAP therapy seeks to overcome the collapse of the upper airways. It acts as a "simple pneumatic splint." He explained "A small generator delivers airflow at certain pressure by tube to a mask worn by the patient which splints open the airways and prevents repetitive collapse." Patients, he said, are often advised to wear the mask for five nights per week for greater than four hours per night. Along with CPAP treatment the clinic would routinely mention weight loss and lifestyle changes.
96. Dr Carlin had reviewed Mr Gordon's records at the Sleep Clinic. He said that in July 2011 although describing Mr Gordon as a snorer, Dr MacGregor was not prepared to completely discount Obstructive Sleep Apnoea Syndrome. The sleep study he referred to was a cardiac sleep study carried out under instruction by the patient himself at home.
97. Dr Carlin helpfully clarified the distinction between Obstructive Sleep Apnoea and Obstructive Sleep Apnoea Syndrome. Obstructive Sleep Apnoea, he explained, is pauses in breathing of obstructive nature happening during sleep. Obstructive Sleep Apnoea Syndrome on the other hand, occurs when breathing pauses are present causing symptoms arising from sleep deprivation, for example, unresolved sleep, daytime sleepiness, lack of concentration and poor memory. Generally he informed the Inquiry patients using CPAP equipment quite quickly obtain improvement in sleep quality, the refreshment of sleep and in any daytime difficulties they experience. The majority of

patients starting CPAP – 70 to 80 per cent – will continue with the treatment and be followed up annually at the clinic.

Dr Carlin agreed with Dr Banham. No firm diagnosis could be made. Mr Gordon's symptoms did not amount to full Obstructive Sleep Apnoea Syndrome. He said they fitted better *"with a diagnostic label of minimal Obstructive Sleep Apnoea Syndrome."*

98. Dr Carlin indicated that Mr Gordon returned the CPAP equipment to the department probably on or about 20 May 2013. As part of the standard process a routine clinic appointment was generated as a follow up to that being done to enquire why the equipment had been returned. The appointment of 11 March 2014 at the Clinic disclosed in the patient episode search records (Crown Production No.14, page 336A) was that appointment. For Mr Gordon, described by Dr Carlin as a "routine patient with no major red flags, no major abnormality in previous sleep testing," the lengthy of time before the appointment was within normal parameters. He stated that Mr Gordon is noted as not attending. A patient is not offered another appointment in such circumstances. That requires to be generated by the patient himself or via his general practitioner by means of a further referral.
99. Dr Carlin explained to the Inquiry that there had been no clear understanding of how the DVLA At a Glance guidance should be applied or how specific situations should be judged. A survey, he said, in 2013 led to the Position Statement from the British Thoracic Society (Crown Production No.24) which he categorised as bringing "considerable clarity to DVLA." While the current pro forma in the Clinic has a section directed to driving, direct inquiry being made about the driving status of the patient

and his driving experience, in mid-2011 there was no protocol/guidance in relation to when and how clinicians should enquire of patients about “driving issues.”

100. Dr Carlin was asked his views on the manifestation of daytime hypersomnolence. He testified as to the difference in symptoms which may occur to a greater or lesser extent. He observed that a “micro sleep event” can last less than 30 seconds. He explained a “sleep attack” is something the public in general would become aware of whereas a patient may or may not be aware of a “micro sleep” event involving lack of concentration. Thinking of a driving situation Dr Carlin said micro sleep, which there is no absolute way to measure, was more likely to occur on long motorway drives than at the start of a journey with short stop/start manoeuvres.

101. Notwithstanding Dr Carlin’s expertise I sustained an objection to a line of questioning from the Crown seeking to ascertain what action Dr Carlin would have taken in the present day if faced with circumstances outlined in Mr Gordon’s records. I considered that enquiry to be beyond the scope of my determination under the Act. I was presiding over a Fatal Accident Inquiry into the circumstances of the death of Mr Gordon on 2 July 2014, not a Public Inquiry on inter alia appropriate medical procedures years later given a certain factual matrix.

DVLA and Fitness to Drive

102. The DVLA exercises functions on behalf of The Secretary of State for Transport. Dr Wyn Parry, the Senior Medical Advisor to the DVLA since 31 March 2014 informed the Inquiry that the DVLA have a Drivers Medical Division of which the Medical Advisors, numbering 23 are part. He explained the role of the Medical Advisors is to advise the

Agency on medical issues regarding driving licences, to interpret medical information submitted along with the applications and to advise the Agency on the applicant's fitness to drive. The decision on whether or not to grant an application is for the Agency although it is based upon the recommendation from the Medical Advisors.

Dr Parry said that of the 650,000 applications which the DVLA handle per annum, about 100,000 are accompanied by a D4 Medical Examination Report. He explained that 90% of decisions upon applications are taken by administrators without reference to Medical Advisors by the application of well-defined protocols.

103. Dr Parry told the Inquiry of the legal basis of the medical standards applied by DVLA. Referring to the then current DVLA At-a-Glance guide to the current medical standards of fitness to drive (November 2014 edition with amendments) (Crown Production No. 37 at page 766) he explained that the Secretary of State for Transport acting through the DVLA has the responsibility to ensure that all licence holders are fit to drive. The legal basis of fitness to drive lies in the third EC Directive on Driving Licences (2006/126/EEC), which came into effect in the UK on 19 January 2013, the Road Traffic Act 1988 and the Motor Vehicles (Driving Licences) Regulations 1999 (as amended). Section 92 and 94 of the Road Traffic Act 1988 refer to prescribed, relevant and prospective disabilities. I set out the relevant provisions and also certain provisions of the Motor Vehicles (Driving Licences) Regulations 1999 (as amended) in Appendix 1.

The medical standards refer to Group 1 and Group 2 licence holders.

Group 1 includes motor cars and motor cycles.

Group 2 includes large lorries (category C) and buses (category D).

The medical standards for Group 2 drivers are very much higher than those for Group 1 because of the size and weight of the vehicle. This also reflects the higher risk caused by the length of time the driver may spend at the wheel in the course of his occupation.

The medical standards are drawn up by the Secretary of State's Honorary Medical Advisory Panels of which there are six in number covering neurology, cardiovascular disease, psychiatry, diabetes mellitus, vision and drugs and alcohol.

104. Mr Gordon's D4 Medical Examination Report dated 22nd November was received by the DVLA on 27 November 2013. The DVLA expect the examining doctor to carry out the assessment while carrying out an examination sufficient to answer the questions asked. It is not for the Medical Advisors to be prescriptive in terms of specific requirements. There is, however, no requirement (my emphasis) upon the doctor carrying out the D4 Medical Examination to have sight of any particular paperwork or medical records relating to the licence applicant before completing the assessment. As the D4 Medical Examination Report can be completed by other than the applicant's general practitioner Dr Parry recognised the request in Section 3 to "please enclose hospital notes" while not strictly relevant to the circumstances surrounding Mr Gordon's death may be pointless. A registered medical practitioner with a licence to practice, who is not the applicants' general practitioner, who has no access to his medical records, is unlikely to have access to relevant hospital records.
105. If the registered medical practitioner with licence to practice undertaking the assessment is not the licence applicant's general practitioner, then in answering the questions on the form, Dr Parry accepted the registered medical practitioner is totally reliant upon what the licence applicant says. The registered medical practitioner has no means of verifying

the accuracy of the responses. He said that while parts of the form depend upon the licence applicant providing the doctor with an accurate history, whether through deliberate falsification, inadvertence or lack of knowledge on the part of the licence applicant, the doctor has no way of knowing whether or not what she is being told is correct. Notwithstanding this view when discussing Section 4F Cardiac Investigations and Mr Gordon's report to Dr Somerville of his "resting ECG" being normal, Dr Parry stated "We (DVLA) have no reason to doubt the accuracy of who submitted the information. We would accept it reported as normal. We would have no reason to verify that information."

106. Dr Parry advised that the rationale behind the request for 3 blood pressure readings, if the applicant is on anti-hypertension treatment, is to obtain information as to whether or not his blood pressure is controlled. Notwithstanding that 3 blood pressure readings are not provided in the D4 Medical Examination Report of Mr Gordon dated 22 November 2013, that the first reading of 176/106 exceeds the DVLA guideline of 180/100, that the second reading is below that threshold, that the average of the two readings is above the threshold, Dr Parry confirmed that no further information was sought by the DVLA. He agreed with the proposition that Mr Gordon's readings were "especially high when someone is on anti-hypertension medication." As however the second reading of 172/94 is within "our [DVLA] standards" and as the Protocol does not provide for "averaging of blood pressure readings" one of the administrators who are not medically qualified processed the application in line with the Protocol as they have no discretion and approved the grant of the application. Dr Parry explained the administrator would only have considered whether the reading was above or below the 180/100 limit, not whether

being in excess of 140/90 it could be said to be a high blood pressure reading per se. Despite the Report requesting 3 blood pressure readings, Dr Parry told the Inquiry, notwithstanding, that “one reading can’t be consistent,” that as long as one reading is under the 180/100 limit the DVLA’s operating instructions per the Protocol are to approve the application. He stated the fact that one blood pressure reading is below the threshold meant that the applicant’s blood pressure was controlled at the time that reading was taken.

107. Dr Parry was unable to answer the question, posed by the Procurator Fiscal Depute, as to how one reading on any one occasion can be indicative of an applicant’s blood pressure, particularly as he accepted that in plain English the word “consistently” means more than one reading. He merely conceded as a “possibility” that it is not possible to judge whether or not someone has sustained high blood pressure that would result in concerns from one reading. Pressed in cross-examination, Dr Parry agreed a single reading was a “snapshot.” He said one isolated reading on its own means nothing without context, and told the Inquiry it was impossible to judge whether or not someone has sustained high blood pressure from one reading. Pressed further on the suggestion of a disconnect between the wording of the At a Glance guidance and the operating instructions of the Protocol Dr Parry, while declining to answer the question posed, commented that more than one reading would fulfil the guidance. Thus far, he said, the Honorary Medical Advisory Panel for Cardiology (being the Panel on driving and disorders of the cardiovascular system) has not asked for that.

108. Had the Drivers Medical Division requested from his general practitioner Mr Gordon's last three blood pressure readings and been provided with those from the general practitioner's screen, namely:

24 October 2013 170/90

17 July 2012 190/90

19 March 2012 191/108

Dr Parry advised DVLA "would be unable to recommend a licence on the basis of hypertension."

109. Dr Parry intimated that having spoken with a senior administrator he understood that the insertion of free text by Dr Somerville in Section 6 of the D4 Medical Examination Report to the effect that "GP suspects white coat hypertension" placed the blood pressure readings in context which could explain why the first reading exceeded the limit of 180/100. He said in such circumstances he understood the Protocol permitted the licensing decision to be made "without access to the medical notes" notwithstanding that the free text is based upon the patient's understanding and interpretation. In cross-examination he said that having spoken with the senior administrator who processed Mr Gordon's application the operating instructions in the Protocol allow the blood pressure readings to be interpreted against the background of the free text. He did not accept this constituted a clinical judgement on the part of the administrator. He said it was written in the Protocol. Nevertheless, he understood why clinicians not familiar with the DVLA Operating Instructions might think the DVLA would chose the higher blood pressure reading disclosed on the D4 Medical Examination Report rather than approve the application based on the lower blood pressure reading. He conceded it would not be

difficult to amend the Protocol to instruct an administrator to average the blood pressure readings provided. No clinical judgement would be required in doing so.

110. Dr Parry was initially referred to the DVLA INF4D Booklet "Medical Examination Report D4" April 2013 Edition (Crown Production No. 31) and to the updated August 2014 Edition which had been agreed by parties in terms of paragraph 24 of the Second Joint Minute of Agreement to be the current version. He readily accepted that the wording of the August 2014 Edition required alteration as he felt it advisable to include a paragraph on Obstructive Sleep Apnoea Syndrome. He informed the Inquiry that "currently there is no reference to Obstructive Sleep Apnoea on the D4 Medical Examination Report but as a result of legislative change (which has taken place) there will need to be." He could not explain why when the guidance had been changed in August 2014 the opportunity had not been taken to amend the D4 Medical Examination Report at the same time. He acknowledged that what he described as the current D4 Medical Examination Report highlighted Obstructive Sleep Apnoea Syndrome and that there should be mention of Obstructive Sleep Apnoea in the current guidance.
111. Given Dr Parry's position as the Senior Medical Advisor to the DVLA I was astonished to be informed by the Procurator Fiscal Depute the following morning before continuing with his evidence that, contrary to what he had told the Inquiry the previous afternoon, further enquiry overnight had revealed that the INF4D Booklet issued by the DVLA and the D4 Medical Examination Report had both been revised in November 2015. I would have expected the Senior Medical Advisor to the DVLA to be aware of the existence of these documents given that they had been in existence for some three months. The Second Joint Minute of Agreement was duly amended by deleting the reference therein

to the earlier August 2014 Edition of the INF4D Booklet being the current version. The November 2015 Editions of both documents were then lodged as Crown Productions Nos. 42 and 43.

112. In November 2013, Question 7 in Section 5 of the D4 Medical Examination Report referred to Obstructive Sleep Apnoea Syndrome, not Obstructive Sleep Apnoea. Dr Parry informed the Inquiry that according to a senior administrator the DVLA were then not likely to have been told of a diagnosis of Obstructive Sleep Apnoea other than by the registered medical practitioner inserting a free text comment in Section 6. Had that been done the Drivers Medical Division would have sent a form SL1 to Mr Gordon with a request for consent. Upon receipt of a duly completed form SL1 (Crown Production No. 33 is the April 12 Edition, Crown Production No. 40 is the current version) giving that consent the Division would have sent form SL2V (Crown Production No. 41 is the current version) to his specialist in secondary care. Had the SL2V been sent to and returned by Mr Gordon's specialist notifying the DVLA that Mr Gordon had Obstructive Sleep Apnoea, had commenced a CPAP trial in February 2012, had not attended his annual CPAP Clinic Review in January 2013 and had returned the CPAP equipment in May 2013 (as he felt it did not help him) but was still within the system and awaiting an appointment in March 2014, Dr Parry stated "we could not have issued a Group 2 licence."

113. Shown the agreed current version of the INF4D Booklet and the D4 Medical Examination Report, Dr Parry commented that it was the intention of the designers of the Booklet and Report to match with the "At a Glance guidance" available to doctors and the public. Otherwise, he conceded, there is potential for confusion. The changes in

Section 4G of the D4 Medical Examination Report, he said, were instituted by the Honorary Medical Advisory Panel for Cardiology (correctly known as The Secretary of State for Transport's Honorary Medical Advisory Panel on driving and disorders of the cardiovascular system). They introduce clarity.

114. Dr Parry was then taken through the current version of the D4 Medical Examination Report (Crown Production No. 43). When referred to Section 5, general Question 7: *"Is there a history of, or evidence, Obstructed Sleep Apnoea Syndrome or any other medical condition causing excessive sleepiness?"* and the subsequent supplementary questions, he volunteered that "I do not think a doctor other than the individual's general practitioner would be able to complete this form..." No part of Question 7 can be answered accurately if it is not the [applicant's] general practitioner. Nevertheless the law at present does not permit the DVLA to make it explicit that only the applicant's general practitioner can undertake a D4 Medical Examination Report/Assessment. The Regulations issued by the Secretary of State for Transport currently allow D4 Medical Examinations to be carried out by Registered Medical Practitioners with a licence to practice. They do not restrict conduct of the examinations to the licence applicant's general practitioner.

When Dr Parry was asked what attitude the DVLA would adopt if they were aware that the Registered Medical Practitioner who conducted the assessment was not the applicant's general practitioner and did not have access to the medical records, he reiterated that he did not believe a doctor other than the applicant's general practitioner would be able to give the information currently required to answer Question 7. He said he expected a Registered Medical Practitioner other than the applicant's general

practitioner to record “unable to answer.” If, as he expected, a Registered Medical Practitioner left the answers to Question 7 blank, the DVLA would make further enquiry of the applicant’s general practitioner to obtain the information to answer the questions. Question 7, he stated, is now highly specific and the DVLA would not expect a patient to have the information to hand to answer it. If however all questions including that of Question 7 in Section 5 were completed by the Registered Medical Practitioner the DVLA would accept the Medical Examination Report following the Registered Medical Practitioner’s assessment even if that individual was not the patient’s general practitioner.

Dr Parry was challenged in further cross-examination to explain why “erring on the side of caution” as he had agreed was the position of the DVLA it was not thought appropriate to refer the content of the answers to Question 7 to an applicant’s general practitioner for verification if the Report is completed by other than his general practitioner. Dr Parry had no answer other than to state that the DVLA currently do not do that.

115. Frequent reference having been made by Dr Parry during his evidence to the operating instructions, the Crown sought to lodge, without objection, for the assistance of the Inquiry, the DVLA operating instructions in relation to blood pressure (said to be the version in force in 2013 and still current). Sadly this latter information also proved to be inaccurate as nearly three weeks later the Procurator Fiscal Depute sought to lodge, again without objection, a further production as Crown Production No. 48 which she described as the now current version of the Blood Pressure operating instructions.

116. Having heard submissions and mindful of the provisions of the Act and the Fatal Accidents and Sudden Deaths Inquiry Procedure (Scotland) Rules 1977 I adjourned the Inquiry to enable the Crown to investigate further with the DVLA administrative staff and to make arrangements, if appropriate, to lead further evidence on the circumstances in which the administrator dealt with Mr Gordon's D4 Medical Examination Report dated 22 November 2013 in light of the Protocol then in force.

The Inquiry is a fact finding tribunal endeavouring to find out what happened and wherever possible, why it happened, so that if precautions can be taken to prevent a recurrence, then they can be taken in the future. It is an investigatory not an adversarial procedure whose aim is to try and get at the truth. In my view, proper and full presentation of the evidence was essential for a proper and meaningful determination to be arrived at.

In the event, with the assistance of Counsel and those instructed for the DVLA, the Crown were able to trace the individual administrator who had dealt with the D4 Medical Examination Report of Mr Gordon in 2013. By arrangement she gave evidence via video link from the DVLA's offices in Swansea.

117. Ms Carol Ann Tamplin, testified that she was a Medical Executive Officer in the DVLA. She had worked for the DVLA in the Drivers Medical Division since 1999.
- She explained her job as a Medical Executive Officer was to discuss cases with front line managers which they referred to her in a supportive role. She also had an enhanced decision making role.

118. Ms Tamplin did not specifically remember Mr Gordon's application. She testified she was "working off file," in this case from the screenshot of the Case Work and Specialist Process System lodged on behalf of the DVLA. This revealed that on 20 December 2013 Ms Tamplin had added H 32 – hypertension - to the system, and on the same date granted Mr Gordon's application for Long Term Vocational Licence (Group 2) (for 5 years as he was over 45) and Long Term Licence (Group 1) to age 70.
119. Ms Tamplin informed the Inquiry that she looked at the whole of the D4 Medical Examination Report dated 22 November 2013 before coming to her decision. Taking what she categorised as *"the best blood pressure reading"* on the day – 172/94 – which is within the DVLA standard, she granted Mr Gordon's application. She said *"We have always been taught to take the best reading we have. That is in the Operating Instructions."* She was not interested in the average of any readings supplied, only the lowest reading on the particular day of the examination if that reading fell below the threshold.
120. In response to Counsel for the DVLA, Ms Tamplin stated that the information in free text in Section 6 of the Medical Examination Report supplied by Dr Somerville "is not necessary because the best blood pressure (reading) on the day met the standard." Pressed on the relevance, if any, to the DVLA, of the information in Section 6 from Dr Somerville, Ms Tamplin said "that information would have been taken into consideration if all blood pressure readings had been over the limit (180/100)." The fact that Dr Somerville had indicated that the D4 Medical Examination was completed by her

without access to medical notes was irrelevant. The Declaration at the end of the Report was signed by the Applicant stating the contents were accurate.

121. Ms Tamplin was asked to consider Crown Production No. 47 being the operating instructions re 4G Blood Pressure which copy although dated 1 October 2014 was said to be the operating instructions in force at December 2013. She told the Inquiry Question 1: "Please give today's blood pressure reading" should be interpreted as meaning "Please give the lowest of today's blood pressure readings (it should be noted that in the current operating instructions (Crown Production No. 48) the question is now "Please record today's best blood pressure reading),"
122. Referring to the request for three blood pressure readings (if available), as Mr Gordon is noted as being in receipt of antihypertension treatment, Ms Tamplin said it would depend upon the age of the readings provided, whether further information was sought from the applicant's general practitioner or the application for licence simply granted. She said that, as per the flow chart, the dates of the readings would be considered and assessed and, if appropriate, further information sought from the applicant's general practitioner. Any additional readings, whether three in number or otherwise, are, however, irrelevant, if on the day of the Medical Examination there is a reading below the threshold of 180/100. In such circumstances even if other readings all disclose the applicant having blood pressure levels above the threshold, the DVLA operating instructions mean the licence will be granted (cf. the agreed statement description of the

DVLA D4 operational instructions Flowchart in use in November 2013 in respect of Section 4G Blood Pressure (Crown Production No. 47) in Appendix 9).

123. If an applicant is on antihypertension treatment and no additional readings are supplied but the blood pressure reading on the day is below the 180/100 threshold, there are no circumstances where the DVLA would request additional readings from the applicant's general practitioner. They would simply proceed to grant the application based on the reading on the day of the D4 Medical Examination.
124. On the question of Mr. Gordon's attendance at the Sleep Clinic, Ms Tamplin said that, had information been disclosed in the D4 Medical Examination Report indicating that Mr Gordon had attended a Consultant at a Sleep Clinic then, in absence of a positive response to Question 7 of Section 5 General in the D4 Medical Examination Report, she would have discussed the issue with a Medical Adviser in order to ascertain whether or not further information was required in relation to the issue.

A summary of the closing submissions of the Crown and other represented parties

Section 6(1)(a)

125. I have attached to this Determination as Appendices number 11 to 16 the detailed written submissions which were lodged before the Inquiry. All parties were generally agreed as to the finding that should be made in terms of section 6(1)(a) relative to where and when Mr Gordon died and the accident resulting in his death took place.

Section 6(1)(b)

126. All parties also agreed as to the finding I should make in respect to the cause of Mr Gordon's death in terms of section 6(1)(b). The cause of the accident resulting in Mr Gordon's death was his negotiation of the roundabout, whilst, in the course of his employment, driving the Ford Transit van at excessive speed, his loss of control of the Transit van resulting in it crossing into the path of the articulated LGV operated by Saints Transport Limited and being driven by their employee Denis Gallacher and colliding with same.
127. Parties agreed there were no pre-collision defects in either the Ford Transit van or trailer or the MAN tractor unit and SD semi-trailer that could have led to a loss of control of either vehicle or increased the severity of the collision. The mechanical conditions of the Ford Transit van and trailer and the MAN tractor unit and SD semi-trailer were not a

contributing factor in the collision (paragraphs 23, 24 and 25 of the second Joint Minute of Agreement, reproduced in Appendix 2).

128. The Procurator Fiscal Depute referred to Dr Julia Bell's affidavit and her evidence in paragraph 2 of the fourth Joint Minute of Agreement (Appendix 8). She highlighted Dr Bell's view that "while the chest injuries were considered to be the main factor in his [Mr Gordon's] death, the possibility that underlying natural disease played a part in the Road Traffic Accident and/or contributed to the death cannot be excluded". Further the Depute made mention of Dr Bell's opinion that she "can't exclude the possibility that [Mr Gordon's] underlying natural disease led to the accident, for example, he may have had a 'heart attack' prior to the crash that led to a reduced level of consciousness which resulted in the collision". Dr Bell had also stated that there would be no acute pathology to suggest that a sleep apnoeic event had occurred.
129. The Depute made mention of the evidence of Mr Denis Gallacher who testified that "when Mr Gordon was around 6 or 7 metres away from him, he looked down from his cabin and saw Mr Gordon lying across the passenger seat with his right hand on the steering wheel at 12 o'clock position". Mr Gallacher told the Inquiry he could only see the back of Mr Gordon's head as he was facing downwards and his trunk was positioned across the seat. The Procurator Fiscal Depute advanced two reasons, which she categorised as possibilities, why Mr Gordon could have been lying across the passenger seats with his head facing down immediately before impact. She said Mr Gordon may have been distracted by something in the cabin, either trying to pick up

something in the passenger seat area or for some other reason having caused to turn his head downwards looking away from the road towards the passenger seat. Alternatively Mr Gordon found himself lying across the passenger seats with his head facing downwards not looking at the road because he had taken ill causing him to lose control of the vehicle he was driving. Counsel representing Drs David Taylor and Lesley Anne Somerville submitted that the Crown's hypotheses as to why Mr Gordon lost control of his vehicle are entirely speculative. He said the Inquiry heard no evidence that it was a medical episode that caused the loss of control that led to the collision. In particular Counsel stated there was no suggestion that Mr Gordon suffered an episode of sleep apnoea or some other event associated with hypertension. Dr Bell's evidence that she "can't exclude the possibility" that underlying natural disease led to the accident did not amount to positive evidence from which the Inquiry could make a finding of what did cause the accident.

130. The solicitor representing the Greater Glasgow Health Board was of a similar view stressing that the complete absence of any medical evidence cannot be taken as evidence of a medical event occurring. He submitted, having regard to Dr Bell's own affidavit evidence, there was no medical or scientific evidence to suggest that Mr Gordon suffered from a medical event which may have contributed to the road traffic accident.
131. Counsel for the DVLA submitted there was no evidence to support a finding that the road traffic accident had a particular cause. He suggested while it is possible to speculate that Mr Gordon might have been distracted by something in the cabin, he might have

decided to reach for something in the cabin or he might have become unwell for some reason, there was no evidence to suggest on the balance of probabilities a probable cause could be identified. The evidence did not support a contention which would entitle the Court to find on the balance of probabilities one possibility should be preferred over any other.

Section 6(1)(c)

132. The Depute, under reference to a Determination by Sheriff Bicket, a Sheriff of South Strathclyde, Dumfries and Galloway at Hamilton into the death of Dawn McKenzie, 11 August, 2015, submitted that the death of Mr Gordon might have been avoided if he had not negotiated the roundabout at excessive speed, lost control of the Ford Transit minibus and entered the opposing lane of Sanderling Road as he exited the roundabout where the Ford Transit minibus collided with the LGV being driven in the opposite direction by Denis Gallacher.

133. The Procurator Fiscal Depute invited me to find that it would have been a reasonable precaution for the DVLA, when assessing Mr Gordon's health for the purpose of issuing a Group 2 licence to have accessed Mr Gordon's GP records for the purpose of considering his previous blood pressure readings and not to have accepted the preferable of two high Blood Pressure readings recorded on Form D4 on 22 November 2013, both of which had been taken on the day of the examination, 5 to 10 minutes apart, and one of which was above the 180/100 threshold of high blood pressure readings.

134. The Depute also submitted that it would have been a reasonable precaution, on hindsight, if the DVLA had sought further medical information and had not accepted the little information that had been submitted in Form D4 in relation to Mr Gordon's hypertension, and that in these circumstances the Group 2 licence may not have been granted on the basis of the further information provided and therefore the death might have been avoided.
135. The solicitor, for Airlink Management Limited, Mr Gordon's employers, submitted that on the basis of the information contained within Mr Gordon's November 2013 application for a vocational driving licence (Group 2 licence) the information provided by him to Dr Somerville and the blood pressure readings obtained by her, it was appropriate for the DVLA in December 2013 to issue Mr Gordon with a vocational driving licence valid for a period of 5 years. Further she submitted it was reasonable for Airlink Management Limited to employ Mr Gordon as a driver. At his interview he had produced a copy of his Certificate of Professional Competence from GTG confirming he had undergone 35 hours CPC earlier in 2014. There was no reason why Airlink Management Limited should not have relied upon the issue of a five year vocational driving licence by DVLA in December 2013 and the CPC documentation which Mr Gordon produced as proof of his fitness and competence for the driving job he was employed to do.

136. Airlink Management Limited's solicitor agreed with the Depute that Mr Gordon's death might have been avoided if he had not negotiated the roundabout at excessive speed, lost control of the Ford Transit van and entered the opposing lane of Sanderling Road as he exited the roundabout where the Ford Transit van collided with the LGV being driven in the opposite direction by Mr Denis Gallacher. The solicitor for Saints Transport Limited and Mr Gallacher, and the solicitor for Airlink Management Limited submitted that there were no reasonable precautions which could have been taken by Airlink Management Limited, Denis Gallacher or Saints Transport Limited whereby the tragedy of Mr Gordon's death might have been avoided.
137. Having regard to the absence of any expert evidence commenting upon the actions of Drs Taylor and Somerville their Counsel submitted there was no basis in the evidence to make any finding under section 6(1)(c) which is to any extent critical of the actions of those doctors. The Crown made no such proposal. Counsel stressed there was no basis upon which to criticise or otherwise make any adverse comment upon any of the doctors' involvement with the care and treatment of Mr Gordon. Both doctors, as he put it, "did what was expected of them".
138. A similar position was unsurprisingly adopted by the Greater Glasgow Health Board. Their solicitor said that neither Dr Banham nor Dr Carlin offered any concerns regarding the medical treatment Mr Gordon received while under the care of the Sleep Clinic under the auspices of the Greater Glasgow Health Board. The Crown did not adduce expert testimony which suggested any concerns regarding the medical treatment

provided by the Health Board. Their solicitor submitted, in absence of any evidence which suggested that Mr Gordon suffered from a significant medical event which may have contributed to the road traffic accident, and in the absence of any criticism of the medical care offered, there were no reasonable precautions which could have been taken by the Health Board which might have avoided Mr Gordon's death.

139. Counsel for the DVLA submitted that if the cause of the road traffic accident could not be determined there were no reasonable precautions whereby the accident resulting in Mr Gordon's death might have been avoided. Because it is not known what caused the accident he said there are no recommendations that can be made under section 6(1)(c).
140. In particular Counsel for the DVLA challenged the reasonable precautions sought by the Crown and submitted they were not supported by the evidence. There was no evidence to suggest that the decision which implemented the advice of the Secretary of State Honorary Medical Advisory Panel on Cardiovascular disease was incorrect. He said there was no evidence that would support the finding that, on the balance of probabilities, if further information had been provided to the DVLA in relation to Mr Gordon's application in November 2013, his application for a Group 2 licence would have been refused.

Section 6(1)(d)

141. All parties agreed there were no defects in any system of working which contributed to Mr Gordon's death or the accident resulting in his death.

Section 6(1)(e)

142. The Crown made a number of submissions under this sub-section. The Procurator Fiscal Depute firstly submitted that, having been legitimately examined in the course of the Inquiry, a fact relevant to the circumstances of Mr Gordon's death was *"the inconsistency of the DVLA's approach to ascertaining fitness to drive (and continue to drive)"*. She maintained the DVLA "At a Glance" guidance, both the version in use in November 2013 and the guidance now in use, were and are not consistent in their terms and approach with the DVLA's operational instructions in relation to assessing high blood pressure (hypertension) in Form D4.
143. While the "At a Glance" guidance states that Group 2 drivers will be disqualified where "resting BP consistently 180mm Hg systolic or more and/or 100mm Hg diastolic or more", the D4 operating instructions for blood pressure indicate that decisions to (re) issue or not to (re) issue a Group 2 licence can be made on the basis of one blood pressure reading only.

144. Additionally the Depute, under reference to Dr Parry's testimony, submitted that, if the object of providing three blood pressure readings for the D4 assessment when the applicant is on anti-hypertensive treatment is to ascertain whether or not the applicant's blood pressure is controlled, this is at odds with the operating instructions in use in 2013 and currently in use which only require one reading below the 180/100 threshold taken on the day of the assessment even when the applicant is undergoing anti-hypertensive treatment. She submitted it is not possible to ascertain whether an applicant's blood pressure is "controlled" on the basis of one blood pressure reading only.
145. Secondly, the Procurator Fiscal Depute criticised "*the lack of clarity of the definition of "consistently" in the Blood Pressure guidance*". The Depute pointed out that, in relation to hypertension, the doctors who have evidence before the Inquiry gave differing definitions. There is no definition given within the DVLA "At a Glance" guidance. The Depute emphasised Dr Parry accepted the same patient could potentially be given different advice about driving by two different doctors who are interpreting the guidance (specifically the meaning of the word "consistently") differently.
146. Thirdly, the PF Depute submitted that it was a fact relevant to the circumstances of Mr Gordon's death that "*the D4 Medical Examination Report can be completed by the examining doctor who has no prior knowledge of the licence applicant and no access to his or her medical records, in particular his/her GP's records*". The Procurator Fiscal Depute highlighted the system of "D4 assessment places significant reliance upon the applicant's honesty and

knowledge in relation to declaring his medical history in the absence of GP records being made available to the doctor” who conducts the examination.

147. Fourthly, the Crown submitted that it was relevant to the circumstances of Mr Gordon’s death that his employers, Airlink Management Limited, did not scrutinise his state of health at interview. The Depute criticised the company’s former operations manager for placing reliance upon the fact that as the DVLA had given Mr Gordon a licence we can “take it for granted he is fit and healthy”. The Depute pointed out that at the time of Mr Gordon’s interview his employers did not seek references or any specific medical information from interviewees, stressing Ms Carr’s evidence that “all other things being equal we would not have taken him (Mr Gordon) on” given his medical issues.
148. Lastly, the Depute made mention of Dr Parry’s evidence on the completion of the now current D4 Medical Examination Report by other than the licence applicant’s general practitioner. She stressed that Dr Parry stated he did not consider it was possible for anyone other than the licence applicant’s general practitioner to complete question 7 of section 5. That fact, the Crown suggested, was relevant to the circumstances surrounding Mr Gordon’s death bearing in mind the public interest and the terms of the DVLA’s INF 4D booklet entitled “Medical Examination Report for a Group 2 (lorry or bus) licence D4.” In said booklet (Crown Productions No. 21 and 32 are copies of the additions of the booklet current in November 2013 and then dated August 2014) it states “the D4 medical assessments must be completed by a doctor registered and licenced to practice in the

United Kingdom or registered within the EU (my emphasis). If your own doctor fills in the D4 medical assessment it may speed up your application. “

149. Counsel for Drs. Taylor and Somerville, although proposing no conclusions or recommendations, provided some helpful observations relevant to the submissions made by the Crown on the decision by the DVLA to grant Mr Gordon a Group 2 licence in December 2013. While recognising it was primarily a matter for the Crown and the DVLA to address he said the doctors had an interest given “their front line position in the D4 assessment process”. Counsel pointed out, first, that on his plain reading section 4G of the D4 Report (in existence in November 2013) (which I have reproduced in paragraph 76 of this Determination) appears to call for three previous blood pressure readings where the applicant, as in Mr Gordon’s case, is on anti-hypertensive treatment. Nevertheless both Dr Parry and Ms Tamplin explained to the Inquiry that should a blood pressure reading on the day of the examination be below 180/100 the licence would be granted without further enquiry (so far as blood pressure was concerned at least). Counsel said there was no attempt to explain how the sound rationale for the question was answered by a single reading on the day of the examination.

Counsel stated that, second, had the DVLA sought Mr Gordon’s last three blood pressure readings from Dr Taylor, the readings Dr Taylor would have provided would have been 170/90 (24/10/2013), 190/90 (19/07/2012) and 191/108 (19/03/2012) and had the DVLA known of Mr Gordon’s blood pressure history, in particular, had they had sight of those three results, his licence application should have been rejected.

150. Counsel added, third, that despite the DVLA's approach of "erring on the side of caution" Dr Parry was unable to reconcile that approach with not taking the highest reading on the D4 medical assessment form, or not taking an average, or relying upon the reference to white coat "hypertension" in the free text in question 6. Counsel reminded the Inquiry that Dr Parry answered by saying that the operating instructions allowed that to happen but understood why that approach was being questioned.
151. Lastly Counsel observed that Ms Tamplin's evidence that, applying the DVLA operating instructions and based on the information given on the D4 Medical Examination Report, the correct licencing decision had been made, must be seen in the context in what Counsel categorised as the "unanimous view" of the medical evidence led before the Inquiry that a single blood pressure reading only gives a "snapshot" from which no conclusion can be drawn about the extent to which blood pressure could be said to be under control.
152. Counsel for the DVLA submitted that Mr Gordon met the DVLA standards for fitness to drive when his application of November 2013 for a Group 2 licence was processed by Ms Tamplin.
153. Counsel said it had not been proved on the balance of probabilities that Mr Gordon did not meet the DVLA standards for fitness to drive at the date of the accident on 2 July 2014 resulting in his death.

154. Counsel for the DVLA submitted that the standards the DVLA apply in assessing fitness to drive were not an issue within the scope of the Inquiry. No evidence was led before the Inquiry to suggest the advice on fitness to drive given to the DVLA by the Secretary of State's Honorary Medical Advisory Panels, consisting of doctors eminent in the fields of cardiology and neurology, together with lay members, was incorrect.
155. Whilst considering that the wording of the DVLA's "At a Glance" guidance differs from the DVLA's operating instructions, Counsel for the DVLA submitted the guide was not inconsistent with the operating instructions. The primary purpose of the guide is to assist doctors in advising patients whether or not patients should advise the DVLA of their medical conditions. The At a Glance guide, Counsel said, is not designed to allow or encourage doctors to "second guess the decision the DVLA will make". No evidence was led before the Inquiry that the Secretary of State's Honorary Medical Advisory Panel on Cardiology have "got it wrong" when it comes to the wording of the operating instructions and/or the At a Glance guide. No evidence was led from those responsible for the drafting of these documents.
156. Counsel for the DVLA said the DVLA had no evidence from doctors that the absence of the definition of the word "consistently" causes any difficulty in practice. No evidence was led before the Inquiry as to how the word should be defined. Counsel emphasised the terms of section 4g of the now current D4 Medical Examination Report which is in the following terms:

“If blood pressure is 180/100mm Hg systolic or more and/or 100mm Hg diastolic or more, please take a further 2 readings at least 5 minutes apart and record the best of the 3 readings in the box provided.”

157. Counsel for the DVLA referred me to the terms of regulation 10(5) of the The Motor Vehicle (Driving Licences) Regulations 1999/2864 (the terms of which I reproduce as part B of Appendix 1 to this Determination) which provides for the D4 medical examination to be performed by a qualified medical practitioner. The Law does not state that the qualified medical practitioner should have access to the driver’s medical records before completing the D4 medical examination. No evidence, Counsel said, was led as to the necessity for or practicability of such a requirement. No evidence was led on the difficulties or otherwise of implementing any such system. Counsel submitted that in the absence of any evidence about the relative advantages and disadvantages of changing the system of completing D4 medical examinations without requiring access to medical records it was not appropriate for the findings sought by the Crown to be made.

Determination – The Legal Framework

158. The provisions governing the conduct of a Fatal Accident Inquiry are to be found in The Fatal Accidents and Sudden Deaths Inquiry (Scotland) Act 1976 and The Fatal Accidents and Sudden Deaths Inquiry Procedure (Scotland) Rules 1977. The standard of proof is the balance of probabilities. Corroboration is not required. Hearsay evidence is

admissible, as is Affidavit evidence. Undisputed evidence, as in this case, may be proved by joint minute or joint minutes of agreement. The facts agreed by the five Joint Minutes of Agreement are treated as proved. I am bound to accept such facts as established. They are reproduced in Appendices 2 to 9.

159. I proceed on the basis of the evidence placed before the Inquiry. Any Determination must be based on the evidence at the Inquiry. The evidence of any witness has two aspects, credibility and reliability. A credible witness may be doing his or her best to tell the truth but may be unreliable in his or her testimony in the sense of being inaccurate or mistaken. Evidence can be unreliable for a multitude of reasons, including the witnesses' recall being affected by the trauma of the incident and/or by the mere passage of time. I am required to determine the credibility and reliability or otherwise of the individual witnesses whose evidence was presented to the Inquiry. Where I have rejected evidence as lacking credibility and/or being unreliable that does not prove that the opposite of what the particular witness said is either true or reliable. I am entitled to accept part of a witness' evidence while rejecting another part and in some respects I have done so (for example, as regards Mr. Newlands' account of the road traffic accident) Evidence which I have rejected proves nothing and has been ignored by me in reaching my Determination.

160. The Determination is linked to the matters set out in section 6(1) of the Act. That section provides that the purpose of a Fatal Accident Inquiry is for the Sheriff to make a

Determination “*setting out the following circumstances of the death so far as they have been established to his satisfaction –*

- (a) *Where and when the death and any accident resulting in the death took place;*
- (b) *The cause or causes of such death and any accident resulting in the death;*
- (c) *The reasonable precautions, if any, whereby the death and any accident resulting in the death might have been avoided;*
- (d) *The defects, if any, in any system of working which contributed to the death or any accident resulting in the death; and*
- (e) *Any other facts which are relevant to the circumstances of the death.”*

161. A Fatal Accident Inquiry is primarily concerned with fact finding. As Lord Hope opined in the case of *Black v Scott Lithgow Limited* 1990 SC 322 at page 327: “*There is no power to make a finding as to fault or to apportion blame between any persons who might have contributed to the accident*”. That having been said I concur with the approach of Sheriff A C Normand in his Determination dated 14 November 2014 in the Fatal Accident Inquiry into the deaths of Mhairi Samantha Convy and Laura Catherine Linder Stewart at 1.8 where he states “*However that is not to say that evidence tending to demonstrate fault may not properly be led before the Inquiry. Nor does it mean that the Sheriff is precluded from making findings which may infer fault where it is proper to do so. This is important when having regard to future safety and the prevention of a recurrence of the accident or the death*”.

162. I accepted all of the unchallenged evidence led at the Inquiry as being credible and reliable evidence. I accepted the terms of the most helpful collision investigation report

(Crown Production No.4) and the largely unchallenged evidence of PC Scott Simpson as both credible and reliable. I preferred the evidence of PC Simpson and the content of his report where it conflicted with part of the testimonies of Messrs. Richard Clifford, Denis Gallacher and Malcolm Newlands as highlighted by the Crown in Paragraphs 5.15 to 5.20 of their written submissions. With that caveat, I accepted the evidence of Ms. Mary Kelly, Mr Richard Clifford (the TOA taxi driver), Mr Denis Gallacher, Mr Brian Rice, (driver Airlink Management Limited), Drs J Dawson, S Banham and C M Carlin, and Mr Duncan Macfarlane which was not otherwise challenged to any material or significant extent as both credible and reliable. While comment was made upon the evidence given by Drs Taylor and Somerville and to some extent certain of parties' submissions proceed thereon no evidence was led that was other than supportive and complimentary of the actions of both doctors. I am satisfied that both doctors were credible and reliable witnesses.

163. Parties assisted the Inquiry by lodging five Joint Minutes of Agreement. The facts contained therein constitute evidence before the Inquiry. I am very much obliged to parties for this assistance. I have set out the relevant terms of the various Joint Minutes of Agreement in appendices 2 to 9.

Determination in terms of Section 6(1)(a): where and when the death and any accident resulting in the death took place

164. I had no difficulty in determining where and when Mr Gordon's death and the accident resulting in his death took place. The evidence in relation to these issues was unchallenged. I determine that in terms of section 6(1)(a) Douglas Brian Gordon, born 24 May 1956 and who resided in Glasgow died at the Southern General Hospital , Govan Road, Glasgow on 2 July 2014 at 13:15 hours. His life was pronounced formally extinct at the hospital at that time. I further determine that the accident resulting in Mr Gordon's death occurred around 11:30am on 2 July 2014 in the eastbound carriage way on Sanderling Road, Paisley approximately 36 metres west of the roundabout junction with White Cart Road, Paisley.

Determination in terms of Section 6(1)(b) – the cause or causes of such death and any accident resulting in the death

165. All parties were agreed as to the causes of Mr Gordon's death being those set out in the post-mortem report from Dr Julia Bell dated 7 August, 2014 namely 1(a) chest injury due to 1(b) road traffic accident (minibus driver).
166. As to the cause or causes of the road traffic accident resulting in Mr Gordon's death parties were also agreed per paragraphs 23 to 25 of the second Joint Minute of Agreement (reproduced in Appendix 2) that there were no pre-collision defects in

respect of the Ford Transit van (minibus), its luggage trailer, the MAN tractor unit or the SD semi-trailer that could have led to a loss of control of the vehicle or trailers or increased the severity of the collision. The mechanical conditions of the vehicles and trailers were not contributory factors in the collision.

167. The Crown advanced a number of possibilities for why Mr Gordon was seen by Mr Gallacher to be lying across the passenger seats of the van (minibus) prior to impact. The possibilities put forward by the Procurator Fiscal Depute were not necessarily exhaustive and were in any event speculative, there being no evidence led before the Inquiry supportive of one possibility to the exclusion of any others. As Counsel for the DVLA expressed it, "there is no evidence to suggest on the balance of probabilities a probable cause can be identified". The views expressed by Dr Julie Bell in her Affidavit that she "can't exclude the possibility that Mr Gordon's underlying natural disease led to the accident" do not amount to evidence that it was a medical episode that caused Mr Gordon to lose control of the Ford Transit van leading to the collision. I agree with the views expressed by Counsel for Drs Taylor and Somerville and the solicitor for the Greater Glasgow Health Board that there is no evidence that Mr Gordon suffered an episode of sleep apnoea or some other event associated with hypertension. I therefore conclude that the reason or reasons why Mr Gordon drove at excessive speed and lost control of the Ford Transit van cannot be established.

Determination in terms of Section 6(1)(c) – the reasonable precautions, if any, whereby the death and any accident resulting in the death might have been avoided

168. I agree with the view expressed by Sheriff James Kenneth Mitchell in his Determination into the death of James Lochrie [2015 FAI 28] at paragraph 173 where he states that *“section 6(1)(c) of the 1976 Act involved an exercise of retrospective consideration of matters with the benefit of hindsight on the basis of acceptable evidence before the Inquiry”*. A reasonable precaution, identified with that benefit of hindsight, need not have been foreseeable as necessary at the time. I do not require to be satisfied that the precaution would in fact have avoided the accident or death, only that it might have done. As the author states in Carmichael, Sudden Deaths and Fatal Accident Inquiries Third Edition at paragraph 5.75 *“what is envisaged is not a “probability” but “a real or lively possibility” that the death might have been avoided by the reasonable precaution”*.
169. It follows from the wording of the subsection that as well as being satisfied that the precaution might have prevented the death or accident I must be satisfied the precaution was reasonable. In assessing the issue of reasonableness I respectfully adopt with approval the words of Sheriff Principal Lockhart in his Determination in the Fatal Accident Inquiry into the deaths occurring at the Rosepark Care Home in Uddingston dated 20 April 2011 where in paragraph 8 he states *“the question of reasonableness is directed to the precaution which is identified. The issue is not whether an individual or an organisation behaved in a reasonable or unreasonable way, but whether or not there is a precaution which is a reasonable one and which might have made a difference”*.

170. I also concur with the approach of Sheriff Fiona L Reith in her Determination into the death of Sharman Weir dated 23 January 2003 wherein she opined:

“It is for the Sheriff to identify the reasonable precautions, if any, whereby the deaths might have been avoided. A Sheriff is required to proceed on the basis of the evidence adduced without regard to any question of the state of knowledge at the time of death. The statutory provisions are concerned with the existence of reasonable precautions at the time of death and are not concerned with where they could or should have been recognised. They do not relate to the question of foreseeability of risk at the time of death which would be a concept relevant to the context of our fault-finding exercise, which this is not... there is no question of the reasonableness of any precaution depending upon the foreseeability of risk. In my opinion, the reference to reasonableness relates to the question of availability and suitability or practicability of the precautions concerned... in my opinion, 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 reasonable precautions, if any, whereby the death might have been avoided.”

171. In considering the conduct of Drs Taylor and Somerville and those medical practitioners at the Sleep Clinic as regards their care, examination and treatment (if any) of Mr Gordon I have regard to the observations of Sheriff L Ruxton in her Determination into the death of Gordon Ewing, Glasgow Sheriff Court 2009 where she stated *“It seems to me that it cannot be said, as was suggested, that consideration of what is or is not reasonable in a “medical FAI” is any different from any other type of Inquiry. It is certainly no different from any*

other Inquiry in which the subject matter under consideration, as here, is of a complex technical nature. In this type of Inquiry, what is important is that the Sheriff understands what is involved and has the assistance of professional and expert witnesses to explain and interpret these complexities – [in the case of Mr Gordon – hypertension, obstructive sleep apnoea and obstructive sleep apnoea syndrome.] Individual actions are not to be judged in strict terms of the civil standard of the reasonably competent medical practitioner. But, fairness in principles of natural justice require that the Court looks at the whole facts and circumstances as they existed at the time and in considering whether a precaution was reasonable will often be informed and guided by the observations and opinions of skilled witnesses who inevitably will consider the issue in the light of accepted professional practices and procedures. The Court can take these matters into consideration while still applying the wisdom of hindsight in determining whether a particular precaution was reasonable: “the two concepts are not necessarily incompatible”.

172. In a previous Inquiry into the death of John Willock [2013] FAI 15 I cited with approval the views of Sheriff Stephen (now Sheriff Principal of Lothian and Borders) in her Determination in an Inquiry into the death of Lynsey Miles dated 27 February 2004 as follows:-

“Again lawyers should be slow to comment upon medical practice, far less criticise medical practice, unless there is clear appropriate testimony which challenged the treatment a patient receives. The view I take of this matter is that for precautions to be reasonable they have to be reasonable given the whole circumstances surrounding the patient and treatment of the patient with particular reference to the treating physician and if appropriate his junior medical staff. Before I can find a precaution to be reasonable in the context of a medical issue, there must either be an admission by the treating doctor that he failed to take a precaution or course of action which he clearly ought to have taken, or to the course of action which, in the exercise of ordinary care, ought not to have been taken. Failing that there would require to be established by independent evidence the manner in which the doctor in a particular area of expertise, and

with the particular experience, ought to have acted. This clearly requires there to be a standard by which the actions of doctors are judged. As I have said it is wrong for lawyers to be quick to criticise doctors without such justification..."

173. No such evidence was led by the Crown or any other party to this Inquiry. Having regard to the absence of any expert evidence commenting upon the actions of the various doctors there is no basis in the evidence to make any finding under this subsection which is, to any extent, critical of their actions. The evidence that was heard by the Inquiry was in particular complimentary of Drs Taylor and Somerville. As Counsel correctly pointed out Dr Somerville was not Mr Gordon's general practitioner and did not have access to his medical notes. Regulation 10(5) of The Motor Vehicles (Driving Licences) Regulations 1999 (SI 1999/2864) (which I have reproduced in part B of Appendix 1) makes it clear that a D4 examination can be undertaken by a qualified medical practitioner (not necessarily the licence applicant's general practitioner). Dr Parry was complimentary of Dr Somerville's examination and assessment observing that the detail set out by her was "rarely seen, a counsel of perfection".

174. The Procurator Fiscal Depute sought a finding in terms of section 6(1)(c). Counsel for Dr Taylor and Somerville and the DVLA made certain submissions and observations which were of assistance. I have considered the competing submissions advanced. This subsection involves an exercise of retrospective consideration of matters with the benefit of hindsight on the basis of the acceptable evidence before the Inquiry. There has to be a real and lively possibility that the accident resulting in the death might have been avoided by the reasonable precautions.

175. The first two findings are made upon the evidence of the eye witnesses to the tragedy (apart from the evidence of Mr Newlands that the Ford Transit van had come round the wrong side of the roundabout in which he is mistaken), the evidence of PC Scott Simpson, incorporating his very helpful detailed collision investigation report and the evidence as set out in the Joint Minutes of Agreement. I find that the death of Mr Douglas Brian Gordon might have been avoided if he had not driven the Ford Transit van through the roundabout at the junction with White Cart Road, Paisley at excessive speed and lost control of the vehicle. Further whilst driving the Ford Transit van in a westerly direction the death of Mr Douglas Brian Gordon might have been avoided if he had not entered the eastbound carriage way of Sanderling Road, Paisley as he exited the roundabout whereby the Ford Transit van collided with the LGV being driven in the opposite direction by Mr Denis Gallacher.
176. There were no reasonable precautions which could have been taken by Saints Transport Limited or their driver Mr Denis Gallacher which might have avoided the tragic accident.
177. There were no reasonable precautions which could have been taken by Drs Taylor or Somerville, Dr J Dawson, Dr C Carlin, Dr S Banham and Mr D Macfarlane which might have avoided Mr Gordon's death or the accident resulting in his death. There was no medical or scientific evidence before the Inquiry to establish that Mr Gordon suffered from a medical event which may have contributed to the road traffic accident. In the

absence of such evidence I concur with the views expressed by Counsel for Drs Taylor and Somerville and the solicitor for the Greater Glasgow Health Board that in the absence of any criticism of the medical care proffered to and received by Mr Gordon I can make no findings relative to any reasonable [medical] precautions whereby the death of the accident resulting in Mr Gordon's death might have been avoided.

178. The third finding is made upon a consideration of the evidence of Dr Taylor, Dr Somerville and in particular Dr Parry, the senior medical advisor to the DVLA and Ms. Carol Tamplin, the senior administrator who actually dealt with Mr Gordon's application. Mr Gordon having answered question 2 in section 4G blood pressure of the D4 Medical Examination Report in the affirmative confirming that he was on anti-hypertensive treatment, the three previous (blood pressure) readings with dates could not be given as Dr Somerville did not have access to Mr Gordon's medical records. As the Report form specifies that these readings are to be provided "if available", Dr Somerville recorded that they were not available, adding in free text in section 6 that the Report was "completed without access to medical notes".

179. Dr Parry stated in evidence that if the DVLA had known of Mr Gordon's last three blood pressure readings from his GP records namely 170/90 (24/10/13); 190/90 (17/7/12) and 191/108 (18/3/12) the DVLA "*would be unable to recommend a licence on the basis of hypertension*". In cross-examination by Counsel for Drs Taylor and Somerville, Dr Parry was referred to Crown Production No. 38, the chronology of Mr Gordon's blood pressure readings over a 4 year period from 2009 to 2013. Of the 19 blood pressure

readings, 16 disclosed a systolic reading of 180 or above and/or a diastolic reading of 100 or above. Having seen these readings Dr Parry agreed that had the DVLA been in possession of same Mr Gordon's application for a vocational (Group 2) licence would have been rejected.

180. Ms. Carol Tamplin testified that further enquiry would be undertaken by the DVLA had they had sight of the last three blood pressure readings from Mr Gordon's general practitioner's records. She informed the Inquiry that if the blood pressure reading provided on the day of the examination had been above the standard 180/100 and had she had access to the last three GP readings (2 of which were more than 3 months old) she would have sought further information from Mr Gordon's general practitioner asking him to re-check Mr Gordon's blood pressure and provide three further readings.
181. I do not require to be satisfied that the precaution would in fact have avoided Mr Gordon's accident or death, only that it might have done so (my emphasis). Having been appraised that he was on anti-hypertensive treatment, the precaution of following up the enquiry in section 4G Blood Pressure of the D4 Medical Examination Report by seeking Mr Gordon's 3 previous blood pressure readings "might have made a difference" (per Sheriff Principal Lockhart in the Rosepark Care Home Inquiry). I cannot be satisfied that it would in fact have avoided Mr Gordon's accident or death as the reason or reasons why he drove at excessive speed and lost control of the Ford Transit van cannot be established. The 3 previous blood pressure readings were however readily available from Mr Gordon's GP had he been asked by The Secretary of State for Transport's

Medical Advisor to produce same, authority therefor having been given by Mr Gordon when he signed section 12 - Consent & Declaration - of the D4 Medical Examination Report. Had a request been made to Dr Taylor for sight of Mr Gordon's general practitioner records relative to his anti-hypertensive treatment and blood pressure readings, while Dr Taylor may have supplied the entire chronology of Mr Gordon's blood pressure readings as listed in Crown Production No. 38, he would certainly have advised the DVLA of the last three blood pressure readings he had recorded for Mr Gordon. Had he done so I am satisfied on the evidence I heard that the DVLA would not have issued Mr Gordon with a Group 2 licence on 23 December 2013. Following Ms Tamplin's evidence it is likely that Mr Gordon's general practitioner would have been asked to obtain and submit to the DVLA 3 further blood pressure readings for Mr Gordon. While the import of such further readings cannot of course be known there is in my judgement a real or lively possibility that the DVLA might not have issued Mr Gordon with a Group 2 licence. Subject to his right to appeal against the decision to refuse the application Mr Gordon would not have been able to reapply for a Group 2 licence for 12 months. That being the case, as the PF depute submitted, Mr Gordon would not have possessed a Group 2 licence in June, 2014, would not have been in a position to apply for the position with Airlink Management Limited as a Group 2 driver in that month and would not therefore have been driving the Ford Transit van in Sanderling Road, Paisley on 2 July, 2014. In these circumstances his death might thereby have been avoided.

Determination in terms of Section 6(1)(d) – the defects, if any, in any system of working which contributed to the death or any accident resulting in the death

182. This subsection differs from that immediately preceding it. To make a finding under this subsection there must be a “causal link” to show that any defect in any system of working actually contributed to Mr Gordon’s death or any accident resulting in his death. No such evidence was led before the Inquiry. All parties, correctly in my view, made no submissions that I should make a finding in respect of this subsection. I have not done so.

Determination in terms of Section 6(1)(e): any other facts which are relevant to the circumstances of the death

183. Although apparently wide in its scope any facts which I find established, on the balance of probabilities, under this subsection must be relevant to the circumstances of Mr Gordon’s death as they may affect the public interest. The “causal connection” required under the preceding subsection is absent from section 6(1)(e).
184. I agree with the views expressed by Sheriff W Holligan in his Determination in relation to the death of John Kelly dated March 2004 where he opined: *“The provisions of section 6(1)(e) are still wider, and in my view, entitle and indeed oblige the court to comment upon and where appropriate make recommendations in relation to any matter which has been legitimately*

examined in the course of the Inquiry as a circumstance surrounding the death if it appears to be in the public interest to make such comment or recommendation."

185. I have carefully considered the submissions for the Crown and the other parties to the Inquiry. I have considered all the competing submissions. I am satisfied that the facts I have found as relevant to the circumstances of Mr Gordon's death reflect many of the submissions advanced.

186. The first four findings are made upon the evidence of Ms. R. Carr, Airlink Management Limited's former operations manager which I accepted. As well as explaining to the Inquiry her methodology when engaging drivers in June/July 2014, she asserted that she placed reliance upon the fact that the DVLA had given Mr Gordon a licence as recently as December 2013. She viewed that as an "assurance" of his fitness to drive. I find this stance to be reasonable and appropriate. As Counsel for Drs Taylor and Somerville said during the oral hearing on submissions *"there is a public system for licencing drivers. If an employer is not entitled to rely upon the public body responsible for licensing drivers then why have one?... [before someone is given] a vocational licence there has to be a medical examination and medical assessment"*.

187. The Procurator Fiscal Depute did not invite me to make any recommendation flowing from her observations as to what she categorised as Airlink Management Limited's lack of scrutiny of driver interviewees' state of health. The evidence from Ms. Carr disclosed that the company's practice has changed since May 2015. References are now sought and

drivers are engaged subject to the receipt of satisfactory references. The Inquiry heard no evidence as to what is required in the references sought. Like Sheriff (now Lord) John Beckett QC in his recent Determination 2015 [FAI] 31 at Paragraph 424 I consider there is nothing to be lost and perhaps something to be gained by asking that a referee disclose information of which he or she is aware which would affect the applicant's fitness to drive. I agree however with Counsel for the company's oral submissions that it would not be reasonable to require each and every applicant for each and every job to produce a medical report. As he put it "commerce would grind to a halt if every [potential] employee had to produce a medical report".

188. Such a request would in any event raise a number of issues. Issues of confidentiality would inevitably arise together with possible data protection issues around storage of any such reports. Consideration would require to be given to the issue of duty of care. To whom would the author of any such medical report owe a duty – his/her patient and/or the potential employer? A request for a medical report to support an application for a job may well impinge upon the doctor/patient relationship. Such issues, while highlighted in the submissions I heard, were not the subject of evidence led. Consequently other than observing that a number of such issues would require to be considered and potentially a number of bodies consulted I make no further observations or recommendations.
189. The fifth and sixth findings are based on the facts proved in paragraphs 23 to 25 of the Joint Minute of Agreement, reproduced in Appendix 2.

190. The seventh to twelfth findings, which can be taken together as a whole, are not contentious in themselves setting out as they do the relevant provisions of the DVLA “At a Glance” guide to the current medical standards of fitness to drive for medical practitioners and the DVLA’s operational instructions regarding section 4G blood pressure of the D4 medical examination report which requires to be submitted together with an application for a vocational (Group 2) licence.
191. The thirteenth finding is made upon an analysis of the evidence led and the competing submissions made to the Inquiry. While the DVLA’s “At a Glance” guidance, in use in November 2013 and the guidance in use as from 11 March, 2016 state that the holders of a Group 2 licence will be disqualified where “resting blood pressure is consistently 180mm Hg systolic or more and/or 100mm Hg diastolic or more, the DVLA’s operating instructions for blood pressure indicate that decisions to (re) issue or not to (re) issue a Group 2 licence can be made on the basis on one blood pressure reading alone.
192. The DVLA’s operating instructions appear to be “at odds” with the rationale requiring the applicant to produce (if available) three previous blood pressure readings in the event of him being on anti-hypertensive treatment. No evidence was led before the Inquiry to explain how the rationale for the question in section 4G of the D4 medical examination report calling, after an affirmative answer, for three blood pressure readings is answered by a single reading on the day of the examination.

193. Dr Parry said that the object of providing three previous blood pressure readings for the D4 medical assessment where the applicant, such as Mr Gordon, is on anti-hypertensive treatment, is to ascertain whether the applicant's blood pressure is controlled. As Dr Parry said in examination in chief the DVLA preferred a series of readings "because blood pressure varies minute by minute". I agree with the Crown's submission that it is not possible to ascertain whether the blood pressure of an applicant is "controlled" on the basis of one blood pressure reading alone.
194. Dr Parry also accepted in cross-examination that the DVLA's approach of "erring on the side of caution" was not readily reconciled with not taking the highest reading recorded on the D4 medical examination report, or not taking an average, or even relying upon the reference to "white coat hypertension" in the free text in section 6 (being information supplied by the applicant to the registered medical practitioner without verification). His explanations that the DVLA's operational instructions were simply followed in my mind confirmed the lack of uniformity in the Agency's approach.
195. The fourteenth finding is made upon my consideration of the evidence led before the Inquiry, in particular the evidence of Drs Taylor, Dawson and Parry. Dr Taylor considered that at least three blood pressure readings would require to be taken in order to ascertain whether the patient's blood pressure "consistently" exceeded the standard. Dr Dawson was of the view that "consistently" in this context meant that at least two measurements should be taken over a period of a month or more. Dr Dawson also

informed the Inquiry that where the measurement taken is severe the next measurement should be checked in a week. He said that when measurements are taken in the blood pressure clinic the first reading was discarded and the second and third readings recorded. Dr Parry expressed it differently stating that “consistently” meant more than one reading being taken. He said, however, that the Secretary of State for Transport’s Honorary Medical Advisory Panel on Cardiology (being the Panel on driving and disorders of the cardiovascular system) had not specified over what period of time the readings should be taken.

196. The fifteenth finding is based upon consideration of the terms of the DVLA’s booklet INF4D entitled Medical Examination Report For a Group 2 (Lorry or Bus) Licence D4 which is for applicants and medical professionals alike. In each of the additions of the said booklet applicable as at November, 2013 (Crown Production No. 31) and now current (as from November, 2015, Crown Production No. 42) it provides that an applicant “is likely to be refused a Group 2 licence if they cannot meet the recommended medical guidelines for inter alia “hypertension where the blood pressure is persistently (my emphasis) 180 systolic or more and/or 100 diastolic or more.” It is not clear to me and Dr Parry was unable to explain when giving evidence to the Inquiry why the word “persistently” has been used in this booklet while the phrase “resting consistently” continues to appear in the DVLA’s guidance. “Assessing fitness to drive: a guide for medical professionals.” (Crown Production No. 52 being a copy extract hereof). The guidance is intended to assist doctors and other health professionals in advising their patients:

- Whether or not the DVLA requires notification of a medical condition;
- What the licensing outcome for the DVLA's medical enquiries is likely to be

Dr Parry agreed that if the wording of the DVLA INF4D Booklet differs from that in the guidance (the latest version being that issued on 11 March 2016) there is potential for confusion. He "expected" the INF4D Booklet to "match" the "At a Glance" guidance where relevant. As I did not hear evidence from the Secretary of State for Transport's Honorary Medical Advisory Panel on Cardiovascular disease or from those responsible for the drafting of the documentation I am restricting my recommendation appropriately to provide that consideration be given by the Secretary of State for Transport's Honorary Medical Advisory Panel on driving and disorders of the cardiovascular system and the DVLA to instituting a review of the documentation.

197. The sixteenth finding is made in reliance upon the evidence of Dr Parry and Dr Lesley Anne Somerville.
198. The seventeenth finding is made in reliance upon the evidence of Dr Parry and Ms Carol Tamplin, who processed Mr Gordon's application for the vocational (Group 2) driving licence and is reflective of a submission made by Counsel for the DVLA.
199. I agree with Counsel that it has not been proved on the balance of probabilities that Mr Gordon did not meet the DVLA standards for fitness to drive as at the date of the accident. This is reflected in my eighteenth finding. No evidence was led as to Mr

Gordon's health on 2 July, 2014. There was no evidence that a medical episode contributed in any way to the tragedy. As I have found, the reason or reasons for Mr Gordon losing control of the Ford Transit van cannot be established.

200. The nineteenth finding is made on the basis on my analysis of the evidence of Dr Somerville, Dr Parry and Ms Tamplin and consideration of the parties' submissions, in particular those for the Crown. If, as Dr Somerville told the Inquiry, and I accept her evidence on this point, she enquired as per her practice of Mr Gordon about attendance at specialist clinics and any condition with which he had been diagnosed at said clinic it would appear that Mr Gordon for whatever reason, whether deliberately or through inadvertence, did not inform her of his attendance at the Sleep Clinic at Gartnavel General Hospital or of the assessment in October 2011 that he was suffering from mild but definite obstructive sleep apnoea or that he was in November, 2013 still a patient of the Sleep Clinic having been part of a CPAP programme, the equipment for which he had returned to the sleep clinic some months earlier in May 2013. Had he done so I am satisfied from the thoughtful manner in which Dr Somerville completed the D4 Medical Examination Report that she would have made mention of this information if not in answering question 7 in section 5 thereof (due to the absence of any reference to obstructive sleep apnoea as distinct from obstructive sleep apnoea syndrome) then in the free text in section 6 and given the details of the consultant if advised of same by Mr Gordon in section 7.

201. I accept the evidence from Ms Tamplin that had information been provided in the D4 medical examination report relative to Mr Gordon's attendance at a sleep clinic she may have discussed the issue with the Medical Advisor to the DVLA to ascertain what further information, if any, was required by the DVLA. As no such information was provided in the D4 Medical Examination Report Ms Tamplin was not prompted to make any such enquiry of a medical advisor.
202. Although the Procurator Fiscal Depute made a submission based upon Dr Banham's evidence, the Doctor was unable to advise the Inquiry when Mr Gordon would have developed obstructive sleep apnoea syndrome. All Dr Banham would say was that "He (Mr Gordon) was a lot closer to obstructive sleep apnoea syndrome than obstructive sleep apnoea" and that it was inevitable that at some stage (my emphasis) Mr Gordon would develop obstructive sleep apnoea syndrome if he did not lose many stones in weight. As to when that may occur would be speculation not founded upon any evidence led at the Inquiry.
203. Had the D4 Medical Examination Report been completed by Mr Gordon's own general practitioner, Dr Taylor, his evidence, which I accept, was that he would have inserted the three previous readings from his own GP records namely 170/190 (24/10/2013), 190/90 (19/07/2012) and 191/108 (19/03/2012). Had the DVLA been aware of these readings and of Mr Gordon's blood pressure history his licence application should, according to Dr Parry, have been refused. However both he and Ms Tamplin stated that applying the DVLA's operating instructions, if on the day of the examination a single blood pressure

reading was given below the threshold, then irrespective of any other readings Mr Gordon's application for a licence would fall to be granted. No "averaging" is applied nor is regard had to any further details in free text in section 6, the application is simply granted on the basis that a single reading falls below the threshold. I fail to see how a single reading satisfies the criteria of "resting consistently" the wording used in the At a Glance guidance in 2013 and in the guidance "assessing fitness to drive" published on 11 March 2016 or "persistently" the word adopted in the agency's INF4D booklet containing useful information for applicants and doctors on the D4 medical examination for a Group 2 licence.

204. The twentieth finding records the provisions of section 4g of the current version of the D4 Medical Examination Report, medical assessment spoken to by Dr Parry. Although he was of the opinion that from the DVLA's point of view the alterations to the terms which had been put in place since the time of Mr Gordon's examination in 2013 introduced clarity by being more prescriptive, there remains in my view the lack of clarity highlighted in my eleventh, twelfth and thirteenth findings. It is unclear how the "best" reading on the day of the examination can be said to be that "resting consistently" or "persistently". The request to provide three previous readings with dates (if available) if the licence applicant is on anti-hypertensive treatment still appears to me "at odds" with the operating instructions providing that if the day's best reading is above 180/100 the application will fall to be refused otherwise it will be granted, irrespective of the answer to the enquiry of whether or not the applicant is on anti-hypertensive treatment,

which appears per the current version of the operating instructions (Crown Production No.48) to be for information only.

205. The twenty-first finding is also based on the evidence of Dr Parry commenting upon changes to question 7 in section 5 General of the D4 Medical Examination Report introduced following advice from the Secretary of State's Honorary Medical Advisory Panel on Neurology. While the current version of the Report/assessment includes a request that questions about diagnosis, control treatment and period of control be answered for ALL sleep conditions it may be of assistance and clarify matters further if specific mention is made of obstructive sleep apnoea.
206. The Law does not permit the DVLA to make it explicit that only a licence applicant's general practitioner can complete the D4 Medical Examination Report. It remains the Law that the D4 Medical Examination Report/Assessment can be completed by any qualified medical practitioner. I highlight this as Dr Parry was quite clearly of the view that the detail now sought in question 7 of section 5 General of the D4 Medical Examination Report was such that he did "not think a doctor other than the individual's general practitioner would be able to complete this form". He expected a qualified medical practitioner, who was not the licence applicant's general practitioner, to be unable to answer the questions posed and to write "unable to answer" or to leave the section blank in which event Dr Parry told the Inquiry the DVLA would revert to the licence applicant's general practitioner for the information to answer the questions posed. Of concern however to me was that Dr Parry also told the Inquiry while it was

very unlikely that a doctor who is not the licence applicant's general practitioner will be able to complete question 7, if the qualified medical practitioner did indeed complete question 7 in section 5, in reliance presumably upon information supplied to him/her by the licence applicant himself/herself without verification, the DVLA would nevertheless accept the report. To remove the element of subjectivity Dr Parry agreed that question 7(b)(v) could be reworded to ask "can you as a registered medical practitioner confirm whether or not the applicant has complied with treatment?".

207. It seems to me in this modern age with technological advancement and most GP records now being held on computer that it may be possible to construct and implement a system whereby the registered medical practitioner carrying out the D4 Medical Examination Assessment, if not the licence applicant's general practitioner, can have "access" electronically to the licence applicant's general practitioner records at the time of completing the D4 Medical Examination Report. In absence of such access, as Counsel for Drs Taylor and Somerville highlighted, the evidence led before this Inquiry revealed (although the reason or reasons why Mr Gordon had the D4 Medical Examination Assessment undertaken by other than his GP have not been established) the possibility of a licence applicant choosing to have the D4 Medical Examination Assessment undertaken by other than his/her general practitioner in the hope that on the day of the assessment, whatever his/her blood pressure history, the reading taken by the registered practitioner (who does not have access to any medical notes) falls below the DVLA's threshold of 180/100 leading to the application for a licence being granted. I accept Counsel for the DVLA's submissions however that the Parliament has not yet provided

that the registered medical practitioner should have access to the licence applicant's medical records before finalising the D4 Medical Examination Report. To sanction input from the licence applicant's general practitioner or the provision of medical records would require legislative change. Such legislative change would have to be preceded by extensive consultation as to the necessity for any such requirement, its practicability and the difficulty of implementation, with relevant bodies including, for example, the General Medical Council, The British Medical Association and Patients' Organisations. On the basis of the limited evidence led before this Inquiry and the submissions made it is inappropriate for me to make any recommendations. The Inquiry did not hear sufficient evidence. No options were canvassed in any detail. Undoubtedly resources and the respect for privacy would require to be balanced against the general public interest in road safety. That exercise is for Parliament.

208. In his Determination (2015 [FAI] 28), to which I have already referred, Sheriff James Kenneth Mitchell recommended that consideration be given by the Secretary of State for Transport as to whether legislative changes should be implemented of which his recommendations number 1 to 3 might be a potential means of addressing vulnerability to incomplete disclosures by licence applicants for whatever reason. I heard no submission on any such suggestion which was not canvassed before me. I refrain from commenting further other than to say these are options for consideration by the Department of Transport and Parliament.

Concluding remarks

209. I echo the comments of Sheriff (now Lord) John Beckett QC in his Determination in the Fatal Accident Inquiry into what has become known as the Glasgow Bin Lorry Inquiry reported [2015] FAI 31 at paragraph 562 where he highlights raising the awareness of dangers involved in driving if subject to a medical condition which could cause the driver to lose control of a vehicle. While the reason or reasons why Mr Gordon lost control of the Ford Transit van cannot be established I heard sufficient evidence at this Inquiry to entitle me to also stress the dangers involved in driving if subject to a medical condition which could cause the driver to lose control of a vehicle.
210. Guidance, including a list of relevant conditions, can be found on the DVLA website: www.gov.uk/driving-medical-conditions. Drivers can contact DVLA if they are not sure what to do. They can consult their doctor if they are in doubt or if they are in need of advice. I have set out in Appendix 10 the list of medical conditions for which there is advice on the DVLA website as to the implications for driving and notification. These include hypertension and obstructive sleep apnoea.
211. Finally, I reiterate my personal expressions of sympathy to the family and friends of Mr Douglas Brian Gordon and offer the condolences of everyone involved with this Inquiry.

APPENDIX 1 – CERTAIN LEGISLATION RELEVANT TO DVLA

A. The Road Traffic Act 1988 includes the following provisions

92. Requirements as to physical fitness of drivers.

(1) An application for the grant of a licence must include a declaration by the applicant, in such form as the Secretary of State may require, stating whether he is suffering or has at any time (or, if a period is prescribed for the purposes of this subsection, has during that period) suffered from any relevant disability or any prospective disability.

(2) In this Part of the Act

“disability” includes disease and the persistent misuse of drugs or alcohol, whether or not such misuse amounts to dependency,

“relevant disability” in relation to any person means –

(a) any prescribed disability, and

(b) any other disability likely to cause the driving of a vehicle by him in pursuance of a licence to be a source of danger to the public, and

“prospective disability” in relation to any person means any other disability which –

(a) at the time of the application for the grant of a licence or, as the case may be, the material time for the purposes of the provision in which the expression is used, is not of such a kind that it is a relevant disability, but

(b) by virtue of the intermittent or progressive nature of the disability or otherwise, may become a relevant disability in course of time.

- (3) If it appears from the applicant's declaration, or if on inquiry the Secretary of State is satisfied from other information, that the applicant is suffering from a relevant disability, the Secretary of State must, subject to the following provisions of this section, refuse to grant the licence...."

94. Provision of information, etc. relating to disabilities

- (1) If at any time during the period for which his licence remains in force, a licence holder becomes aware –
- (a) that he is suffering from a relevant or prospective disability which he has not previously disclosed to the Secretary of State, or
 - (b) that a relevant or prospective disability from which he has at any time suffered (and which has been previously so disclosed) has become more acute since the licence was granted,
- the licence holder must forthwith notify the Secretary of State in writing of the nature and extent of his disability.
- (2) The licence holder is not required to notify the Secretary of State under subsection (1) above if
- (a) the disability is one from which he has not previously suffered, and
 - (b) he has reasonable grounds for believing that the duration of the disability will not extend beyond the period of three months beginning with the date on which he first becomes aware that he *suffers* from it.
- (3) A person who fails without reasonable excuse to notify the Secretary of State as required by subsection (1) above is guilty of an offence.

- (3A) A person who holds a licence authorising him to drive a motor vehicle of any class and who drives a motor vehicle of that class on a road is guilty of an offence if at any earlier time while the licence was in force he was required by subsection (1) above to notify the Secretary of State but has failed without reasonable excuse to do so.
- (4) If the prescribed circumstances obtain in relation to a person who is an applicant for, or the holder of, a licence or if the Secretary of State has reasonable grounds for believing that a person who is an applicant for, or the holder of, a licence may be suffering from a relevant or prospective disability, subsection (5) below applies for the purpose of enabling the Secretary of State to satisfy himself whether or not that person may be suffering from that or any other relevant or prospective disability.
- (5) The Secretary of State may by notice in writing served on the applicant or holder –
- (a) require him to provide the Secretary of State, within such reasonable time as may be specified in the notice with such an authorisation as is mentioned in subsection (6) below, or
 - (b) require him, as soon as practicable, to arrange to submit himself for examination –
 - (i) by such registered medical practitioners as may be nominated by the Secretary of State, or
 - (ii) with respect to a disability of a prescribed description, by such officer of the Secretary of State as may be so nominated,
 for the purpose of determining whether or not he suffers or has at any time suffered from a relevant or prospective disability, or

- (c) except where the application is for, or the licence held is, a provisional licence, require him to submit himself for such a test of competence to drive as the Secretary of State directs in the notice.
- (6) The authorisation referred to in subsection (5)(a) above –
 - (a) shall be in such form and contain such particulars as may be specified in the notice by which it is required to be provided, and
 - (b) shall authorise any registered medical practitioner who may at any time have given medical advice or attention to the applicant or licence holder concerned to release to the Secretary of State any information which he may have, or which may be available to him, with respect to the question whether, and if so to what extent, the applicant or licence holder concerned may be suffering, or may at any time have suffered, from a relevant or prospective disability.”

99. Duration of licences

- (1A) In so far as a licence authorises its holder to drive any prescribed class of goods vehicle or passenger-carrying vehicle, it shall, unless previously revoked, suspended or surrendered, remain in force –
 - (a) except in a case falling within paragraph (c) or (d) of this subsection –
 - (i) for the period ending on the forty-fifth anniversary of the applicant’s date of birth or for a period of five years, whichever is the longer, or
 - (ii) where the applicant’s age at the date on which the licence is to come into force will exceed forty-five but not sixty-five years, for the period ending on

the sixty-sixth anniversary of the applicant's date of birth or for a period of five years, whichever is the shorter,

(b) except in a case falling within paragraph (d) of this subsection, if the Secretary of State so determines in the case of a licence to be granted to a person appearing to him to be suffering from a relevant or prospective disability, for such period of not more than three years and not less than one year as the Secretary of State may determine...

... and any such period shall begin with the date on which the licence in question is expressed to come into force."

108. Interpretation

(1) In this Part of this Act ...

..."prescribed" means prescribed by regulations...

B. The Motor Vehicles (Driving Licences) Regulations 1999 (SI 1999/2864) provide *inter alia*

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10. Applications for the grant of licences: general

(5) An applicant for a Group 2 licence shall, if required to do so by the Secretary of State, submit in support of his application a report (in such form as the Secretary of State may require) signed by a qualified medical practitioner, prepared and dated not more than four months prior to the date on which the licence is to take effect, for the purpose of satisfying the Secretary of State that he is not suffering from a relevant or prospective disability."

APPENDIX 2 – JOINT MINUTE OF AGREEMENT

The following facts were proved in a Joint Minute of Agreement lodged on 8 February 2016

videlicet:-

1. That Douglas Brian Gordon, born 24 May 1956, was a driver by occupation at the time of his death.
2. That in terms of section 1(1)(a)(i) of the Fatal Accidents and Sudden Deaths Inquiry (Scotland) Act 1976, Douglas Brian Gordon was engaged in his occupation, being employed as a PCV driver by Airlink Management Limited at the date and time of his death.
3. That at the time of his death, Douglas Brian Gordon held a valid driver's licence, with current entitlements to drive vehicles under categories A, AM, B, BE, B1, C, CE, C1, C1E, D, DE, D1, D1E, F, K, L, N, P and Q.
4. That Douglas Brian Gordon commenced employment with Airline Management Limited on 30 June 2014. His job was to convey passengers and their luggage between the Park and Fly car park operated by Airlink Management Limited at McDowell Street, Paisley, and Glasgow Airport.
5. That at the time of the collision on 2 July 2014, Douglas Brian Gordon was driving a white Ford transit sixteen passenger seater public service vehicle bearing vehicle registration mark SJ13JYU, which was towing a 750kg luggage trailer bearing identification number 070611. That this vehicle is a category D vehicle and that Douglas Brian Gordon's licence entitled him to drive said vehicle until 23 December 2018, at which time the licence would require to have been renewed.

6. That no passengers were being transported in the aforementioned vehicle being driven by Douglas Brian Gordon at the time of the incident.
7. That the said Douglas Brian Gordon is hereinafter referred to as “the deceased.”
8. That on 2 July 2014 at around 11.30am, paramedic William Fleming and Ambulance Care Assistant Desmond Donnelly were on duty and responded to a call to attend a road traffic collision at Sanderling Road, Paisley. Upon arrival, William Fleming examined the deceased. The initial examination revealed a head injury, possible chest injury and lower limb crush injury. The deceased was trapped in the minibus he had been driving. He was conscious and feeling short of breath. William Fleming applied a cervical collar, gave the deceased oxygen and carried out basic observations.
9. That a short time later, the police, fire service and Emergency Retrieval Medical Service (hereinafter referred to as “ERMS”) arrived at the scene. ERMS doctors Catheryn Bennett and Neil Dignon attended along with critical care nurse Graham Percival.
10. That at around 12.24pm, the deceased was extracted from the vehicle by the fire service personnel and ambulance personnel. During the extraction process the deceased’s condition deteriorated.
11. That Dr Catheryn Bennett, anaesthetic registrar, performed emergency anaesthesia bilateral thoracotomies, traumatic cardiac arrest protocol and gave the deceased three units of blood. The deceased was also administered an intravenous painkiller.

12. That the deceased was thereafter conveyed by ambulance to the Accident and Emergency Department at the Southern General Hospital, Glasgow, utilising a police escort to facilitate the transfer.
13. That upon arrival at the Southern General Hospital, the deceased was in cardiac arrest. He was given three further units of blood and 1mg of adrenalin. After consultation between Dr Nicola Littlewood, Accident and Emergency Consultant, and Dr Wotherspoon, Surgical Consultant, it was agreed that surgical intervention was likely to be futile.
14. That Douglas Brian Gordon was pronounced dead on 2 July 2014 at 1.15pm at the Southern General Hospital, Govan Road, Glasgow, by Dr Nicola Littlewood.
15. That on 9 July 2014, a post mortem examination was carried out on the deceased by Dr Julia Bell, Forensic Pathologist. The cause of death was found to be 1a) Chest injury due to 1b) Road traffic accident (minibus driver). Crown Production number 2 comprises the Post Mortem Report dated 7 August 2014.
16. That Dr Julia Bell, Forensic Pathologist, concluded in the post mortem examination that the deceased "had sustained severe injuries, in keeping with him having been involved in a road traffic accident... Externally, there were various bruises and abrasions on the face, trunk and limbs in addition to a deep laceration on the right knee and a few small lacerations on the face. Deep to this, in the chest, there were multiple fractures or nearly all of the ribs on the right side associated with significant haemorrhage into the right chest cavity and multiple lacerations of the right lung, and there were also a few rib fractures on the left. There were also fractures of the thoracic vertebrae and sternum. In terms of other injuries, there were fractures of the

front and back of the pelvis associated with a moderate amount of haemorrhage but there were no significant injuries elsewhere... [I]n terms of natural disease, the heart was enlarged and concentric left ventricular hypertrophy, in keeping with the history of hypertension, and there was also moderate atheromatous narrowing of two of the main coronary arteries. Whilst the chest injuries were considered the main factor in his death, the possibility that underlying natural disease has played a part in the road traffic accident and/or contributed to his death cannot be excluded."

17. That Crown Production number 3 is the Toxicology Report for the deceased, dated 30 July 2014. That the Toxicology Report confirms that the blood and urine analysis was negative for alcohol, paracetamol, opiates and drugs of abuse. Blood tests were positive for therapeutic levels of ketamine which was administered in hospital post-accident.
18. That Crown Production number 1 is the Register of Births, Deaths and Marriages intimation of death form stating that the deceased, Douglas Brian Gordon, died on 2 July 2014 at 1.15pm at the Southern General Hospital, Glasgow and that the cause of death was 1a) Chest injury, due to 1b) Road traffic accident (minibus driver).
19. That at approximately 3.05pm on 2 July 2014, Edward Brown, Crime Scene Examiner attended at Sanderling Road, Glasgow Airport, Paisley and took photographs of the locus. These said photographs are contained within Crown Production numbers 9 and 10. Said photographs are as follows:

Crown Production number 10:

Photographs 1 – 14	Views of collision between a white Ford minibus SJ13 JYU travelling west along Sanderling Road at Glasgow Airport and white MAN lorry T40STS travelling east along Sanderling Road.
Photographs 15 – 20	Close up views as directed by Collision Investigator.
Photographs 23 – 26	Close up views as directed by Collision Investigator.
Photographs 29 – 30	Close up views as directed by Collision Investigator.
Crown Production number 9:	
Photographs 31 – 33	View of driver's seat belt in the minibus.
Photograph 34	View east towards the roundabout at Sanderling Road.
Photographs 35 – 37	View of roundabout with Sanderling Road running left to right.
Photograph 38	View from the roundabout with Sanderling Road ahead.
Photograph 39	View from Sanderling Road heading west through roundabout.

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| Photograph 40 | View from Sanderling Road towards roundabout with White Cart Road to right. |
| Photograph 41 | View from Sanderling Road heading west through roundabout. |
| Photograph 42 | View from Sanderling Road heading east through roundabout. |
| Photograph 43 | View from Sanderling Road heading west through roundabout. |
| Photographs 44 – 45 | View from roundabout towards White Cart Road. |
| Photograph 46 | View of chalk marks on road to rear nearside of MAN lorry. |
| Photographs 47 – 48 | Views from Driver's cab of MAN lorry. |
| Photographs 49 - 50 | Views of front offside wheel of minibus. |
20. That Crown Production number 20 comprises three photographs of the locus of the collision taken by eye witness Malcolm Newlands with his mobile phone immediately after the collision.
 21. That Denis Gallacher confirmed to Police Constable Brian McNab in the presence of Police Constable Lawson, in terms of s172 Road Traffic Act at 1215 hours on 2 July 2014 that he was the driver of the heavy goods vehicle registration number T40 STS at the time of the accident.
 22. That Denis Gallacher, driver of heavy goods vehicle bearing vehicle registration mark T40 STS, gave Police Constable Brian McNab a roadside specimen of breath in terms of

s6 Road Traffic Act 1988 at around 1215 hours on 2 July 2014. He tested negative for alcohol.

23. That on 7 July 2014, George Scott McIntyre, Vehicle Examiner with the Vehicle and Operator Services Agency, at Karen Yuill Recovery Ltd., Blantyre Industrial Estate, Blantyre, conducted an examination of a white Ford transit sixteen passenger seater public service vehicle bearing vehicle registration mark SJ13JYU, which was towing a 750kg luggage trailer bearing identification number 070611, driven by the deceased. At the time of the inspection, there were no pre collision defects noted that could have led to a loss of control of the vehicle or trailer or increased the severity of the collision. The mechanical condition of the vehicle and trailer were not contributory factors in the collision.
24. That on 8 July 2014, George Scott McIntyre, Vehicle Examiner with the Vehicle and Operator Services Agency, at Karen Yuill Recovery Ltd., Blantyre Industrial Estate, Blantyre, conducted an examination of a white MAN TGX26:440 HGV tractor unit bearing vehicle registration mark T40STS, driven by Denis Gallacher. At the time of the inspection, there were no pre collision defects noted that could have led to a loss of control of the vehicle or increased the severity of the collision. The mechanical condition of the vehicle was not a contributory factor in the collision.
25. That on 7 July 2014, George Scott McIntyre, Vehicle Examiner with the Vehicle and Operator Services Agency, at Karen Yuill Recovery Ltd., Blantyre Industrial Estate, Blantyre, conducted an examination of an SD semi-trailer bearing identification number C068435, attached to the aforesaid tractor being driven by Denis Gallacher. At the time of the inspection, there were no pre collision defects noted that could have led to a loss

of control of the trailer or increased the severity of the collision. The mechanical condition of the trailer was not a contributory factor in the collision.

26. That in respect of the deceased, all copies of medical records and DVLA records and documentation lodged as Crown productions are accepted as principals.

APPENDIX 3 – PROVENANCE OF CROWN PRODUCTIONS

The following facts were proved in the Second Joint Minute of Agreement lodged on 8

February 2016 *videlicet*:

1. That Crown Production No 4 is the Police Scotland Collision Investigation Report in respect of the death of Douglas Brian Gordon, prepared by Police Constable Scott Simpson and corroborated by Police Constable Ewan Thomson.
2. That Crown Production No 5 is a true and accurate copy of the Scale Plan Drawing produced by Police Scotland of the locus of the incident resulting in the death of Douglas Brian Gordon.
3. That Crown Production No 6 is a true and accurate copy of Southern General Hospital records relating to the deceased's admission on 2 July 2014.
4. That Crown Production No 7 is a true and accurate copy of the Emergency Medical Retrieval Service (hereinafter "EMRS") records relating to the deceased's treatment by EMRS on 2 July 2014.
5. That Crown Production No 8 is a true and accurate copy of the contract of employment of the deceased, as issued by Airlink Management Ltd and signed by the deceased and Rhianna Carr, Operations Manager for Airlink Management Ltd on 30 June 2014.
6. That Crown Production No 11 is a true and accurate copy of the GP records of the deceased, numbered for convenience.
7. That Crown Production No 12 is a true and accurate copy of the Sleep Clinic records of the deceased, numbered for convenience.

8. That Crown Production No 13 is a true and accurate copy of the Blood Pressure Clinic records of the deceased, numbered for convenience.
9. That Crown Production No 14 comprises a true and accurate copy of a Patient Episode Search obtained by the Medical Records Department, Gartnavel General Hospital, on 24 September 2015 and a true and accurate copy of the Patient Activity Record of the deceased obtained by Duncan MacFarlane, physiologist, on 17 December 2015, downloaded from the NHS Greater Glasgow and Clyde Health Board database.
10. That Crown Production No 15 is a true and accurate copy of DVLA issued current substantive driving entitlement information in relation to the deceased, as at the date of his death.
11. That Crown Production No 16 is a true and accurate copy of a form D2 renewal application form for a lorry, bus or minibus driving licence in the name of the deceased, dated 22 November 2013 and signed by the deceased, a counterpart driving licence dated 7 April 2012 in the name of the deceased and a D4 medical examination form in the name of the deceased, dated 22 November 2013 and signed by the deceased, said examination having been carried out by Dr Lesley Anne Somerville.
12. That Crown Production No 17 is a true and accurate copy of a form D2 renewal application form for a lorry, bus or minibus driving licence in the name of the deceased, dated 11 March 2003 and signed by the deceased, and a D4 medical examination form in the same of the deceased, dated 11 March 2003 and signed by the deceased, said examination having been carried out by Dr Weir, Dumbarton Road, Glasgow.
13. That Crown Production No 18 is a true and accurate copy of Airlink Management Ltd's Staff handbook, dated November 2013. This edition was the current edition available to

employees when the deceased commenced employment with Airlink Management Ltd on 30 June 2014.

14. That Crown Production No 21 is a true and accurate copy of a Sleep Consultation form in the name of the deceased. This form was completed by physiologists at the Sleep Clinic being attended by the deceased.
15. That Crown Production No 22 is a true and accurate copy of a First Clinic Appointment template form to be completed by patients at the first clinic appointment at the Sleep Clinic at Gartnavel General Hospital. This form is currently in use, but was not used when the deceased was a patient at the Clinic.
16. That Crown Production No 24 is a true and accurate copy of a British Thoracic Society Position Statement entitled "Driving and Obstructive Sleep Apnoea (OSA)/Obstructive Sleep Apnoea Syndrome (OSAS)" and dated June 2014.
17. That Crown Production No 25 is a true and accurate copy of DVLA guidance entitled "For Medical Practitioners: At a glance Guide to the current Medical Standards of Fitness to Drive", dated August 2010 (incorporating September 2010 amendments). It was the current version in May 2011.
18. That Crown Production No 26 is a true and accurate copy of DVLA guidance entitled "For Medical Practitioners: At a glance Guide to the current Medical Standards of Fitness to Drive", dated August 2011. This was the current version in October 2011.
19. That Crown Production No 27 is a true and accurate copy of DVLA guidance entitled "For Medical Practitioner: At a glance Guide to the current Medical Standards of Fitness to Drive", dated December 2011 (incorporating April 2012 amendments). This was the

current version in February 2012 (with the exception of the April 2012 amendments which are stated on p570 of Crown Production No 27).

20. The Crown Production No 28 is a true and accurate copy of DVLA guidance entitled "For Medical Practitioners: At a glance Guide to the current Medical Standards of Fitness to Drive", dated 2013. The Guide was published in November 2013 and was the current version in July 2014.
21. That Crown Production No 29 is a true and accurate copy of DVLA guidance document INF2D entitled "How to fill in your Application for a lorry, bus or minibus driving licence (D2)" and dated April 2013. This was the current edition of the guidance when the deceased completed form D2 and submitted it to the DVLA in November 2013.
22. That Crown Production No 30 is a true and accurate copy of DVLA guidance document INF2D entitled "How to fill in your Application for a lorry, bus or minibus driving licence (D2)" and dated October 2015. This is the current version of said guidance.
23. That Crown Production No 31 is a true and accurate copy of DVLA guidance document INF4D entitled "Medical examination report D4: Information and useful notes" and dated April 2013. This was the current edition of the guidance when form D4 was completed and submitted to the DVLA in November 2013.
24. That Crown Production No 32 is a true and accurate copy of DVLA guidance document INF4D entitled "Medical examination report for a Group 2 (lorry or bus) licence D4" and dated August 2014.
25. That Crown Production No 33 is a true and accurate copy of DVLA form SL1, which was in use in 2013.

26. That Crown Production No 34 is a true and accurate copy of DVLA form SL2, which was in use in 2013.
27. That Crown Production No 35 is a true and accurate copy of DVLA leaflet INF159, entitled "Tiredness can kill – advice for drivers" and dated July 2013. This is the current version of said leaflet.
28. That Crown Production No 36 is a true and accurate copy of a Curriculum Vitae in the name of Douglas Brian Gordon, obtained from Airlink Management Ltd.
29. That Crown Production No 37 is a true and accurate copy of DVLA guidance entitled "For Medical Practitioners: At a glance Guide to the current Medical Standards of Fitness to Drive", dated November 2014 (including August 2015 and January 2016 amendments). [This is the edition of the guide current during the hearing of evidence before the Inquiry. It has since been superceded by the DVLA Guidance entitled "Assessing Fitness to Drive: a guide for medical professionals" published on 11 March, 2016.].

The following facts were proved in the Third Joint Minute of Agreement *videlicet*:-

That Crown Production 38 is a document entitled "Chronology of blood pressure readings in Mr Gordon's medical records." Said document is an accurate record of the blood pressure readings recorded in Douglas Brian Gordon's GP records, Blood Pressure Clinic records and DVLA Form D4 dated 22 November 2013.

APPENDIX 4 – THE LOCUS OF THE ACCIDENT

The following facts were proved in paragraph numbers 30 to 42 of said Second Joint Minute of Agreement *videlicet*:-

30. That the locus of the collision resulting in the death of Douglas Brian Gordon was Sanderling Road, Paisley, approximately 36 metres west of the roundabout junction with White Cart Road. Sanderling Road is unclassified and is located on the periphery of Glasgow Airport.
31. That at the immediate locus, Sanderling Road is a single carriageway road which extends generally east and west with one lane for traffic in each direction, hazard warning lines (long white lines with short gaps which warn of a hazard) separate the lanes. Sanderling Road and White Cart Road to its north form a roundabout junction which is controlled by “give way” lines.
32. That the eastbound lane of Sanderling Road on the immediate approach to the roundabout separates, forming two lanes at the roundabout. The east and westbound lanes of Sanderling Road at the junction are separated by means of white diagonal stripes bordered by broken white lines and a raised kerb traffic island. A fingerpost advanced direction sign and a yellow reflective bollard incorporating a “keep left” instruction sign are located on the traffic island and visible to eastbound drivers. The carriageway surface on the approach to the junction is coated with a grip enhancing

surface dressing. The carriageway is bordered to the north and south with raised kerbs, grass verges and then trees and bushes.

33. That the hub of the roundabout is circular in shape and is bound by a raised kerb. A banked paved surface extends towards the centre of the roundabout from the kerb and chevron markings are incorporated within the paved surface indicating the direction of travel around the roundabout. The centre of the roundabout is covered in gravel in an area of mature trees and bushes. Three signs, blue coloured instructional signs indicating turning left are mounted on poles located on the gravelled area of the roundabout and are located in positions where they are clearly visible to drivers approaching the roundabout.
34. That the westbound lane on Sanderling Road on the approach to the roundabout separates, forming two lanes on the immediate approach to the roundabout. The eastbound and westbound lanes of Sanderling Road at the junction are separated by means of white diagonal stripes bordered by broken white lines and a raised traffic island. An advanced direction sign and a yellow reflective bollard incorporating a "keep left" instruction sign are located on the traffic island and visible to westbound drivers. The carriageway surface on the approach to the junction is coated with a drip enhancing surface dressing. The carriageway is bordered to the north by a raised kerb then footway which extends towards a grass verge with bushes and trees on same.
35. That double yellow lines are located adjacent to the north and south kerbs of Sanderling Road along with the double yellow kerb markings. Street lights are located at the locus on the north and south verges. They were not in operation at the time of the incident.

36. That approaching the locus of the collision westbound, the direction of travel of the deceased, the carriageway is level and forms a slight right hand bend as it extends from the roundabout junction with Abbotsinch Road which is located approximately 150m east of the locus. The carriageway straightens and extends towards the roundabout junction with White Cart Road where the carriageway deviates to the left immediately prior to the junction to filter drivers onto the roundabout. Continuing westbound, a driver leaves the roundabout at its first exit where the carriageway straightens and continues west.
37. That approaching the locus of the collision eastbound, the direction of travel of Denis Gallacher, a driver will travel on a straight, generally level section of carriageway and negotiate a light controlled pedestrian crossing. On the approach to the roundabout junction with White Cart Road, the carriageway forms a slight right hand bend before deviating to the left immediately prior to the junction.
38. That the road surface of Sanderling Road is constructed of a bitumen compound with stone chips and was in an excellent state of repair. On the approaches to the roundabout junction the carriageway surface is coated in a grip enhancing surface dressing. This was also in excellent condition. Roadside furniture was in good condition and clearly visible.
39. That at the time of the incident it was daylight. Overhead conditions were clear and dry. There was a light wind. Visibility was excellent.
40. That a 30mph speed limit applies at the locus for the vehicles involved in the collision that resulted in the death of the deceased.

41. That a westbound driver, direction of travel of the deceased, approaches the locus from the roundabout junction with Abbotsinch Road and travels on a level section of carriageway negotiating a slight right hand bend which straightens towards the roundabout junction with White Cart Road. A westbound driver would have a maximum potential view towards the roundabout of approximately 150 metres from Abbotsinch Road. This view is dependent on the location, size and proximity of preceding and opposing vehicles. On the approach to the roundabout junction with White Cart Road there is no available view through the roundabout to the west due to the area of trees situated on the elevated centre of the roundabout. On the immediate approach to the roundabout a view becomes available approximately 7 metres east of the "give way" road markings, the view available from lane one of two. From this position a potential view of approximately 115 metres is available through the roundabout and west along Sanderling Road. On leaving the roundabout junction a westbound driver has a maximum potential view west of in excess of 300 metres. This view is dependent on the location, size and proximity of preceding and opposing vehicles.
42. That an eastbound driver on Sanderling Road, driving in the direction of Denis Gallacher, approaches the locus of the collision on a generally straight and level section of the carriageway from a roundabout junction approximately 300 metres west of the locus of the collision. A view towards the locus is available for the whole length of the carriageway taking into account the location, size and proximity of preceding and opposing vehicles. The elevated seating position within the Large Goods Vehicle (hereinafter referred to as "LGV") being driven by Denis Gallacher would assist any

available view towards the locus. There is no view available through the roundabout due to the area of trees situated on the elevated centre of the roundabout.

APPENDIX 5 – THE VEHICLES INVOLVED IN THE ACCIDENT AND THEIR POSITIONS FOLLOWING THE COLLISION

The following facts were proved in paragraph numbers 43 to 46 of the Second Joint Minute of Agreement *videlicet*:-

WHITE MAN TE26:440 Registration Mark T40 STS

43. That two vehicles were involved in the collision. The vehicle driven by the deceased was a sixteen passenger seater white Ford Transit minibus, registration mark SH13JYU which was towing a trailer. The trailer was a Bringham twin axle 750kg luggage trailer which does not need a braking system due to its gross weight. The trailer was unladen and was undamaged as a result of the collision. The second vehicle involved was a white articulated LGV. The tractor unit was a MAN TGX26:440 registration mark T40STS. The tractor unit has three axles, axles one and two are fitted with twin wheels. The tractor unit was towing a white coloured box style semi trailer which was fitted with three axles, single wheels fitted to each axle. The trailer was undamaged as a result of the collision.
44. That the Ford Transit vehicle being driven by the deceased was found by collision investigators in its resultant position facing generally west straddling the centre line markings, the front of the vehicle encroaching onto the westbound lane, the majority of the vehicle on the eastbound lane.

45. That the LGV vehicle being driven by Denis Gallacher was located wholly on the eastbound lane adjacent to the north kerb and was facing east. The LGV had been moved back a short distance by the driver to allow access to the deceased who was initially trapped within his vehicle as a result of the collision.
46. That the point of impact between the Ford Transit vehicle and the LGV occurred wholly on the eastbound lane of Sanderling Road, approximately 36 metres west of the junction with White Cart Road.

APPENDIX 6 – THE DAMAGE TO THE VEHICLES

The following facts were proved in paragraph numbers 47 to 66 of the Second Joint Minute of Agreement *videlicet*:-

WHITE MAN TG26:440 Registration Mark T40 STS

47. There was extensive impact damage evidence to the front offside corner of the LGV, across an area extending approximately 85 centimetres in towards the centre of the vehicle from its offside edge and approximately 232 centimetres up from ground level onto the windscreen. The windscreen was shattered. Trim panels in the area were scuffed, scored and sections were detached. The remaining panels were forced towards the nearside causing induced damage to the front nearside corner of the vehicle where trim panels were cracked and forced out.
48. All front side lights were destroyed.
49. The front offside wing of the Ford Transit was embedded within the front panel of the LGV adjacent to the front offside lamp aperture. The wing was embedded within an area extending approximately 62-72 centimetres in from the offside of the vehicle and approximately 87-153 centimetres up from ground level.
50. The front bumper was forced back at its offside edge and partially detached. The offside area of the cab tilt mechanism was forced back and had yellow and blue plastic embedded on the forward facing aspect of the mechanism. The coloured plastic had come from a business graphic which was fixed to the front offside door of the Ford Transit.

51. The driver's door had been damaged; the panel forced back and fractured. The driver's door mirror was forced back against the door window. Steps located at the front offside corner of the vehicle had been forced back and were crushed.
52. The tread area of the front offside tyre had sustained an impact, forcing the wheel and tyre out towards the offside, contact continued across the inner side wall and inner aspect of the wheel rim. As a consequence of this impact the front offside wheel and tyre were forced back. The front axle was forced back and towards the centre of the vehicle causing damage to the leaf spring and associated suspension components.
53. A trim panel located behind the front offside wheel had been forced back against the leading edge of the offside fuel tank. The leading edge of the fuel tank was crushed, with white paint from the trim panel adhering to the impact area.

WHITE FORD TRANSIT MINIBUS Registration Mark SJ13JYU

54. The front offside corner of the vehicle had sustained a substantial impact, crushing this area of the vehicle back and towards the centre.
55. The offside corner of the front bumper cover was shattered and detached, the metal bumper bar was forced back and towards the nearside. The remnants of the bumper cover and grill were forced towards the nearside.
56. Upper and lower engine bay cross members were forced back and towards the nearside. The engine and ancillaries were forced back and towards the nearside.
57. All front lights were detached.
58. The bonnet was forced back and down at its leading edge, the bonnet surface creased and scored across an area extending approximately 115cm from the offside of the vehicle. There were red coloured scuff marks within the damaged area.

59. The windscreen was shattered, the driver's door glass was shattered, the glass panel behind the driver's door was shattered and the glass behind the nearside sliding door was shattered.
60. The front offside outer wing was detached, the inner wing crushed back.
61. The offside longitudinal chassis rail had been forced back and out at an approximate 90 degree angle, folding at a point approximately 47cm back from its leading edge. The chassis rail had been forced back against the front offside wheel and tyre. This wheel and tyre has been forced back against the trailing edge of the wheel arch and in towards the centre of the vehicle. The wheel rim had sustained a substantial dent as a consequence of the chassis rail striking the wheel and the tyre was partially deflated. Offside front suspension components were damaged.
62. The offside driver's door was extensively crushed. Fire and rescue personnel removed the door from the vehicle to assist with the removal of the deceased, cutting the "A" pillar from the vehicle in the process. The offside "B" pillar and the panel directly behind same was crushed and forced back and in towards the centre of the vehicle. The offside sill was crushed back.
63. The leading edge of the roof towards the offside of the vehicle was forced back and down, the roof crushed towards the nearside of the vehicle. There was a defined vertical crease within the crushed area consistent with having been created by the front offside corner of the LGV. Adjacent to the top of the front offside "A" pillar encroaching onto the roof there was a scuffed area. The scuffing was blue in colour and was consistent with having been created by coming into contact with blue coloured lettering to the front of the LGV.

64. Driver and front seat passenger airbags deployed as a result of the collision. The driver's seatbelt webbing displayed stretching and burning and had been cut by rescue personnel in order to remove the deceased from the vehicle. The seatbelt buckle was within its keeper. The deceased was wearing his seatbelt at the time of the collision.
65. The driver's seat, foot well, dashboard and steering wheel were all crushed as a result of the collision and were forced back and towards the centre of the vehicle.
66. The aforementioned damage is consistent with the front offside of the Ford Transit minibus colliding with the front offside of the LGV.

APPENDIX 7 – DVLA

The following facts were proved in paragraph numbers 67 to 70 of the Second Joint Minute of Agreement *videlicet*:-

67. The driving requirement for the driving post that the deceased held with Airlink Management Ltd, was a D entitlement (PCV entitlement). On 1 April 1991, the deceased passed the test which entitled him to drive category D vehicles.
68. As a Group 3 driver, the deceased required to renew his licence every five years following his 45th birthday on 24 May 2001, in accordance with section 99 (1A) of the Road Traffic Act 1988. He completed DVLA form D2 and underwent a D4 medical examination in March 2003 and again in November 2013. The deceased did not apply for renewal in 2008, therefore did not hold such a licence between March 2008 and 23 December 2013. The renewal applications of March 2003 and November 2013 were granted. Neither the deceased nor any medical practitioner provided any further medical information relating to him to DVLA after the application for renewal was made in November 2013.
69. When completing DVLA form D2 the applicant must sign and date a declaration stating “I declare that I am a resident in the UK and understand that it is a criminal offence to take a false declaration to get a driving licence and that to do so can lead to prosecution and a maximum penalty of up to two years imprisonment. I also understand that failing to provide information is an offence that could lead to prosecution and a fine of up to £1000.”

70. When completing an application for a Group 2 licence, the applicant must sign and date the "Consent and declaration" section of DVLA form D4. This states that "I authorise my doctor(s) and specialist(s) to release reports/medical information about my condition relevant to my fitness to drive, to the Secretary of State's medical adviser. I authorise the Secretary of State to disclose such relevant medical information as may be necessary to the investigation of my fitness to drive, to doctors, paramedical staff and panel members. I declare that I have checked the details I have given on the enclosed questionnaire and that, to the best of my knowledge and belief, they are correct. I understand that it is a criminal offence if I make a false declaration to obtain a driving licence and can lead to prosecution."

APPENDIX 8 – THE FOURTH JOINT MINUTE OF AGREEMENT

The following facts were proved in the Fourth Joint Minute of Agreement *videlicet*:-

1. On 4 July 2014, at Karen Yuill Recovery, Ltd., Blantyre Industrial Estate, Blantyre, PC Brian McNab recovered a two handled zip bag from underneath the passenger seat of the white Ford Transit vehicle registration SJ13JYU. Within the bag, which was unzipped, was a mobile phone. The mobile phone was switched on. The mobile phone was not interrogated by the police.
2. Dr Julia Bell, pathologist who carried out the post mortem on Douglas Brian Gordon on 9 July 2014 at Southern General Hospital, Glasgow, has stated that while there was evidence of chronic heart disease, she would not necessarily have expected to find any acute changes or pathology if Mr Gordon had had a “heart attack” prior to the collision. Dr Bell also stated that there would be no specific acute pathology to suggest that a sleep apnoeic event had occurred.

**APPENDIX 9 – DVLA D4 OPERATING INSTRUCTIONS IN RESPECT OF
SECTION 4G BLOOD PRESSURE (REF CROWN PRODUCTION NOS. 47 & 48) AND
DVLA 4 OPERATING INSTRUCTIONS IN RESPECT OF SLEEP DISORDERS (REF
CROWN PRODUCTION NOS. 45& 46)**

The following facts were proved in the Fifth Joint Minute of Agreement lodged on 8 March 2016 *videlicet*:-

1. The following statement is a description of the DVLA D4 Operating Instructions flowchart in use in November 2013 in respect of Section 4G Blood Pressure (Crown Production No. 47):

- (i) *“Check previous case papers (if applicable)”* means that if there are previous relevant medical records on the case then that needs to be checked.
- (ii) *“Please give today’s blood pressure reading”* means that the doctor undertaking the D4 examination is expected to record the blood pressure (BP) reading as taken at the time of the examination.
- (iii) If the BP reading recorded on D4 is 180/100 or greater, then the individual checking the D4 needs to ensure that there are three additional readings of BP recorded on D4 in the boxed provided.
- (iv) If all three readings are available, then they need to check that these readings are from within the last three months.
- (v) If all the three readings are from within the last three months, they need to check whether all three readings are under 180/100 or not.
- (vi) If all three readings are under 180/100, and there are no unfavourable comments (relevant to BP), then both vocational and ordinary car licences can be issued.

(This is from the point of view of the hypertension issue. Before issuing a licence they would need to ensure that all other standards for other sections are also met).

- (vii) If the BP recording on D4 is 180/100 or greater, and all three readings are not available and/or all three readings are not from within the last three months, then the VBPEXAMP letter is sent out by DVLA to the individual's GP. This is a letter which makes the GP aware that the BP recorded on the D4 examination day was 180/100 or greater and asks the GP to recheck the individual's BP to provide three further readings.
 - (viii) If the BP recorded at the time of the D4 examination is less than 180/100, then, if the rest of the D4 is favourable, both vocational and ordinary driving licence are issued.
 - (ix) Information about anti-hypertension medication is noted for the purpose of gathering information.
 - (x) The Note which reads *"DO NOT reject for additional blood pressure readings regardless of who completed the D4"* means that if the additional BP readings are not provided, the application form should not be rejected but should go for further information from the applicant's own GP via the VBPEXAMP letter.
2. The following statement is a description of the DVLA D4 Operating Instructions flowchart currently in use in respect of Section 4G Blood Pressure (Crown Production No 48):
- (i) The D4 examining doctor is instructed to *"Please record today's best blood pressure reading."* The doctor is advised that *"If blood pressure is 180/100mm Hg systolic or*

more and/or 100mm Hg diastolic or more, please take a further 2 readings at least 5 minutes apart and record the best of the 3 readings in the box provided."

- (ii) If the reading is 180/100 or greater, the vocational licence (VOC) application needs to be refused with a letter explaining the reason for it.
- (iii) The D4 examining doctor will then continue completing the rest of the form for the ordinary driving licence (ODL).
- (iv) *"Is the applicant on anti-hypertensive treatment?"* is a question which is asked for information gathering reasons.
- (v) The three previous blood pressure readings are requested for information gathering reasons, but according to Dr Kumar, Medical Advisor to Cardiology medical Advisory Panel and the Secretary of the Panel may be taken into account in the licensing depending upon what the information available is for all three readings and what information is available on the other sections of the D4 formcontrol of blood pressure is a dynamic process. It is very difficult to write operating instructions for every possible scenario, and clerks are advised to seek further advice if in doubt. Operational Instructions are written for straight forward scenarios."
- (vi) Where the Note states to *"Discuss with MED EO if GP indicates "white coat hypertension"*, the case is discussed with a senior experienced clerk who decides whether it is appropriate to refer to a Medical Adviser before a licensing decision is made as all available information (the case as a whole) needs to be taken into account.
- (vii) **VREV** is the standard coded letter for vocational revocation.

- (viii) **CIVH32** is a customer information letter for revocation of vocational cases when they fail to meet hypertension standards.
3. A change was made to the D4 Operational Instructions in 2015 at the request of DVLA's Business Support Group for Operational Issues. With the previous Operational Instructions, if the blood pressure reading was 180/100 or greater on the day of the D4 examination and three other readings were either not available or were not all from within the last three months, a letter (VBPEXAMP) was to be sent to the GP to obtain a further three readings over a period of time. This was causing considerable delay in the processing of the case and in reaching a licensing decision, according to DVLA. With the current D4 Operational Instructions in respect of blood pressure, the best of three readings on the day of examination is recorded and if it is 180/100 or greater, the vocational licence is refused. If subsequently supporting medical evidence is submitted that blood pressure has been better controlled, then reapplication is considered.
4. The following abbreviations which appear in the DVLA D4 Operating Instructions flow charts in respect of Sleep Disorders in use in November 2013 and currently (Crown Productions 45 and 46) are explained as follows:
- (i) Licence types
 - F** Non-medically restricted licence
 - A** 1 year licence
 - C** 3 year licence
- (Licensing decisions are for ODL and VOC and are quoted as ODL/VOC e.g. C/A 3 year ODL and 1 year VOC).
- VOC** Group 2 licence (bus/lorry)

ODL Group 1 licence (car/motorbike)

(ii) Refusal/revocation codes

These are in 2 parts: the information letter and the condition code.

R01 Group 2 medical information letter to refuse/revoke for excessive sleepiness

S05 Group 1 medical information letter to refuse/revoke for excessive sleepiness

S05 Condition code for OSAS for both Group 1 and 2

VREVS05 Replacement for R01 from 2015 onwards

VADDS05 Replacement for S05 letter from 2015 onwards when sent with VREVS05.

(iii) Standard letters

VSLEEP 123 Letter indicating that a short period/medical review licence has been issued for VOC

VLHRETAIN Letter indicating that a non-medical review licence has been issued for VOC

SL1V Medical questionnaire to the applicant regarding OSAS

SL2V(C) Medical questionnaire to the applicant's General Practitioner (or consultant) regarding OSAS

VGPCONNOTES Request for clinic letters from GP or consultant

VLHRETOSAS Replacement for VLHRETAIN from 2016 onwards

VSPLOSAS Replacement for VSLEEP123 from 2016 onwards.

(iv) Treatment

CPAP Continuous Positive Airway Pressure Machine

(v) Other

MED EO Senior experienced clerks

APPENDIX 10 – POSSIBLE CONDITIONS LISTED ON THE DVLA WEBSITE FOR WHICH DVLA OFFERS ADVICE ABOUT THE IMPLICATIONS FOR DRIVING AND NOTIFICATION – www.gov.uk/driving-medical-conditions

A

Absence seizures

Acoustic neuroma

Addison's disease

Agoraphobia

AIDS

Alcohol problems

Alzheimer's disease

Amyotrophic Lateral Sclerosis

Amputations

Angina

Angioma

Angioplasty

Ankylosing spondylitis

Anorexia nervosa

Anxiety

Aortic aneurysm

Arachnoid cyst

Arnold-Chiari malformation

Arrhythmia

Arterial defibrillator

Arteriovenous malformation

Arthritis

Asperger syndrome

Ataxia

Attention deficit/hyperactivity disorder (ADHD)

Autistic spectrum disorders (ASD)

B

Balloon angioplasty (leg)

Bipolar disorder

Blackouts

Blepharospasm

Blood clots

Blood pressure

Brachial plexus injury

Brain abscess, cyst or encephalitis

Brain aneurysm

Brain angioma

Brain haemorrhage

Brain injury (traumatic)

Brain tumours

Branch retinal vein occlusion

Broken limbs and driving

Burr hole surgery

C

Caesarean section

Cancer

Cataracts

Catheter ablation

Cardiac problems

Carotid artery stenosis

Cataplexy

Cerebral palsy

Chronic aortic dissection

Cognitive problems

Congenital heart disease

Convulsions

Coronary artery bypass or disease

Coronary angioplasty

Cystic fibrosis

D

Deafness

Defibrillator

Déjà vu

Dementia

Depression

Diabetes

Diabetic retinopathy

Dilated cardiomyopathy

Diplopia (double vision)

Dizziness

Drug misuse

E

Eating disorders

Empyema (brain)

Epilepsy

Essential tremor

F

Fainting

Fits

Fractured skull

Friedrich's ataxia

G

Giddiness (recurring)

Glaucoma

Global amnesia

Grand mal seizures

Guillain-Barré syndrome

H

Head injury

Heart attack

Heart arrhythmia

Heart failure

Heart murmurs

Heart palpitations

Heart valve disease or replacement valve

Hemianopia

High blood pressure

HIV

Hodgkin's lymphoma

Huntington's disease

Hydrocephalus

Hypertension

Hypertrophic cardiomyopathy

Hypoglycaemia

Hypoxic brain damage

Hysterectomy

I

Implantable cardioverter defibrillator (ICD)

Intracerebral haemorrhage

Ischaemic heart disease

K

Kidney dialysis

Kidney problems

Korsakoff's syndrome

L

Labyrinthitis

Learning difficulties

Left bundle branch block

Leukaemia

Lewy body dementia

Limb disability

Low blood sugar

Lumboperitoneal shunt

Lung cancer

Lymphoma

M

Macular degeneration

Malignant brain tumours

Malignant melanoma

Manic depressive psychosis

Mafran syndrome

Medulloblastoma

Memory problems (severe)

Meningioma

Mini-stroke

Monocular vision

Motor neurone disease

Multiple sclerosis

Myasthenia gravis

Myocardial infraction

Myoclonus

N

Narcolepsy

Night blindness

Nystagmus

O

Obsessive compulsive disorder

Obstructive sleep apnoea

Optic atrophy

Optic neuritis

P

Pacemakers

Palpitations

Paranoia

Paranoid schizophrenia

Paraplegia

Parkinson's disease

Peripheral arterial disease

Peripheral neuropathy

Personality disorder

Petit mal seizures

Pituitary tumour

Post-traumatic stress disorder (PTSD)

Psychosis

Psychotic depression

R

Renal dialysis

Retinal treatment

Retinopathy

S

Schizo-affective disorder

Schizophrenia

Scotoma

Seizures

Sight in one eye only

Sleep apnoea

Sleepiness (excessive daytime)

Spinal problems and injuries and driving

Stroke

Subarachnoid haemorrhage

Syncope

T

Tachycardia

Temporal lobe epilepsy

Tonic clonic fits

Tourette's syndrome

Transient global amnesia

Transient ischaemic attack (TIA)

Tunnel vision

U

Usher syndrome

V

Valve disease or replacement valve

Ventricular defibrillator

Vertigo

Vision in one eye only

Visual acuity (reduced)

Visual field defects

VP shunts

W

Wolff-Parkinson-White syndrome

APPENDIX 11 – SUBMISSIONS ON BEHALF OF THE CROWN IN THE FATAL ACCIDENT INQUIRY INTO THE DEATH OF DOUGLAS BRIAN GORDON

1. INTRODUCTION

1.1 The Crown wishes to begin its submissions by formally offering sincerest condolences to Mr Gordon's family.

2. INQUIRY

2.1 The Inquiry heard evidence over ten days. The following witnesses were called by the Crown and gave evidence:

1. Mary Kelly, former partner of the deceased
2. Richard Clifford, eye witness
3. Denis Gallacher, driver of white MAN LGV, vehicle registration T40STS
4. Malcolm Newlands, eye witness
5. PC Scott Simpson, Collision Investigator
6. Rhianna Carr, formerly employed by Airlink Management Ltd
7. Brian Rice, formerly employed by Airlink Management Ltd
8. Dr David Taylor, GP
9. Dr Jesse Dawson, Consultant, Blood Pressure Clinic
10. Dr Christopher Carlin, Consultant, Head of Sleep Clinic
11. Dr Lesley Anne Somerville, examining doctor, D4 assessment
12. Dr Stephen Banham, Retired Head of Sleep Clinic
13. Duncan MacFarlane, Physiologist
14. Dr Gareth Wyn Parry, Senior Medical Advisor, DVLA

2.2. The Inquiry thereafter heard evidence from Carole Tamplin, Medical Executive Officer, DVLA, led by Counsel for DVLA.

2.3. Five Joint Minutes of Agreement were tendered by parties.

2.4. An Affidavit was provided by Dr Julia Bell, Forensic Pathologist.

3. SUBMISSIONS ON FINDINGS

3.1 Section 6 of the 1976 Act requires the presiding Sheriff to make determinations in the following matters:

- a. Where and when the death and any accident resulting in the death took place;
- b. the cause of such death and any accident resulting in the death;
- c. the reasonable precautions, if any, whereby the death and any accident resulting in the death might have been avoided;
- d. the defects, if any, in any system of working which contributed to the death or any accident resulting in the deaths;
- e. any other facts which are relevant to the circumstances of the death.

In terms of Section 6 of the Fatal Accident and Sudden Deaths Inquiry (Scotland) Act 1976 the Crown respectfully invites your Lordship to consider making findings in the following terms:

3.2 Section 6(1)(a) – WHERE AND WHEN THE DEATH AND ANY ACCIDENT RESULTING IN THE DEATH TOOK PLACE

Douglas Brian Gordon died at Southern General Hospital, Govan Road, Glasgow. That his life was formally pronounced extinct at 13.15pm on 2 July 2014. That the road traffic accident resulting in the death of Mr Gordon occurred at around 11.30am on 2 July 2014 on Sanderling Road, Paisley, approximately 36 metres west of the roundabout junction with Whitecart Road.

3.3 Section 6(1)(b) – THE CAUSE OR CAUSES OF DEATH AND ANY ACCIDENT RESULTING IN THE DEATH

In terms of Section 6(1)(b) of said Act, the Crown respectfully submits that your Lordship can make a finding that the cause of death was:

1a) Chest injury

due to

1b) Road traffic accident (minibus driver)

The accident occurred when Mr Gordon lost control of the Ford Transit van (vehicle registration SJ13 JYU) that he was driving, crossing onto the path of oncoming large goods vehicle registration T40 STS, driven by Denis Gallacher, and colliding with same.

The reason why Mr Gordon lost control of the vehicle he was driving is not known with certainty. Some witness evidence, however, does give an indication of the possible reasons why Mr Gordon lost control of the vehicle.

Dr Julia Bell, pathologist

Dr Julia Bell, Forensic Pathologist, indicates in her Affidavit that “in terms of natural disease, the heart was enlarged with concentric left ventricular hypertrophy, in keeping with the history of hypertension, and there was also moderate atheromatous narrowing of the two main coronary arteries. While the chest injuries were considered to be the main factor in his death, the possibility that underlying natural disease played a part in the road traffic accident and/or contributed to the death cannot be excluded.” Dr Bell explains that she “can’t exclude the possibility that [Mr Gordon’s] underlying natural disease led to the accident, for example, he may have had a ‘heart attack’ prior to the crash that led to a reduced level of consciousness which resulted in the collision.” Dr Bell further explains that “given the extent of heart disease that was present, Mr Gordon was at risk of sudden death.” Notably, Dr Bell also gives evidence (Fourth Joint Minute, para 2) that while there was evidence of chronic heart disease, she would not necessarily have expected to find any acute or pathology if Mr Gordon had had a ‘heart attack’ prior to the collision. In this regard, she also states that there would be no acute pathology to suggest that a sleep apnoeic event had occurred.

PC Scott Simpson, Collision Investigator

PC Simpson, Collision Investigator, stated in his evidence that the degree of damage to Mr Gordon’s vehicle, in his experience, was more extensive than the degree of damage that would be found where a vehicle had been travelling at only 30 mph at the time of impact. PC Simpson considered that Mr Gordon was therefore driving in excess of 30 mph at the time of the collision.

Denis Gallacher eye witness

Denis Gallacher, eye witness, stated in evidence that when he first saw Mr Gordon and his van, he was about 30 yards from the roundabout and the van was exiting the roundabout. When Mr Gordon was around 6 to 7 metres away from him, Mr Gallacher said that he looked down from his cabin and saw Mr Gordon lying across the passenger seat, with his right hand on the steering wheel, at 12 o'clock position. Mr Gallacher stated that he could only see the back of Mr Gordon's head as he was facing downwards and his trunk was positioned across the seat. Mr Gallacher could not see the deceased's left arm and hand at this time. Mr Gallacher described the deceased releasing his grip on the wheel for a very short time and then hearing a loud rev on the engine, before the van "shot over" to the opposite side of the road. Mr Gallacher said that Mr Gordon's head remained down and he did not see Mr Gordon's face until just before the vehicle collided, when Mr Gordon looked up and attempted to steer to the left.

The Crown respectfully submits that there are arguably two reasons why Mr Gordon could have been lying across the passenger seats with his head facing down immediately before impact.

The first possibility is that upon manoeuvring off the roundabout, Mr Gordon became distracted by something in the cabin, either trying to pick up something in the passenger seat area, or for some other reason had cause to turn his head downwards, looking away from the road toward the passenger seat. PCs Simpson and McNab confirmed in their

evidence that paperwork and business cards, as well as a bag with a mobile phone were found underneath the front passenger seat of the van.

The second possibility is that Mr Gordon was lying across the passenger seats with his head faced downwards, not looking at the road, because he had taken ill, causing him to lose control of the vehicle he was driving.

Parties have agreed that there were no pre collision defects in the Ford Transit van driven by Mr Gordon that could have led to a loss of control of the vehicle or trailer or could have increased the severity of the collision. It has also been agreed by parties that the mechanical condition of the vehicle and trailer were not contributory factors in the collision.

3.4 Section 6(1)(c) – THE REASONABLE PRECAUTIONS, IF ANY, WHEREBY THE DEATH AND THE ACCIDENT RESULTING IN THE DEATH MIGHT HAVE BEEN AVOIDED

In terms of Section 6(1)(c), the Crown makes the following submission:

That it would have been a reasonable precaution for DVLA when assessing Mr Gordon's health for the purpose of issuing a Group 2 licence to have accessed Mr Gordon's GP records for the purpose of considering his previous blood pressure readings and not to have accepted the preferable of two high blood pressure readings recorded on form D4 on 22 November 2013, both of which had been taken on the day of the examination, 5-10 minutes apart, and one of which was above the 180/100 threshold of high blood pressure readings.

While Mr Gordon indicated in Question 2 of Section 4G of the November 2013 Form D4 that he was taking anti-hypertensive treatment, three previous blood pressure readings with dates of the readings were not provided, as requested on the form. This information was not later sought by DVLA. The one blood pressure reading (of two) which was taken on the day of the examination which met the standard was accepted by DVLA.

Dr Parry, Senior Medical Officer for DVLA, indicated in his evidence that if DLVA had known of Mr Gordon's last three recorded GP blood pressure readings, taken over a period of several months, a Group 2 licence would not have been issued to Mr Gordon.

Carole Tamplin, Medical Executive Officer, however, stated in her evidence that had the blood pressure reading provided on the day of the examination been outwith the standard (i.e. equal to or above 180/100), and had she had access to the last three GP readings, (two of which were more than three months old), she would have sought further information from the GP by sending out a VBPEXAMP letter, which asks the GP to re-check the individual's blood pressure and provide three further readings. However, given the fact that one of the two readings taken on the day of the examination was below 180/100, the reading was accepted in any event without the need to consider any additional readings, as the best reading given on the day would always be the reading that was accepted.

Ms Tamplin also stated in evidence that in accordance with the DVLA "Hints and Tips" document, if the applicant's blood pressure reading on form D4 had been "high", meaning equal to or over 180/100 and where the applicant's blood pressure is being monitored by the

GP, a letter H12H would be sent to the GP. Ms Tamplin explained that letter H12H is a questionnaire sent to the GP asking for the last three blood pressure readings. Presumably upon receipt of the three blood pressure readings, two of which were more than three months old, a form VBEXAMP letter would then have been sent to the GP, seeking up to date readings, as stated above.

The "Hints and Tips" document also states in relation to blood pressure that "If poor control refuse/revoke." When asked by Your Lordship a question in relation to how one would know whether there was poor control of blood pressure, Ms Tamplin answered that this "doesn't come into it" because if a reading is provided within the standard, a licence will be issued. Following the logic of this answer, it would appear that where one isolated reading meets the standard, no assessment is done beyond this as to whether the applicant has poorly controlled blood pressure.

It should be noted that in relation to Mr Gordon's blood pressure history from 16 April 2010 onwards, as helpfully outlined in Crown Production No.38, sixteen of the nineteen blood pressure readings taken between 16 April 2010 and 24 October 2013 were higher than the 180/100 standard set by DVLA.

In the event that previous GP blood pressure readings had been sought by DVLA, and possibly also up to date new blood pressure readings which may ultimately have resulted in the Group 2 licence not being issued on 23 December 2013, as indicated by Dr Parry, Mr Gordon would not have been able to re-apply for the licence for 12 months (unless he

successfully appealed the decision). This being the case, Mr Gordon would not have had a Group 2 licence in June 2014, would not have been in a position to apply for a job with Airlink Management Ltd as a Group 2 driver in June 2014 and would not, therefore, have been driving the Ford Transit minivan at Sanderling Road on 2 July 2014. His death might thereby have been avoided in these circumstances.

3.5 Section 6(1)(d) – THE DEFECTS, IF ANY, IN ANY SYSTEM OF WORKING WHICH CONTRIBUTED TO THE DEATH OR ANY ACCIDENT RESULTING IN THE DEATH

In terms of Section 6(1)(d), the Crown makes no submissions.

3.6 Section 6(1)(e) – ANY OTHER FACTS WHICH ARE RELEVANT TO THE CIRCUMSTANCES OF THE DEATH

Purpose of Section 6(1)(e)

Section 6(1)(e) allows your Lordship to make determinations about any other facts that are relevant to the circumstances of the deaths but which have not been proved to have any causative effect¹. Comments or determinations in terms of section 6(1)(e) can be made on a wider basis than subsections (a) to (d) if the court is satisfied that it is in the public interest to do so.

In the recent Determination on 11 August 2015 in relation to the death of Dawn McKenzie, Sheriff Bicket adopted Sheriff Holligan's approach from the Determination in relation to the death of John Kelly in March 2004. This states:

¹ IHB Carmichael, *Sudden Deaths and Fatal Accident Inquiries*, 3rd edn, para. 5-77

“The provisions of section 6(1)(e) are still wider, and in my view, entitle and indeed oblige the court to comment upon, and where appropriate make recommendations in relation to any matter which has been legitimately examined in the course of the Inquiry as a circumstance surrounding the death if it appears to be in the public interest to make such comment or recommendation.”²

In terms of section 6(1)(e), the Crown respectfully submits that the following facts are relevant to the circumstances of the deaths, having been legitimately examined in the course of this Inquiry as circumstances surrounding the death of Mr Gordon:

- (i) *Inconsistency of DVLA approach to ascertaining fitness to drive (and continue to drive)*

That the DVLA “At a Glance” guidelines, both the guidance in use in November 2013 and the guidance currently in use, were and are not consistent in their terms and approach with DVLA’s Operational Instructions in relation to assessing high blood pressure (hypertension) in form D4.

While the “At a Glance” guidelines state that Group 2 drivers will be disqualified where “resting BP consistently 180mm Hg systolic or more and/or 100 mm Hg diastolic or more,” (my emphasis) the D4 Operating Instructions for blood pressure indicate that decisions to (re) issue or not to (re) issue a Group 2 licence can be made on the basis of one blood pressure reading only.

² Determination in relation to the death of John Kelly, March 2004, Sheriff Holligan; adopted in the Determination in relation to the death of Dawn McKenzie, 11 August 2015, Sheriff Bicket.

Dr Parry also stated in evidence that the object of providing three previous blood pressure readings for the D4 assessment where the applicant is taking anti-hypertensive treatment (Question 2) was to ascertain whether the applicant's blood pressure is controlled. However, the relevant Operating Instructions in use in November 2013 and those currently in use only require one reading below the 180/100 threshold reading, taken on the day of the assessment, in order for the applicant to pass that part of the assessment, even where the applicant is taking anti-hypertensive treatment. The Crown respectfully submits that it is not possible to ascertain whether blood pressure of an applicant is "controlled" on the basis of one blood pressure reading only.

(ii) *Lack of clarity of definition of "consistently" in blood pressure guidance*

That the meaning of the word "consistently" as used in the "At a Glance" guidelines in relation to hypertension was defined in different ways by different medics who gave evidence to the Inquiry in relation to the matter.

Dr Taylor, GP, explained that where a patient has very high blood pressure, the practice would be to bring the patient back to the surgery three times over two weeks to monitor blood pressure. Where the patient's reading is slightly lower, for example, 160/90, the patient would be asked to return to surgery three times over three months for monitoring. Dr Taylor considered that at least three readings would require to be taken in order to ascertain whether the patient's blood pressure "consistently" exceeded the standard.

Dr Dawson, previously of the Blood Pressure Clinic, considered that “consistently” in this context means that at least two measurements should be taken over a period of a month or more. Dr Dawson also stated that where the measurement taken is severe, the next measurement should be checked in a week and he explained that when measurements are taken in the clinic, the first reading is disregarded and the second and third readings are recorded.

As stated above, Dr Parry stated that “consistently” meant more than one reading being taken and indicated that the Advisory Panel on Cardiology had not specified how far apart readings should be taken.

There is no definition provided by DVLA of the word “consistently” in the context of the “At a Glance” guidance.

Dr Parry accepted in evidence that the same patient could potentially be given different advice about driving by two different doctors who are interpreting the guidance (specifically the meaning of “consistently”) differently.

(iii) *Completion of form D4 without access to medical records*

That form D4 can currently be completed by an examining doctor who has no prior knowledge of the applicant and who has no access to the applicant’s medical records, in particular, GP records.

In this case, evidence was given by Dr Somerville, the D4 assessing doctor, that she would ask applicants questions in relation to their attendance at specialist clinics and any condition with which the applicant had been diagnosed at said clinics.

In the absence of any information being recorded in relation to Mr Gordon's attendance at the sleep clinic and his diagnosis of sleep apnoea, the Crown respectfully submits that it can be inferred that the deceased imparted no such information to Dr Somerville, despite the fact that he was still at that time, in November 2013, a patient of the sleep clinic. DVLA therefore did not have relevant information in relation to Mr Gordon's health when making the decision in relation to whether he should be issued a Group 2 licence.

Carole Tamplin, Medical Executive Officer, stated in evidence that had information been provided in form D4 in relation to his attendance with a Consultant at a sleep clinic, in absence of a positive response to Question 7 of the form D4 in relation to sleep disorders, Ms Tamplin would have discussed this matter with a Medical Adviser in order to ascertain whether further information was required in relation to this issue. In this context, it should be pointed out that by this time, Mr Gordon had not been using the CPAP equipment for *at least* 7 months, having handed the equipment back to the sleep clinic in May 2013. The date when Mr Gordon actually ceased using the equipment is unknown, the last appointment that he attended at the sleep clinic having been on 2 February 2012.

Dr Banham's evidence in respect of Mr Gordon's sleep disorder was that "when I said that he did not have OSAS, he would have been on a journey towards that condition." Dr Banham described a spectrum of sleep breathing disorders and when asked what the risks would be where Mr Gordon did not continue with CPAP treatment, Dr Banham stated that left untreated, and in the event that Mr Gordon did not lose many stones in weight, it was inevitable that at some stage in the future Mr Gordon would develop OSAS. Dr Banham said that Mr Gordon was "a lot closer to OSAS than to OSA," and surmised, albeit somewhat speculatively, that if there were to be no change in Mr Gordon's weight, within a couple of years of ceasing treatment, he would be having consistent difficulties with sleepiness during the daytime.

As well as the lack of information in relation to Mr Gordon's sleep disorder, Dr Somerville also had no access to the deceased's previous blood pressure readings which were available in the GP records and which, had DVLA had sight of them, would have resulted in the Group 2 licence not being issued, according to Dr Parry and would have resulted in further information being sought, according to Carole Tamplin.

The current system of D4 assessment therefore places significant reliance on the applicant's honesty and knowledge in relation to declaring his medical history in the absence of GP records being available to the examining doctor.

In this context, it is also notable in that Dr Parry stated in evidence that there are sections of the current form D4, particularly Question 7 of Section 5, which he considers cannot be completed by anyone other than the applicant's GP, (or presumably a doctor who has access to the applicant's GP records).

(iv) *Airlink Management Ltd's lack of scrutiny of driver interviewees' state of health*

Airlink Management Ltd did not at the time of interviewing Mr Gordon for the Group 2 driver position seek references or any specific medical information from interviewees, other than to ask the interviewee a general question relating to whether he/she had any medical issues. In evidence, Rhianna Carr, former Operations Manager, indicated that "we know that they have a licence and take it for granted that they are fit and healthy. DVLA have given them a licence."

Ms Carr indicated in evidence that if made aware of medical conditions of potential employees that may affect their driving, she would speak to Airlink's insurers in order to ascertain whether the driver would be covered by insurance. Ms Carr stated in evidence that had she known that Mr Gordon had been diagnosed with sleep apnoea, she would have to have looked into the issue and probably would have to have sought medical advice. Ms Carr also indicated that had she known that Mr Gordon suffered from hypertension and took medication for this condition, she would have asked the advice of her insurers.

Ms Carr indicated that “All other things being equal, we would not have taken him on,” given his medical issues.

4.0 RESPONSE TO DVLA SUBMISSIONS

4.1 The Crown should like to take the opportunity to respond to comments made by DVLA in their submissions.

4.2 In relation to the Crown’s recommendation in respect of s6(1)(c), DVLA considers it trite that “if Mr Gordon had not been driving that vehicle on that date at that place he could not have been involved in the road traffic accident that caused his death.” (page 5, DVLA submissions). The Crown’s position is stated in detail above. Trite or not, the Crown respectfully submits that an analogous finding was made by Sheriff Bicket in the determination in respect of the FAI of Dawn McKenzie³. In this case, which concerned the death of a foster carer who was stabbed to death by her foster son, Sheriff Bicket held that –

“The death of Mrs McKenzie might have been avoided if Foster Care Associates Scotland (hereinafter FCAS), when considering if they had a suitable placement for child D when so requested to do so by Glasgow City Council (hereinafter GCC), had taken proper account of Mr and Mrs McKenzie’s status as new carers, and lack of

³ Determination into the death of Dawn Fiona Byrne McKenzie, 11 August 2015, Sheriff Bicket, Hamilton:
<http://www.scotcourts.gov.uk/search-judgements/judgement?id=eb67e6a6-8980-69d2-b500-ff0000d74aa7>

suitable prior experience or adolescent aged children such as child D and accordingly had not recommended them as suitable prospective carers for child D.”

Effectively, Sheriff Bicket held that if the foster child had not been placed with Mrs McKenzie, for the reasons stated above, Mrs McKenzie’s death might have been avoided, as the child would not have been living in her home and would not have stabbed her to death.

The Crown submits that it would have been a reasonable precaution, on hindsight, in terms of s6(1)(c), if DVLA had sought further medical information and had not accepted the little information that had been submitted in Form D4 in relation to Mr Gordon’s hypertension, and that in these circumstances the group 2 licence may not have been granted on the basis of the further information provided and that therefore the death might have been avoided.

- 4.3 The Crown does not assert that DVLA’s decision was incorrect (page 6, DVLA submissions), in terms of the following DVLA processes. It is simply submitted that, on hindsight, given the two high blood pressure readings that were recorded on Form D4, only one of which met the standard, it would have been a reasonable precaution to seek further information in respect of Mr Gordon’s blood pressure history, in particular given the information that the Court has in respect of Mr Gordon’s high blood pressure readings over several years and his attendance at the blood pressure clinic.

4.4 DVLA considers that “there was no evidence in the FAI that would support a finding that on the balance of probabilities if further information had been provided to the DVLA in relation to Mr Gordon’s application in November 2013, Mr Gordon’s application for a group 2 licence would have been refused.” This assertion by DVLA is not consistent with the evidence of Dr Parry, who in evidence conceded that a group 2 licence would not have been issued to Mr Gordon, had DVLA had knowledge of his last three blood pressure readings. Moreover, in the context of Mr Gordon’s longstanding poor blood pressure history (as outlined in Crown Production 38), had DVLA requested further information from the GP and potentially thereafter from the blood pressure it can indeed be argued that the application may have been refused.

4.5 DVLA considers that the Crown misunderstands the purpose of the At a Glance guidance (page 8 DVLA submissions) and stated in submissions that “the primary purpose of the Guide is to assist doctors in advising patients whether or not patients should advise the DVLA of their medical condition.”

It is also, however, the duty of doctors advising patients in relation to driving to advise a patient when the doctor considers that a patient should not be driving, pending a final decision being made by DVLA⁴. In order to give such advice, the Crown argues that doctors must surely base their advice to patients upon information or criteria that is consistent with the criteria upon which DVLA

⁴ See At a Glance Guide, page 9, March 2016 edition

ultimately makes its decisions as to whether or not a person is fit to drive or to continue driving.

- 4.6 DVLA contests the Crown's position that there is a lack of clarity of the definition of "consistently" in the At a Glance blood pressure guidance (page 10, DVLA submissions). DVLA states in submissions that "it is clear that the doctors who were asked about what they meant by "consistently" gave what they considered to be in its ordinary meaning." The Crown respectfully disagrees with this submission. The medics who were asked what they understood by the word "consistently," explained their interpretation of its use in the context of the At a Glance guidelines in respect of hypertension. All of the doctors interpreted "consistently" in a different way, resulting in a different approach to reaching a decision about a patient's state of health in relation to blood pressure issues.

Dr Parry accepted in evidence that the varying interpretations of the word "consistently" could potentially result in differing decisions being made by medics in relation to the same patient.

Section 6(1)(e) does not require the Crown to present to the Court evidence that the word "consistently" should be interpreted in any particular way. Nor does the Crown for the purposes of s6(1)(e) require to show that the Medical Advisory Panel was "wrong." The Crown has simply highlighted that there is a lack of clarity in relation to terminology used by DVLA which creates the potential for lack of consistency in the decision making of medics.

4.7 The issue of Form D4 being completed without access to medical records was explored during this Inquiry. Dr Somerville spoke to her role as a medic completing Form D4 without access to medical records. Dr Parry also gave evidence in respect of this issue. Dr Parry specifically stated in evidence that he did not consider that it was possible for anyone OTHER THAN a GP (or presumably a doctor with access to the patient's GP records) to complete Question 7 of Section 5 of the most up to date Form D4.

In conclusion, the Crown would like to thank the witnesses for their assistance and your Lordship for the courtesy and patience shown during this Fatal Accident Inquiry.

ANNEX 1: LEGAL FRAMEWORK FOR SUBMISSIONS

The Crown would respectfully submit that the following are general propositions of law which are applicable to the proceeding submissions:

3.1 The meaning of "Accident"

The Crown respectfully adopts the description of an accident in this context as "an unfortunately incident that happened unexpectedly and unintentionally, typically resulting in damage or injury."⁵

⁵ Determination into the death of Alexander Cusker, 16 December 2008, Sheriff JK Mitchell, Glasgow:

<http://www.scotcourts.gov.uk/opinions/Cusker.html>: In Mr I H B Carmichael's *Sudden Deaths & Fatal Accident Inquiries*, third edition, at para 5.69, the learned author states:- "Accidents can occur anywhere and in almost any context...If a patient died...as a result of an error which occurred in a...therapeutic procedure, that death results from an 'accident.' I respectfully accept the learned author's approach to and interpretation of the term "accident" as it is used in the 1976 Act. In its common usage, an "accident" is "an unfortunate incident that happens unexpectedly and unintentionally, typically resulting in damage or injury": see the New Oxford Dictionary.

3.2 A Fatal Accident Inquiry is not a fault finding exercise

“The function of the sheriff at a fatal accident inquiry in making his determination does not include making any finding of fault or apportioning blame between any persons who might have contributed to the accident. The Act does not empower the sheriff to do that. this was authoritatively stated in the case of **Black v Scott Lithgow Limited** 1990 SC 322; 1990 SLT 612 in which Lord President Hope, in his opinion, took the opportunity to state the function in the following terms:-

“There is no power in this section to make a finding as to fault or to apportion blame between any persons who might have contributed to the accident. ...It is plain that the function of the sheriff at a fatal accident inquiry is different from that which he is required to perform at a proof in a civil action to recover damages. His examination and analysis of the evidence is conducted with a view only to setting out in his determination the circumstances to which the subsection refers, insofar as this can be done to his satisfaction. He has before him no record or other written pleading, there is no claim or damages by anyone and there are no grounds of fault upon which his decision is required. The inquiry is normally held within a relatively short time after the accident ...It provides that first opportunity to canvass matters relating to precautions which might have avoided the death or any defects in any system of working which contributed to it, at a stage when these issues have not been clearly focused by the parties to any future litigation which may arise. And it is not uncommon

...to find questions being asked about possible precautions or defects which are not the subject of averment in the subsequent action of damages.” (p 327 and 615G to H)”⁶

3.3 A Fatal Accident Inquiry is not the proper forum for determination of criminal or civil liability

“Some of the solicitor and counsel acting for the parties represented at the Inquiry made certain submissions as to how the terms of the subsections of section 6(1) of the Act should be interpreted and applied in my determination. It was submitted that particular rules apply in the case of fatal accident inquiries that involve medical professionals. It was said that in order for me to hold that there were reasonable precautions that might have been taken by members of the medical profession whereby the death might have been avoided the standard required to be applied was, by analogy, the one to be found in *Hunter v Hanley* 1955 SC 200. In other words, I was not entitled to consider evidence of what others say they might have done or do in deciding whether there existed a reasonable precaution. Only expert evidence on what would have been a reasonable precaution for the particular medical practitioner to have taken considered similarly to the *Hunter v Hanley* professional negligence standard was sufficient. In the absence of the Crown leading such expert evidence, it was argued, I did not have sufficient evidence before me to entitle me to be satisfied that such reasonable precautions existed. I reject that argument. It is based on a misunderstanding of the law in relation to fatal accident inquiries. Entitlement to decide whether I am satisfied that it has been established that there exists a reasonable

⁶ Determination into the death of Margaret Westwater Gill, 30 September 2009, Sheriff I H L Miller, Glasgow;
<http://www.scotcourts.gov.uk/opinions/2B224908.html>

precaution whereby the death and any accident resulting in the death may have been avoided, in my opinion, only requires it to be demonstrated, with the benefit of hindsight, that the precaution might have prevented the death or accident and, that it was a reasonable precaution in the ordinary sense of that word. In that regard I agree with the comments made by Sheriff Reith QC (et al.) that the reference of the precautions concerned... A fatal accident inquiry is not the proper forum for determination of criminal or civil liability”⁷

3.4 Is it proper to apply hindsight when identifying reasonable precautions. The “reasonableness” of the precaution relates to “availability and suitability” rather than foreseeability of risk.

“in my opinion a Fatal Accident Inquiry is very much an exercise in applying the wisdom of hindsight. It is for the Sheriff to identify the reasonable precautions, if any, whereby the death might have been avoided. A Sheriff is required to proceed on the basis of the evidence adduced without regard to any question of the state of knowledge at the time of death. The statutory provisions are concerned with the existence of reasonable precautions at the time of death and are not concerned with where they could or should have been recognised. They do not relate to the question of foreseeability of risk at the time of death which would be a concept relevant to the context of our fault-finding exercise, which this is not. The statutory provisions are widely drawn and are intended to permit retrospective consideration of the matters with the benefit of hindsight and on the basis of the information and evidence available

⁷ Determination into the death of Keiran Nichol, 3 June 2010, Sheriff G Liddle, Edinburgh:
<http://www.scotcourts.gov.uk/opinions/2010FAI25.html>

at the time of the Inquiry. There is no question of the reasonableness of any precaution depending upon the foreseeability of risk. In my opinion, the reference to reasonableness relates to the question of availability and suitability or practicability of the precautions concerned... In my opinion, 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 no reasonable precautions, if any, whereby the death might have been avoided, 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 their 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 a death in the future.”⁸

3.5 The test for a 6(1)(c) finding relates to a “lively possibility” that the death may have been avoided

The Crown respectfully adopts

“In relation to making a finding as to the reasonable precautions, if any, whereby the death and any accident resulting in the death might have been avoided (section 6(1)(c)) it is clearly not necessary for the court to be satisfied that the proposed precaution would in fact have avoided the accident or the death, only that it might have done, but the court must, as well as being satisfied that the precaution might have prevented the accident or death, be satisfied that the precaution was a reasonable one.”

“The phrase ‘might have been avoided’ is a wide one which has not, so far as I am aware, been made the subject of judicial interpretation. It means less than ‘would, on

⁸ Determination into the death of Sharman Weir, 23 January 2003, Sheriff FL Reith, Glasgow:

http://www.scotcourts.gov.uk/opinions/2B1596_01.html

the probabilities have been avoided' and rather directs one's mind in the direction of the lively possibilities."⁹

3.6 With reference to submissions relating to the conduct of medical practitioners, the following remarks are respectfully adopted:

"In terms of section 6(1)(c) (the reasonable precautions, if any, whereby the death and any accident resulting in the death might have been avoided), there are two parts to any finding under this heading. First, the court must be satisfied that the precaution was such that it might (not would) have prevented the death. Secondly, in addition the court must be satisfied that the precaution is a reasonable one. What is reasonable has been the subject of much discussion. I was referred to a number of observations by learned Sheriffs in various inquiries. It seems to me clear that, having regard to the purpose of a fatal accident inquiry, the court is afforded a wide discretion to consider these issues with the benefit of hindsight. The statutory provisions are not concerned with whether such reasonable precautions could or should have been recognised, only whether they existed. The sheriff is encouraged to look at the broad circumstances in which the death occurred to determine whether any such precautions existed whereby the death might have been avoided. Therefore I concur with the view of my learned colleague Sheriff Fiona Reith QC that there can be no question of the reasonableness of the precaution depending on foreseeability of risk. (Inquiry into the death of Sharmain Weir, Glasgow 23 January 2003) Notions of reasonable foreseeability, standards and duties of care are properly matters for another forum. The purpose of identifying

⁹ Sheriff Kearney's determination of 17 January 1986, in the death of James McAlpine, referred to at paragraph 8-99 of the 3rd edition of *Sudden Deaths and Fatal Accident Inquiries* by Ian Carmichael

reasonable precautions which might have prevented the death is to inform those looking to the future so that steps may be taken to prevent future accidents and death.

Equally, it seems to me that it cannot be said, as was suggested, that consideration of what is or not reasonable in a “medical FAI” is any different from any other type of inquiry. It is certainly no different from any other inquiry in which the subject matter under consideration, as here, is of a complex technical nature. In these types of inquiry, what is important is that the sheriff understands what is involved and has the assistance of professional and expert witness to explain and interpret these complexities – in this case, procedures involved in the induction of anaesthesia. Individual actions are not to be judged in strict terms of the civil standard of the reasonably competent medical practitioner. But, fairness and principles of natural justice require that the court looks at the whole facts and circumstances as they existed at the time and in considering whether a precaution was reasonable will often be informed and guided by the observations and opinions of skilled witnesses who inevitably will consider the issue in that light of accepted professional practices and procedures. The court can take these matters into consideration whilst still applying the wisdom of hindsight in determining whether a particular precaution was reasonable: the two concepts are not necessarily incompatible.”¹⁰

Also, see para 3.3 above.

¹⁰ Para 117-119 Determination into the Death of Gordon Ewing, Sheriff L Ruxton, Glasgow Sheriff Court 2009

3.7 The definition of and test for identifying and a defect in a system of work under 6(1)(d)

“Different considerations apply to a finding under section 6(1)(d) (the defects, if any, in any system of working which contributed to the death). Here the court must be satisfied, on the balance of probabilities, that there is a casual link between the defect and the death. –

Although the wording of the subsection has its origins in the Factories Acts of the late 19th century, the phrase “system of working” in modern times is widely interpreted. In the words of the learned author, *[t]he phrase “system not working” must be understood as including... any system – or lack of system – of working such as supervision where necessary, or routine in a custodial institution, where such has contributed positively to the death or accident resulting in death. It must also include systems (or lack of systems) and routines of laboratory, diagnostic, medical, surgical and therapeutic procedures (Carmichael, ibid at 5-76).¹¹*

The standard to be applied when considering this section is, in the Crown’s respectful submission, helpfully outlined in Sheriff Kearney’s determination of 17 January 1986, in the death of James McAlpine, which are referred to at paragraph 8-99 of the 3rd edition of *Sudden Deaths and Fatal Accident Inquiries* by Ian Carmichael.

Sheriff Kearney observed:-

“In deciding whether to make any determination (under section 6(1)(d)) as to the defects if any in any system of working which contributed to the death or any accident resulting in the death, the court must, as a precondition to making any such recommendation, be satisfied that the defect in question did in fact cause or contribute

¹¹ Para 120-121 Determination into the Death of Gordon Ewing, Sheriff L Ruxton, Glasgow Sheriff Court 2009

to the death. The standard of proof and rules of evidence (apart from the consideration that evidence did not require to be corroborated) is that applicable in civil business (1976 Act section 4(7)) and accordingly the standard to proof is that of the balance of probabilities.”

3.8 Function of s6(1)(e)

This section allows the making of determinations relevant to the deaths, but which have not been proved to have any causative effect.¹²

¹² IHB Carmichael, Sudden Deaths and Fatal Accident Inquiries, 3rd Edition, paragraph 5-77

APPENDIX 12 – SUBMISSIONS FOR AIRLINK MANAGEMENT LIMITED (MR GORDON’S EMPLOYERS)

1. Executive Summary

- 1.1 The evidence does not support a finding that Mr Gordon’s health contributed either to the road traffic accident or to Mr Gordon’s death.
- 1.2 On the basis of the information contained within Mr Gordon’s November 2013 application for a vocational driving licence, the information provided by him to Dr Somerville and the blood pressure readings obtained by her, it was appropriate for DVLA in December 2013 to issue Mr Gordon with a vocational driving licence valid for a period of 5 years.
- 1.3 It was reasonable for Airlink to employ Mr Gordon as a driver. Approximately six months before his employment, Mr Gordon had undergone the D4 medical assessment (November 2013) and had then been issued by DVLA with a vocational driving licence (December 2013). This licence entitled him to drive Group 2 vehicles until December 2018. At interview, he produced a copy of his Certificate of Professional Competence (CPC) confirming that he had undergone 35 hours CPC earlier in 2014.
- 1.4 There was no reason why Airlink should not have relied on the issue of a five year vocational driving licence in December 2013 by DVLA and on the Certificate of Professional Competence documentation which Mr Gordon provided as proof of his fitness and competence for the driving job he was employed to do.
- 1.5 Appropriate training had been provided to Mr Gordon by Airlink.

- 1.6 An appropriate and properly maintained vehicle had been provided to Mr Gordon by Airlink.
- 1.7 It is respectfully submitted that there were no reasonable precautions which Airlink might have taken whereby Mr Gordon's death might have been avoided.
- 1.8 It is respectfully submitted that the three eye-witnesses Richard Clifford, Denis Gallacher and Malcolm Newlands were credible witnesses. They have done their best to tell the truth.
- 1.9 When the evidence of one witness is contrasted with the evidence of another there are conflicts. This is entirely in keeping with what one might expect when assessing the eye witness accounts from different witnesses in respect of a sudden, unexpected and distressing event viewed from different vantage points.
- 1.10 When the evidence of the eye witnesses is contrasted with the collision investigation report there are apparent discrepancies. These discrepancies give rise to questions about the reliability of the eye witness evidence.
- 1.11 In respect of Mr Clifford, it is respectfully submitted that he assumed, rather than observed, that Mr Gordon had been trying to rectify the position of the minibus.
- 1.12 Mr Gallacher's evidence that he saw Mr Gordon try to steer the minibus to the left may not be reliable. According to PC Simpson, the physical evidence does not support this. However, it cannot be ruled out. The post-impact position of the minibus may have had some bearing on Mr Gallacher's recollection of the events second earlier.

- 1.13 In respect of Mr Newland's impression that the minibus had come round the wrong side of the roundabout, it is respectfully submitted that the witness is mistaken.
- 1.14 It is respectfully submitted that Mr Gordon's death might have been avoided if the Ford Transit minibus had not entered the opposing lane of Sanderling Road as he exited the roundabout where the minibus collided with the LGV being driven in the opposite direction by Denis Gallacher.
- 1.15 It is respectfully submitted that the mechanical condition of the Ford Transit minibus and the trailer were not contributory factors in the collision.
- 1.16 It is respectfully submitted that the MAN tractor unit and SD semi-trailer were not contributory factors in the collision.
- 1.17 The court will be respectfully invited to find that Mr Gordon's death was on 2 July 2014 at 13.15 hours at the Southern General Hospital, Glasgow. The accident resulting in the death took place at around 1130 hours on 2 July 2014 at Sanderling Road, Paisley. The cause of death was chest injury due to road traffic accident.
- 1.18 The court will be respectfully invited to find that there were no defects in any system of working which contributed to the death or any accident resulting in the death.
- 1.19 The court will be respectfully invited to find that there are no other facts which are relevant to the circumstances of the death.

2. Mr Gordon's health

Overview

- 2.1 The court has heard detailed evidence in respect of Mr Gordon's medical history, health issues and treatment.

Submission

- 2.2 The evidence does not support a finding that Mr Gordon's health contributed to the road traffic accident or to Mr Gordon's death.

3. Mr Gordon's November 2013 D2 application for a vocational driving licence

Overview

- 3.1 Mr Gordon's D2 application for his vocational driving licence is dated 22 November 2013. It is contained within Crown production 16. Part 4 of the D2 form is headed "Your health." The first question asked in this section is "Have you ever had, or do you currently suffer from any of the following conditions?" and the section goes on to list twenty-three conditions. One of the conditions listed (at 21) is "sleep apnoea syndrome." Mr Gordon answered "No" to the first question.
- 3.2 As part of the application process, Mr Gordon underwent a D4 vision and assessment on 22 November 2013. The assessment was carried out by Dr Somerville. She recorded her findings on the eight page medical examination report contained in Crown production 16.
- 3.3 In her evidence (Day 6: 16 February 2016), she stated that her methodology in carrying out a D4 medical examination was to ask the person general questions initially about illness, hospital attendances, operations, clinic attendances,

medication and any regular attendance at the person's GP. The initial questions were to guide what questions may need to be answered more fully and to provide her with an overall awareness of the person's health. She would then go through each question on the form individually with the person.

- 3.4 Part 4G of the medical examination report is headed "Blood pressure." It contained two sections. The first section contained the request "Please record today's blood pressure reading" and a box for the insertion of the reading. Dr Somerville inserted the reading "176/106". The second section contained the question "Is the applicant on anti-hypertensive treatment?" and then the request "If YES provide previous readings with dates if available." Dr Somerville answered the question "yes" and inserted "not available" after the request for three previous readings. She inserted the reading "172/94" and the date 22 November 2013. In her evidence, she explained that this was the second reading taken by her on the day of her examination of Mr Gordon. She took a second reading because Mr Gordon told her that he had white coat syndrome. She explained with white coat syndrome that the blood pressure reading often settles if repeated 5-10 minutes later.

- 3.5 Part 5 of the medical examination report is headed "General." It contains eleven numbered questions about a wide variety of medical conditions. Mr Gordon answered all questions in the negative. The relevant questions are 7 and 11. Question 7 is in two parts. Question 7(a) asks "Is there any history of, or evidence of, obstructive sleep apnoea syndrome?" and question 7(b) asks "Is there any other medical condition causing excessive daytime sleepiness?"

Question 11 asks “Does the applicant have any other medical condition that could affect safe driving?” Dr Somerville stated in evidence that she asked Mr Gordon “have you ever had sleep apnoea?” Mr Gordon answered this question in the negative. She stated that she usually asked people she was examining if they were sure because some people may not know what sleep apnoea is. If symptoms suggestive of sleep apnoea were given, she would advise them to see their GP to get it investigated. She stated that if the person she was examining said that she/he had been to a sleep clinic then she would document this in PART 7 where it requests consultants’ details.

- 3.6 Part 6 of the medical examination report is headed “Further details” and has a box for the medical examiner to enter information. Dr Somerville entered the following information: “Completed without access to medical notes” and “Attends GP for BP. GP suspects has white coat hypertension.”
- 3.7 Part 7 of the medical examination report is headed “Consultants’ details.” Dr Somerville stated in evidence that she would usually ask the person she was examining “Do you attend or have you recently attended any hospital clinic?” She stated that this was one of the initial general questions she would ask and then she would ask it again when she reached Part 7.
- 3.8 Following the medical examination, the D2 and D4 forms were submitted to DVLA.
- 3.9 The D2 and D4 forms were received by DVLA, Swansea. The application was referred by an administrative officer to Carole Tamplin, a medical executive officer there.

- 3.10 Carole Tamplin gave evidence (Day 11: 11 March 2016). She has worked in the drivers' medical section at DVLA since 1999. She stated that she took the best blood pressure reading on the day of the examination. The best reading on Mr Gordon's D4 application was 172/94 which was within the acceptable standard of 180/100. She explained that during her 20 years' with DVLA when two readings have been taken on the same day it has always been the best reading which is taken by DVLA.
- 3.11 In respect of Part 7 of the D4 form, Carole Tamplin stated that information about a consultant would prompt action on her part in that she would discuss the issue with a medical assessor. She did not know whether or not an administrative officer would bring such an entry to her attention.

Submission

- 3.12 On the basis of the information contained within Mr Gordon's November 2013 application for a vocational driving licence, the information provided by him to Dr Somerville and the blood pressure readings obtained by her, it was appropriate for DVLA in December 2013 to issue Mr Gordon with a vocational driving licence valid for a period of 5 years.

4. Mr Gordon's employment by Airlink

Overview

- 4.1 Mr Gordon's former partner Mary Kelly gave evidence to the Inquiry (Day 1: 8 February 2016) that, after the death of his wife, he had been actively seeking work. He was always at the job centre and training things. It was her impression the staff at the job centre encouraged him to apply for driving jobs.

- 4.2 Rhianna Carr gave evidence to the Inquiry (Day 2: 9 February 2016) in respect of Airlink's employment of Mr Gordon. Mr Gordon had submitted his CV (Crown production number 36) in response to an advert. The CV showed that Mr Gordon had previous driving experience. In 2014 Mr Gordon had undergone 35 hours driver CPC (Certificate of Professional Competence) training with GTG Training. She was aware of GTG as a training organization because a few years' earlier GTG had provided training for Airlink drivers. She stated that CPC training was a job requirement. All applicants were expected to have CPC and those who did not were dispensed with. The driving requirement for this position was a full category D entitlement. Mr Gordon had been granted a full category D entitlement for a period of five years in December 2013 by DVLA.
- 4.3 Mr Gordon was interviewed by Rhianna Carr in June 2014. At interview, she asked if he had any health conditions which might affect his ability to drive. Rhianna Carr explained in her evidence that a question is asked about health conditions because she would need to inform the company's insurers. She would take advice from the company's insurers in respect of health conditions. By way of illustration, she informed the court that one of the drivers had type 2 diabetes which she needed to inform the company's insurers about. Mr Gordon said that he did not, that he had just passed his medical in December and there were no issues. She had taken copies of his driving licence and CPC training card which she kept on file. She remembers him as being very friendly, having a nice manner, being well spoken and pleasant which were important qualities in

customer service. She later handed her file copies of Mr Gordon's driving licence and CPC training card to the police.

4.4 Around 29 June 2014 he was offered the job of day shift driver. Defence production number 3 consists of a thread of emails which show that on 29 June 2014 Mr Gordon accepted the job offer.

4.5 Mr Gordon commenced employment on 30 June 2014. He received training on this day between 8.45am and 1.15 pm from Brian Rice.

4.6 Brian Rice gave evidence to the Inquiry (Day 2: 9 February 2016). The training is recorded on Crown production number 19. The shift report for 30 June 2014 states "Douglas was in for training between 8.45am and 1.15pm for training" (email entry at foot of second page of Defence production number 3).

4.7 Brian Rice stated in evidence that the training of a new driver included the following: showing the route to and from the airport; showing the driver the one way system, where to pick up and drop off; using radio to contact office; how to load and unload the trailer; how to remove and attach the trailer which involved disconnecting the electrics, safety clip and two safety pins, to remove another big pin, safety cable, remove number plate then in reverse to put it all back together again; taking the new driver to all sites and introducing the new driver to everyone; explaining daily check sheets for bus roadworthiness; explaining the rota and holiday request form.

4.8 Brian Rice described Mr Gordon as a lovely big guy. He did not recall Mr Gordon having any issues with the training. He spoke with Mr Gordon on 1 July

2014. He could not remember anything being said by Mr Gordon which caused him a concern.

4.9 Rhianna Carr stated in her evidence that she saw Mr Gordon on 30 June 2014 (day of his training) and on 1 July 2014. As operations manager, she would have caught up with him three or four times over the course of a day. She further stated that a receptionist had informed her that on the morning of 2 July 2014 Mr Gordon had had a coffee break in the reception area.

4.10 At the time of Mr Gordon's employment, Airlink carried out disclosure checks in respect of new employees; the company did not seek references. Since May 2015, the company has sought references in addition to carrying out disclosure checks.

Submission

4.11 It was reasonable for Airlink to employ Mr Gordon as a driver. Approximately six months before his employment, Mr Gordon had undergone the D4 medical assessment (November 2013) and had then been issued by DVLA with a vocational driving licence (December 2013). This licence entitled him to drive Group 2 vehicles until December 2018. At interview, he produced a copy of his Certificate of Professional Competence from GTG confirming that he had undergone 35 hours CPC earlier in 2014.

4.12 There was no reason why Airlink should not have relied on the issue of a five year vocational driving licence in December 2013 by DVLA and CPC documentation which Mr Gordon provided as proof of his fitness and competence for the driving job he was employed to do.

4.13 Appropriate training had been provided to Mr Gordon by Airlink.

4.14 An appropriate and properly maintained vehicle had been provided to Mr Gordon by Airlink.

4.15 It is respectfully submitted that there were no reasonable precautions which Airlink might have taken whereby Mr Gordon's death might have been avoided.

5. The road traffic accident on 2 July 2014

Overview

5.1 That on 2 July 2014 at around 1100 hours Mr Gordon was driving a white Ford Transit minibus bearing registration mark SJ 13 JYU ["the minibus"] between McDowall Street, Paisley and Glasgow Airport. In Sanderling Road, Paisley the minibus collided with a heavy goods vehicle registration number T40 STS ["the HGV"] being driven by Denis Gallacher. The minibus was being driven in a western direction. After negotiating the roundabout adjacent to the BP service station, the minibus and trailer entered the eastbound lane. The HGV was being driven in an eastern direction in the eastbound lane. The collision took place in eastbound lane approximately 36 metres west of the roundabout junction with White Cart Road, as illustrated in Crown production number 5 (scale plan).

5.2 That at the time of the collision, the minibus did not have any passengers in it. The minibus was towing a luggage trailer.

5.3 Richard Clifford gave evidence to the Inquiry (Day 1: 8 February 2016).

5.4 Mr Clifford stated that at around 1115 hours on 2 July 2014 he drove his taxi from White Cart Road onto the roundabout with Sanderling Road. He saw the minibus being driven "quite fast" by Mr Gordon. Although he had right of way, he stopped abruptly on the roundabout to avoid being struck. The minibus went

straight ahead but trailer was moving left to right. He thought that because of the speed of the minibus coming round the roundabout the trailer wasn't stable.

- 5.5 When questioned by the court, Mr Clifford stated that the minibus was in the left hand lane (bounded by the double yellow lines) when it entered the roundabout. The minibus then changed lanes on the roundabout. The minibus moved across onto the other side of the road just as it left the roundabout. There was nothing on the road to force the minibus onto the other side of the road. It was all over in about ten seconds. Mr Gordon would not have seen the HGV until the last minute because of the trees and foliage on the roundabout.
- 5.6 Mr Clifford thought that the minibus was drifting a bit and Mr Gordon was trying to rectify his position and the trailer at the back would not allow him to do it. He later clarified when questioned by the court that it was an assumption on his part that Mr Gordon was trying to rectify the position of the minibus.
- 5.7 Mr Clifford described Mr Gordon as sitting up at the wheel in a normal manner when the minibus entered the roundabout. He thought that the look on Mr Gordon's face was maybe apologetic as he (Mr Clifford) had right of way on the roundabout and Mr Gordon was going fast.
- 5.8 Mr Clifford, Mr Gallacher and others tried to assist and comfort Mr Gordon who was trapped in the minibus until the arrival of the emergency services.
- 5.9 Denis Gallacher gave evidence to the Inquiry (Day 1: 8 February 2016).
- 5.10 Mr Gallacher stated that he drove on Sanderling Road every day. On the day of the accident, he was driving his HGV maybe 30 yards from roundabout when the minibus being driven by Mr Gordon came off the roundabout. He looked down

and saw Mr Gordon lying across the passenger seats with his right hand at 12 o'clock on the steering wheel. Mr Gordon's face was down in the seat and he could only see the back of his head. Mr Gordon was not looking towards the road.

- 5.11 Mr Gallacher described hearing a loud rev from the engine and seeing the vehicle shoot over to his side of the road. It was only in the last 7 metres or so that the minibus shot over to his side of the road. Just before the collision, the driver looked up and tried to steer to the left. Mr Gordon partially released his grip for a second and then tightened his grip. When later questioned by the court, Mr Gallacher stated that the release was a very small release, it was not to the extension of fingers and it was for nanoseconds. Mr Gallacher stated that he did brake to try to avoid the collision.
- 5.12 Immediately after the collision, Mr Gallacher reversed his vehicle about 4 feet to allow the fire brigade access to the minibus. Before he exited the lorry cab, he called his work, told them what had happened and asked them to call the fire brigade and ambulance. He described the emergency services as being there within minutes. He spoke to Mr Gordon who was trapped in the minibus and was having trouble breathing.
- 5.13 Malcolm Newlands gave evidence to the Inquiry (Day 1: 8 February 2016).
- 5.14 At the time of the collision, Mr Newlands was driving a silver Ford Transit van in Sanderling Road in an easterly direction behind the HGV being driven by Mr Gallacher. He described seeing the collision between the HGV and the minibus

being driven by Mr Gordon. It was his impression that the minibus had come round the wrong side of the roundabout.

Submission

- 5.15 It is respectfully submitted that the three eye-witnesses were credible. They have done their best to tell the truth.
- 5.16 When the evidence of one witness is contrasted with the evidence of another there are conflicts. This is entirely in keeping with one might expect when assessing the eye witness accounts of different witnesses in respect of a sudden, unexpected and distressing event viewed from different vantage points.
- 5.17 When the evidence of the eye witnesses is contrasted with the collision investigation report there are apparent discrepancies. These discrepancies give rise to questions about the reliability of the eye witness evidence.
- 5.18 In respect of Mr Clifford, it is respectfully submitted that he assumed, rather than observed, that Mr Gordon had been trying to rectify the position of the minibus.
- 5.19 Mr Gallacher's evidence that he saw Mr Gordon try to steer the minibus to the left may not be reliable. According to PC Simpson, the physical evidence does not support this. However, it cannot be ruled out. The post-impact position of the minibus may have had some bearing on Mr Gallacher's recollection of the events seconds later.
- 5.20 In respect of Mr Newlands' impression that the minibus had come round the wrong side of the roundabout, it is respectfully submitted that the witness is mistaken.

- 5.21 It is respectfully submitted that Mr Gordon's death might have been avoided if the Ford Transit minibus had not entered the opposing lane of Sanderling Road as he exited the roundabout where the minibus collided with the LGV being driven in the opposite direction by Denis Gallacher.

6. The Police Scotland collision investigation and the evidence of PC Scott Simpson

Overview

- 6.1 Crown production number 4 is the Police Scotland collision investigation report. It was prepared by Police Constable Scott Simpson and corroborated by Police Constable Ewan Thomson, PC Simpson gave evidence to the Inquiry (Day 2: 9 February 2016). PC Simpson's experience and qualifications are set out on page 4 of the report. Much of the report has been incorporated into the second joint minute of agreement.
- 6.2 PC Simpson was asked what impact the trailer would have had on the minibus if the minibus was speeding around the roundabout and the trailer was moving from side to side. He explained that 750kg is maximum allowed weight for the trailer when full. The trailer was empty. He stated that he was unable to say whether having an unladen trailer would then cause a swaying action. He further explained that the maximum allowed weight of the trailer is such that it did not require an additional braking system. He concluded from this that it had obviously been decided that a trailer of this size does not impact enough on vehicle handling to require an additional braking system. If a trailer is heavy enough then the main vehicle's brakes may not be enough and then would need

additional braking system. However, the weight of the trailer in this case did not require that additional braking system.

- 6.3 PC Simpson was asked whether the trailer swaying from side to side would have an impact on the minibus. He emphasised that there is the potential for it to cause an imbalance to the rear of the minibus but that was all he could say. He further stated that he was not aware of an accident having been contributed by the scenario of a trailer swaying from side to side.
- 6.4 PC Simpson repeated in evidence the opinion expressed in the report (near top of page 13) that the damage sustained by the vehicles would suggest that the minibus was travelling at a speed in excess of the 30mph speed limit.
- 6.5 PC Simpson repeated in evidence the conclusion expressed in the report (at foot of page 14) that the collision was the result of Mr Gordon negotiating the roundabout at excessive speed, losing control of his vehicle and entering the opposing lane of Sanderling Road as he exited the roundabout where he collided with the LGV being driven in the opposite direction by Denis Gallacher. At the time of the collision it was daylight, overhead conditions were overcast and it was dry. The carriageway surface was in a good state of repair and visibility was good. Mechanical examination of the vehicles involved revealed no defects.
- 6.6 PC Simpson confirmed that business cards and paperwork were found in the driver's compartment. He was unable to say where these items had been prior to the collision.

6.7 PC Simpson calculated, on the assumption that Mr Gordon was driving the minibus at 30 mph, the time gap between the minibus being driven onto the roundabout and the minibus colliding with the HGV would be 5.82 seconds.

6.8 PC Simpson stated that there was no physical evidence to support the proposition that just before the collision Mr Gordon had tried to steer the minibus to the left but that the proposition could not be discounted.

Submission

6.9 It is respectfully submitted that Mr Gordon's death might have been avoided if he had not negotiated the roundabout at excessive speed, lost control of the Ford Transit minibus and entered the opposing lane of Sanderling Road as he exited the roundabout where the Ford Transit minibus collided with the LGV being driven in the opposite direction by Denis Gallacher.

7. The inspection of the vehicles and trailer units

7.1 The Ford Transit minibus and the MAN tractor unit of the HGV were damaged. The damage is described in Crown production number 4 and in the joint minutes. The damage can be seen in photographs contained in Crown production numbers 9, 10 and 20.

7.2 The trailer which the Ford Transit minibus was towing did not require a separate braking system. The minibus and trailer were inspected on 7 July 2014 by George Scott McIntyre, Vehicle Examiner appointed by the Department of Transport under the provisions of the Road Traffic Acts 1988 and 1991. Mr McIntyre's vehicle examination report is included as an appendix to Crown production number 4 (Police Scotland collision investigation report) and referred to at page

13 of the report. His findings are summarised at paragraph 23 of the first joint minute of agreement. There were no pre-collision defects noted that could have led to a loss of control of the Ford Transit minibus or trailer or increased the severity of the collision. The mechanical condition of the Ford Transit minibus and trailer were not contributory factors in the collision.

- 7.3 The SD semi-trailer and MAN tractor unit of the HGV was inspected on 7 and 8 July 2014 respectively by said George Scott McIntyre. Mr McIntyre's vehicle examination report is an appendix to Crown production number 4 (Police Scotland collision investigation report) and referred to at page 13 of the report. His findings are summarised at paragraphs 25 and 24 of the first joint minute of agreement. At the time of the inspection, there were no pre-collision defects noted that could have led to a loss of control of the vehicle or increased the severity of the collision. The mechanical condition of the SD semi-trailer and the MAN tractor unit of the HGV were not contributory factors in the collision.

Submission

- 7.4 It is respectfully submitted that the mechanical condition of the Ford Transit minibus and the trailer were not contributory factors in the collision.
- 7.5 It is respectfully submitted that the mechanical condition of the MAN tractor unit and SD semi-trailer were not contributory factors in the collision.

8. Injuries and cause of death

Overview

- 8.1 Mr Gordon sustained injuries in the collision and was trapped in the minibus. The emergency services attended. Mr Gordon was extracted from the vehicle by

fire personnel and ambulance personnel. The medical treatment administered to Mr Gordon at the scene of the accident and subsequently is detailed in paragraphs 8 to 13 of the first joint minute. The injuries are detailed in the post mortem report (Crown production number 1). He died from those injuries on 2 July 2014 at 1315 hours at the Southern General Hospital, Glasgow.

- 8.2 The toxicology report (Crown production number 3) confirms that the blood and urine analysis was negative for alcohol, paracetamol, opiate and drugs of abuse. Blood tests were positive for therapeutic levels of ketamine which was administered in hospital post-accident.

Submission

- 8.3 The cause of death was chest injury due to road traffic accident.

9. Proposed determination

The court is respectfully invited to make the following findings:

Section 6(1)(a): When and where the death and any accident resulting in the death took place

The death was on 2 July 2014 at 0115 hours at the Southern General Hospital, Glasgow. The accident resulting in the death took place at around 1130 hours on 2 July 2014 at Sanderling Road, Paisley

Section 6(1)(b): The cause or causes of the death and any accident resulting in the death

The cause of death was chest injury due to road traffic accident.

Section 6(1)(c): The reasonable precautions if any whereby the death might have been avoided

Mr Gordon's death might have been avoided if Mr Gordon had not negotiated the roundabout at excessive speed, lost control of the Ford Transit minibus and entered the opposing lane of Sanderling Road as he exited the roundabout where the Ford Transit minibus collided with the LGV being driven in the opposite direction by Denis Gallacher.

Section 6(1)(d): The defects, if any, in any system of working which contributed to the death or any accident resulting in the death

None.

Section 6(1)(e): Any other facts which are relevant to the circumstances of the death

None.

**APPENDIX 13 – SUBMISSIONS ON BEHALF OF DENIS GALLACHER AND
SAINTS TRANSPORT LIMITED**

Douglas Brian Gordon, born 24 May 1956, died following a road traffic accident on 2 July 2014. This is a mandatory Inquiry in terms of section 1(1)(a)(i) of the Fatal Accidents and Sudden Deaths Inquiry (Scotland) Act 1976 (hereinafter referred to as “the Act”), his death having occurred during the course of his employment as a PCV driver.

Section 6(1) of the Act provides that at the conclusion of the evidence and any submissions thereon, or as soon as possible thereafter, the sheriff has to make a determination setting out the following circumstances of the death, so far as they have been established to his satisfaction –

- (a) where and when the death and any accident resulting in the death took place;
- (b) the cause or causes of such death and any accident resulting in the death;
- (c) the reasonable precautions, if any, whereby the death and any accident resulting in the death might have been avoided;
- (d) the defects, if any, in any system of working which contributed to the death or any accident resulting in the death; and
- (e) any other facts which are relevant to the circumstances of the death.

1. In relation to section 6(1)(a) of the Act, namely where and when the death of Douglas Brian Gordon took place, and any accident resulting in his death took place, the Court is invited to accept the submissions made on behalf of the Crown.
2. In relation to section 6(1)(b) of the Act, namely the cause or causes of Mr Gordon's death, the Court is invited to accept the submission of the Crown.

In relation to the cause or causes of the accident resulting in the death, the Court is invited to determine that the cause of the accident was the loss of control of the Ford Transit vehicle, registered mark SJ13 JYU driven by Douglas Brian Gordon, whereby it crossed into the path of oncoming heavy goods vehicle registered mark T40 STS and collided with same.

The Inquiry heard evidence from the following eye-witnesses to the accident:-

Richard Clifford has held a drivers licence for 40 years and spent 29 years working as a taxi driver in the Glasgow area. His evidence was that he stopped at a roundabout intending to turn right and saw the heavy goods vehicle travelling towards the roundabout coming from the right, which slowed down on approach to the roundabout.

As Mr Clifford was about to enter the roundabout he saw the minibus driven by the deceased enter the roundabout from his left. The minibus had a trailer attached. Mr Clifford said the minibus "came flying along as if from the back road from Paisley" and that "it was quite fast coming along the road." Mr Clifford had to "stop abruptly" on the

roundabout as the minibus carried on across the roundabout, crossing in front of Mr Clifford and leaving the roundabout at the exit Mr Clifford had intended to use. Mr Clifford's evidence was that had he not stopped, the minibus would have struck his vehicle. The trailer was moving from right to left, and "bouncing all over the place at the back," which he attributed to the speed the minibus travelled across the roundabout.

Mr Clifford saw the deceased, Mr Gordon, when the minibus crossed in front of him. The deceased was sitting in the driver's seat and looked at him with an expression Mr Clifford described as "apologetic maybe." Mr Clifford then followed after the minibus and was therefore facing up Sanderling Road and able to see what happened thereafter.

Mr Clifford's evidence was that shortly after it left the roundabout, the minibus travelled across the other side of the road and collided with the front offside of the lorry which had been approaching the roundabout. He could see no cars in the minibus' lane which might have caused the deceased to cross onto the opposing carriageway.

Denis Gallacher is a heavy goods vehicle driver by occupation. He has held a driving licence for 30 years and an HGV driving licence for around 10 years. He was driving the lorry registered mark T40 STS to Glasgow Airport eastbound along Sanderling Road and was approaching the roundabout junction with White Cart Road when he saw the white Ford Transit minibus driven by the deceased exit the roundabout. Mr Gallacher described the now deceased as lying across the front passenger seat, with his right hand still on the steering wheel at the 12 o'clock position. His face was down towards the seat, so he could

only see the back of his head. He could not see where his left hand was. He described how the deceased loosened his grip on the steering then he heard a loud rev coming from the engine of the minibus which “shot over” to his side of the road. The minibus crossed to Mr Gallacher’s side of the road after passing the traffic island at the point where the centre road markings become a single broken line (seen in Photo 1 in production 10). Just before the minibus collided with the lorry driven by Mr Gallacher, the deceased lifted his head, turned it in the direction of the lorry and tried to steer to the left. Mr Gallacher was then able to see the deceased’s face due to the high vantage point of being in an HGV. Mr Gallacher braked, but could not avoid the collision. He contacted his depot for them to call the emergency services. He reversed the lorry approximately 4 feet to allow access to Mr Gordon by the emergency services. The Court had the opportunity to assess the credibility and reliability of Mr Gallacher. I would invite the court to accept that he was an entirely straightforward and truthful witness.

Malcolm Newlands was driving a Ford Transit van eastbound on Sanderling Road. Ahead of him was another Transit van and in front of that was the lorry involved in the collision. His evidence was that he saw the front of a white Transit van appearing as if it had been in the wrong lane or come the wrong way around the roundabout, although he did not see where it had come from. It collided with the lorry. Mr Newlands stopped his vehicle and took 3 photographs on his phone. His evidence was that he thought that if the van had travelled the correct way round the roundabout he would have seen it doing so.

It is submitted that the evidence of Richard Clifford and Denis Gallacher should be preferred over that of Mr Newlands in relation to the movement of the minibus prior to impact. It is submitted that Mr Newland's evidence is unreliable. He is mistaken that the minibus crossed the roundabout the wrong way or came from the nearside of the eastbound carriageway before the collision. He was further away from the locus, behind another vehicle, without the benefit of the unrestricted views of the minibus Mr Clifford and Mr Gallacher had. It is submitted that as Mr Newlands didn't actually see where the minibus came from before the collision, he has made erroneous assumptions.

The Inquiry also heard evidence from the skilled witness, PC Simpson who has been a qualified Collisions Investigator since 2005. He found no physical evidence consistent with the minibus travelling the wrong way round the roundabout or coming from the nearside of the lorry driven by Mr Gallacher.

PC Simpson examined the scene of the accident and found the road signage to be clear and visible. He marked at "A" on the scale plan he created (Crown Production 5) a locked tyre mark he found at 38m west of the roundabout junction. In his opinion this was caused by the front nearside wheel of the lorry driven by Denis Gallacher locking prior to impact. In his opinion the lorry driver reacted to the minibus entering his lane by braking. This has locked his front nearside tyre and created the mark found on the road.

The tachograph was taken from the lorry driver by Denis Gallacher and information it contained was downloaded and analysed. It showed that the lorry was being driven at 24.9

mph before a sharp reduction in speed at 10:28:42, which PC Simpson attributed to Denis Gallacher reacting to the pressure of the Ford Transit and braking. Prior to that there was a reduction in speed in accordance with what he would expect of a driver approaching the roundabout. In PC Simpson's opinion, Denis Gallacher was driving within the speed limit prior to impact, correctly positioned in his lane. Although there was insufficient physical evidence found at the scene from which PC Simpson could calculate an exact speed for the minibus at the time of the collision, in his opinion the damage sustained by the vehicles suggested a speed in excess of 30mph by minibus.

PC Simpson's evidence was that if the minibus had been travelling at 30mph it would travel at 13.41 metres per second. Given the point of impact was approximately 36 metres west of the roundabout, the minibus travelling at 30mph would therefore have taken less than 3 seconds to travel from the exist of the roundabout to the point of impact. It was agreed that drivers travelling eastbound, in the direction of Denis Gallacher have no view available through the roundabout due to the area of trees situated on the elevated centre of the roundabout (Joint Minute 2, paragraph 42). A driver's reaction time is on average 1-2 seconds. The accident therefore happened very quickly and could not have been avoided by Denis Gallacher.

It was agreed (Joint Minute 1, paragraphs 24 and 25) that the HGV tractor unit and SD semi-trailer driven by Denis Gallacher were examined by a VOSA vehicle examiner and at the time of the inspections, there were no pre collision defects that could have led to a loss of control of the trailer or increased the severity of the collision. The mechanical condition of

the vehicle and trailer were not a contributory factor in the collision. It was also agreed that the vehicle driven by Mr Gordon had no pre-collision defects that could have led to a loss of control.

It was the unchallenged opinion of PC Simpson that Mr Gordon's excessive speed and lack of observation and attention in all likelihood caused the loss of control of the vehicle which has ultimately led to the collision. He could not, however, discount a medical event.

It was agreed (Joint Minute 1, paragraph 16) that evidence of chronic heart disease was found at the post mortem by the pathologist, Dr Bell and she cannot exclude the possibility that natural underlying disease played a part in the road traffic accident.

It is therefore submitted that the probable cause of the accident was Mr Gordon's loss of control of the vehicle, but the reason for him driving at excessive speed, leaning across the passenger seat and not looking ahead cannot be established.

3. In relation to section 6(1)(c) of the Act, namely reasonable precautions, if any, whereby the death and any accident resulting in the death might have been avoided are concerned, the Court is not invited to make any finding. It is submitted that by reference to the evidence led in the Inquiry there were no reasonable precautions which would have been taken by Denis Gallacher or Saints Transport Ltd., which might have prevented this tragedy.
4. In relation to section 6(1)(d) of the Act, namely the defects, if any, in any system of working which contributed to the death or any accident resulting in the death, the

Court is not invited to make any finding. It is submitted that the Inquiry has heard no evidence of any defects in any system of working operated by Mr Gallacher or Saints Transport Ltd., which contributed to the accident resulting in the death of Mr Gordon.

5. In relation to section 6(1)(e), namely any other facts which are relevant to the circumstances of the death, Denis Gallacher and Saints Transport Ltd., have no recommendations to put before the Inquiry for consideration.

Finally, on behalf of Denis Gallacher and Saints Transport Ltd., I express deepest sympathies to the family and friends of Mr Douglas Gordon.

APPENDIX 14 – SUBMISSIONS ON BEHALF OF DR DAVID TAYLOR (MR GORDON'S GENERAL PRACTITIONER) AND DR LESLEY ANNE SOMERVILLE, MEDICAL PRACTITIONER WHO UNDERTOOK THE D4 MEDICAL ASSESSMENT FOR MR GORDON

Introduction

1. Dr Taylor and Dr Somerville, as well as their solicitors and counsel, would like to begin by offering their condolences to the family and friends of Douglas Gordon. This submission is directed at the actions of Dr Taylor and Dr Somerville and why no criticism can legitimately be made of their care and treatment of, and advice to, Mr Gordon. Dr Taylor instigated the process that led to Mr Gordon be diagnosed with OSA. He also gave Mr Gordon advice on the prospects of obtaining such a licence. Dr Somerville was directly involved in the process that led to Mr Gordon being granted a Group 2 driving licence in December 2013. The decision to grant that licence has been put in issue before the Inquiry. Accordingly, some comment is also made on the process that led to the grant of that licence.

The Law

2. There is no dispute between the parties as to the applicable law. It is not proposed to rehearse it again in this submission. It was recently summarised by Sheriff Weir, QC in his Determination in the Inquiry into the death of Sheila Mary Hislop. Dr Taylor and Dr Somerville adopt that account of the applicable law.
3. There is only one matter to add to Sheriff Weir's summary of the law and it concerns the evidence required before criticism can properly be made of a doctor. The law on that

issue was explained by Sheriff Stephen (now Sheriff Principal of Lothian and Borders) in her Determination at an Inquiry into the death of Lynsey Myles:-

“Again lawyers should be slow to comment upon medical practice, far less criticise medical practice, unless there is clear appropriate testimony which challenges the treatment a patient receives. The view I take of this matter is that for precautions to be reasonable they have to be reasonable given the whole circumstances surrounding the patient and treatment of the patient with particular reference to the treating physician and if appropriate his junior medical staff. Before I can find a precaution to be reasonable in the context of a medical issue, there must either be an admission by the treating doctor that he failed to take a precaution or course of action which he clearly ought to have taken, or to the course of action which, in the exercise of ordinary care, ought not to have been taken. Failing that there would require to be established by independent evidence the manner in which the doctor in a particular area of expertise, and with the particular experience, ought to have acted. This clearly requires there to be a standard by which the actings of doctors are judged. As I have said it is wrong for lawyers to be quick to criticise doctors without such justification...”

That passage has since been cited with approval.

4. No such evidence has been led in this case. Furthermore, it appears never to have been the intention of the Crown (or any other party) to lead such evidence.

The Statutory Questions

5. The circumstances in which Mr Gordon died are largely agreed or are otherwise uncontroversial. Dr Taylor and Dr Somerville concur in the findings that the Crown

have proposed in terms of s.6(1)(a) of the 1976 Act. So far as s.6(1)(b) of the 1976 Act is concerned, Dr Taylor and Dr Somerville concur in the Crown's proposal that your Lordship can make a finding that the cause of death was "*1(a) Chest injury, due to 1(b) Road traffic accident (minibus driver)*". Beyond that, Dr Taylor and Dr Somerville submit that the Crown's hypotheses as to why Mr Gordon lost control of his vehicle are entirely speculative. The Inquiry heard no evidence that it was a medical episode that caused the loss of control that led to the collision. In particular, there was no suggestion that Mr Gordon suffered an episode of sleep apnoea or some other event associated with hypertension. The height of Dr Bell's evidence was that she "*can't exclude the possibility*" that underlying natural disease led to the accident. That does not amount to positive evidence from which the Inquiry can make a finding of what did cause the accident. Indeed, there was quite clear and vivid evidence from Mr Clifford that Mr Gordon was seemingly conscious and aware as he passed through the roundabout just moments before the collision. In short, Dr Taylor and Dr Somerville submit that the Inquiry has no evidence before it that allows any positive finding to be made as to the cause of Mr Gordon losing control of his vehicle.

6. In those circumstances, and having regard to the absence of any expert evidence commenting on the actions of Dr Taylor and/or Dr Somerville, there is no basis in the evidence to make any finding under s.6(1)(c) or s.6(1)(e) which is, to any extent, critical of the actions of those doctors. In the event, the Crown make no such proposals. However, lest it be thought that either doctor seeks to shield behind what might be characterised as a "legal" argument, the evidence that was heard by the Inquiry was

supportive and complimentary of the actions of both doctors. Thus examining the evidence that was heard, and setting to one side the warning of Sheriff Stephen, there remains no basis on which the actions of either doctor are open to criticism.

The actions of Dr Taylor

7. Dr Taylor was Mr Gordon's General Practitioner. Two main issues were canvassed with Dr Taylor: the diagnosis of Mr Gordon with sleep apnoea and his blood pressure.

8. There is a preliminary issue to discuss about sleep apnoea before turning to Dr Taylor's evidence on the matter. It is the difference between "Obstructive Sleep Apnoea" ("OSA") and "Obstructive Sleep Apnoea Syndrome" ("OSAS"). At points some witnesses used those terms interchangeably and, potentially, confusingly (including in some literature). There is, however, an important difference: OSA is a fairly common condition whereas OSAS is where OSA causes significant tiredness during normal waking hours. For the DVLA, however, it was the symptoms and not the diagnosis that was of concern to them: whether it was OSA or OSAS that had been diagnosed, they had to be notified if excessive daytime/awake time sleepiness was being caused.

9. So far as the diagnosis of OSA and/or OSAS was concerned, Dr Carlin explained that this would not be made at GP level. The referral by Dr Taylor to the Respiratory Medical clinic was described by Dr Carlin as *"very detailed for primary care"* and *"thorough"*. The note of Mr Gordon's attendance at his GP that led to the referral notes *"no falling asleep at wheel."* That, it is submitted, is significant as it shows that Dr Taylor

was alert to potential fitness to drive issues. Mr Gordon did not present to Dr Taylor with symptoms that would require notification to the DVLA. In any event, he made the appropriate referral. Dr Bannan explained that Mr Gordon was not, following testing, diagnosed with OSAS but he was *“on a journey to OSAS.”* By February 2012, however, Mr Gordon appeared to have improved.

10. Dr Taylor was not directly involved in Mr Gordon’s application for a Group 2 licence.

But he had, prior to the application being made, expressed an opinion on the likelihood of it being granted. Based on the readings in Mr Gordon’s medical records, had Dr Taylor known Mr Gordon held a Group 2 licence, he would have advised him he should stop driving and inform the DVLA. He understood that to be in accordance with GMC Guidelines. The decision to grant Mr Gordon a Group 2 licence is more fully discussed below. It is, however, submitted that Dr Taylor’s evidence properly reflects the GMC Guidelines and, on a plain interpretation of the DVLA guidance, his advice was correct. There is a final point to note. On the D4 form completed by Dr Somerville, in section 6 she has recorded: *“Attends GP for BP. GP suspects has white coat hypertension as home readings normal.”* That overstated Dr Taylor’s view: he hoped it might be a contributory factor but Mr Gordon had had consistently high blood pressure. That is no criticism of Dr Somerville: her source for that note was Mr Gordon.

11. In summary, it is submitted that there is no basis on which the actions of Dr Taylor can be criticised and there is no basis on which any recommendation can or should be made about how Dr Taylor could have acted differently so as to prevent Mr Gordon’s death.

The actions of Dr Somerville

12. Dr Somerville only saw Mr Gordon once: on 22 November 2013 when she undertook a D4 medical examination. She was not Mr Gordon's GP and did not have access to his medical notes. Parliament, in the form of Regulations laid before it by the Secretary of State for Transport, has approved a system whereby any registered medical practitioner can undertake a D4 examination. Her completion of that form was not only subject to no criticism but was praised as a "*rarely seen... counsel of perfection*" by the DVLA's Senior Medical Advisor, Dr Parry. There can, it is submitted, be no criticism of Dr Somerville's actions when she examined the deceased.

13. There are perhaps three points worth highlighting in relation to the D4 form completed by Dr Somerville:
 - a. Question 4G bears to be in two parts: (1) what is the applicant's blood pressure at the time of the examination; and (b) is the applicant on anti-hypertensive treatment? If the answer to (b) is "yes", the form directs that three previous readings be provided with dates if available. Both Dr Taylor and Dr Somerville gave evidence to the effect that they understood these to be two separate questions. Dr Taylor would have completed the three previous readings had he been undertaking Mr Gordon's D4 assessment. Had those readings been provided on the form, Mr Gordon's licence would have been refused. Dr Somerville had no previous readings available to her and annotated the form accordingly. She also recorded that the form had been completed "*without access to medical notes*" in section 6. Dr Somerville will always note that on a D4

medical form but has never had any follow-up enquiry from the DVLA in relation to it.

- b. Dr Somerville did not have access to Mr Gordon's GP records. She had no suitably secure facility available to her to store such records. She could never in a position to answer the second question in section 4G: even if the patient arrived with a note of previous blood pressure readings she would not accept them as she could not verify them. Accordingly, that question would always be answered as "not available" and she would record that there was no access to the notes.
- c. Dr Somerville was not Mr Gordon's GP. That would have been obvious from the D4 form. It would not, however, have changed how the form was processed or the information scrutinised by the DVLA.

14. In summary, it is submitted that there is no basis on which the actions of Dr Somerville can be criticised and there is no basis on which any recommendation can or should be made about how Dr Somerville could have acted so as to prevent Mr Gordon's death.

The decision to grant Mr Gordon a licence

15. Dr Taylor gave evidence that he had advised Mr Gordon that he would not obtain a Group 2 licence if he applied. Of course, in the event, it was granted. That fact should not, it is submitted, reflect adversely on Dr Taylor. Indeed, it is submitted that Dr Taylor was correct in his advice. That appears to be a view that Dr Parry expressed towards the conclusion of his evidence.

16. The Crown have made submissions on the decision to grant Mr Gordon a Group 2 licence in December 2013. That is primarily a matter for the Crown and the DVLA to address. It is a matter that both Dr Taylor and Dr Somerville have at least some interest in however (given their front line role in the D4 process). It is a matter that the Crown has asked the Inquiry to consider. In that context, Dr Taylor and Dr Somerville make the following observations, which may be of assistance to the Inquiry:
- a. The D4 form as completed by Dr Somerville was *"rarely seen... counsel of perfection"* (according to Dr Parry). Accordingly, the disconnect between what ought to have happened according to Dr Parry (namely, licence refused) and what did happen (licence granted) appears to result from the DVLA's own procedures.
 - b. On its plain reading, section 4G of the D4 form appears to call for three previous blood pressure readings where the applicant is on anti-hypertensive treatment. The rationale for that question, Dr Parry explained, was to check that blood pressure was under control. Dr Parry and Ms Tamplin both explained, however, that should the blood pressure reading on the day of examination be below 180/100, the licence would be granted without further inquiry (so far as blood pressure was concerned, at least). There was no attempt to explain how the sound rationale for the question was answered by a single reading on the date of the examination.

- c. Had the DVLA sought Mr Gordon's last three blood pressure readings from Dr Taylor, the readings Dr Taylor would have provided would have been 170/90 (24/10/2013), 190/90 (19/07/2012) and 191/108 (19/03/2012).
- d. Dr Parry's evidence was that had the DVLA known of Mr Gordon's blood pressure history, in particular had it received those three results, his licence application should be been rejected.
- e. Indeed, Dr Parry went further and accepted that if Mr Gordon had his D4 completed by his GP his application would be rejected but if he had it completed by a doctor who did not have access to his medical records, and on the day of the examination produced a single reading that was below 180/100, his licence would be granted.
- f. In cross-examination Dr Parry accepted that the DVLA's approach of "erring on the side of caution" was not readily reconciled with not taking the highest reading on the form; or not taking an average; or relying upon the reference to "white coat hypertension" in section 6. His answer was that the "operating instructions" allowed that to happen but he understood why that approach was being questioned.
- g. Ms Tamplin's evidence, however, explained that, applying the DVLA operating instructions, and based on the information given on the D4 form, the correct licencing decision had been made.
- h. That evidence must be set in the context of the unanimous view of the medical evidence led that a single blood pressure reading only gives a "snap shot" from

which no conclusions can be drawn about the extent to which blood pressure could be said to be under control.

17. In short, Mr Gordon was granted a licence when his medical history ought to have seen his application refused. There is no criticism of the doctors involved in the licensing process. But they have an interest in those decisions being consistent with the promulgated guidance. It is for the Inquiry to make what recommendations it considers appropriate in terms of s.6(1)(e) of the 1976 Act.
18. For completeness, Dr Taylor and Dr Somerville note that a significantly revised version of the “At-a-Glance” Guide was published by the DVLA in March 2016. It is mentioned simply so that the Inquiry is aware of its existence. At least insofar as hypertension is concerned, the advice appears to be largely the same. An electronic copy is enclosed with this submission.

Conclusion

19. Dr Taylor and Dr Somerville submit that there is no basis on which to criticise or otherwise make adverse comment on any of their involvement with the care and treatment of Mr Gordon. Both doctors did what was expected of them. Concerns have been raised in the course of the Inquiry about the decision to grant Mr Gordon a Group 2 licence in December 2013. Dr Taylor and Dr Somerville have, for the purposes of this Inquiry, only an indirect interest in that issue. However, as the matter will have to be considered by the Inquiry, they have sought to summarise what appears to be

important evidence that bears on that issue in an attempt to assist the Inquiry. They do not propose any conclusions or recommendations based on that evidence.

20. Finally, Dr Taylor and Dr Somerville, and their representatives, would like to restate their condolences to Mr Gordon's family and friends.

APPENDIX 15 – SUBMISSIONS ON BEHALF OF GREATER GLASGOW HEALTH BOARD

Introduction

- 1.1 In this Inquiry I represented the interests of the Greater Glasgow Health Board. This representation was across the Board and applied to all employees of Greater Glasgow Health Board, including Dr Jesse Dawson, Consultant Physician, Dr Christopher Carlin, Consultant Physician, Dr Stephen Banham, Consultant Physician, and Mr Duncan Macfarlane, Physiologist.
- 1.2 In the first instance, I would offer my own sympathies and the sympathies of the Greater Glasgow Health Board to the family of Mr Douglas Gordon.
- 1.3 I note that this has been a relatively lengthy Fatal Accident Inquiry, which involved the detailed consideration of a number of areas relating to Mr Gordon, including his health, his employment and his driving licence. It is my intention only to address the aspects of the Inquiry which are relevant to my client, namely Mr Gordon's health.

Statutory Framework and the Law

- 2.1 The legal framework under which the Court's determination is issued can be found within Section 6 of the Fatal Accident and Sudden Deaths Inquiry (Scotland) Act 1976, which provides as follows:-

“At the conclusion of the evidence and any submissions thereon or as soon as possible thereafter the Sheriff shall make a determination setting out the following circumstances of the death so far as they have been established to his satisfaction;

- (a) Where and when the death or any accident resulting in the death took place;*
- (b) The cause or causes of such death and any accident resulting in the death;*
- (c) The reasonable precautions, if any, whereby the death and any accident resulting in the death might have been avoided;*
- (d) The defects, if any, in any system of working which contributed to the death or any accident resulting in the death; and*
- (e) Any other facts which are relevant to the circumstances of the death.”*

2.2 The Court is to make a finding in terms of Section 6(1)(c) where it is satisfied that a *reasonable* precaution *might* have avoided the death. In relation to section 6(1)(c), it was indicated by Sheriff Principal Lockhart, in his determination in the **Fatal Accident Inquiry into the deaths at the Rosepark Nursing Home, April 2011**, that:

“... the question of reasonableness is directed to the precaution which is identified. The issue is not whether an individual or an organisation behaved in a reasonable or unreasonable way, but whether or not there was a precaution which is a reasonable one and which might have been a difference”

2.3 Of course, the casual connection need not be as strong as is required in a civil proof in which it would have to be demonstrated that the death would have been avoided, based on the balance of probabilities. According to ‘Sudden Deaths and Fatal Accident Inquiries, 3rd Edition (page 174),’ Carmichael comments that, *“What is envisaged is not a ‘probability’ but a real or lively possibility that the death might have been avoided by the reasonable precaution.”* Therefore, where the evidence is absent or witnesses cannot say that the death might have been avoided, the test is not satisfied.

2.4 Carmichael goes on to indicate that, for a finding to be made under section 6(1)(d) there must be evidence on the balance of probabilities sufficient to justify the finding(s). He explains that:

“[for] any system of working which contributed to the death or any accident resulting in the death, the court must as a precondition to making any such recommendation, be satisfied that the defect in question did in fact cause or contribute to the death. The standard of proof and the rules of evidence (apart from the consideration that evidence did not require to be corroborated⁰ is that applicable in civil business (1976 Act section 4(7)) and accordingly the standard of proof is that of the balance of probabilities.”

Submissions in terms of the Act in respect of Sections 6(1)(a) and 6(1)(b)

3.1 The Sections of the Act where your Lordship is obliged to make a determination are Sections 6(1)(a) and (b) of the 1976 Act.

(1)(a): Place and time of death

3.2 It is submitted that Mr Gordon was involved in a road traffic accident at around 11:30am on Wednesday, 2 July 2014 on Sanderling Road, Paisley. Mr Gordon was subsequently pronounced dead at 1:15pm on Wednesday, 2 July 2014 at the Southern General Hospital, Govan Road, Glasgow.

6(1)(b): Cause of death

3.3 It is submitted that, in terms of the Post Mortem Report prepared by Dr Julia Bell, Forensic Pathologist, on 7 August 2014 (Crown Production 2), Mr Gordon died as a result of 1a) Chest injury, due to 1b) Road traffic accident.

Submissions in terms of the Act in respect of Sections 6(1)(c), 6(1)(d) and 6(1)(e)

4.1 In terms of Section 6(1)(c), 6(1)(d) and 6(1)(e), the Court has required to hear a substantial amount of medical evidence relating to Mr Douglas Gordon. The Court has heard all relevant medical evidence from Dr Jesse Dawson, Consultant Physician, Dr Christopher Carlin, Consultant Physician, Dr Stephen Banham, Consultant Physician, Mr Duncan Macfarlane, Physiologist, Dr David Taylor, GP, and Dr Lesley-Ann Somerville, GP. The Court has also heard medical evidence from Dr Gareth Wyn Parry, the Chief Medical Officer for the DVLA, and received two affidavits from Dr Julie Bell, Forensic Pathologist.

4.2 In the Affidavit evidence, Dr Bell states that:

“in terms of natural disease, the heart was enlarged with concentric left ventricular hypertrophy, in keeping with the history of hypertension, and there was also moderate atheromatous narrowing of the two main coronary arteries. While the chest injuries were considered to be the main factor of his death, the possibility that underlying natural disease played a part in the road traffic accident and/or contributed to the death cannot be excluded.”

4.3 Dr Bell goes on to make a number of comments relating to the possibility that Mr Gordon may have suffered a major medical event, such as a myocardial infarction or an episode of sleep apnoea, which could have contributed to the road traffic accident. Dr Bell clarifies that she would not necessarily expect to find any pathology to confirm whether Mr Gordon suffered from a myocardial infarction or an episode of sleep apnoea. Of course, the complete absence of any evidence cannot be taken as evidence of an event occurring. Accordingly, by Dr Bell’s own Affidavit evidence, there is no medical or scientific evidence to suggest that Mr Gordon suffered from a medical event which may have contributed to the road traffic accident.

4.4 It is in the absence of any stateable scientific or medical evidence to suggest that, I would only briefly address the remaining medical evidence relating to Greater Glasgow Health Board. Mr Gordon was referred to Respiratory Medicine at Gartnavel General Hospital on 20 May 2011. Following referral, Mr Gordon was examined by Dr Gordon MacGregor, Consultant Respiratory Physician, on 7 July 2011. Dr MacGregor made arrangements for Mr Gordon to undergo a sleep study. A sleep study was performed on 6 October 2011. Following a review of the sleep

study data, it was decided that Mr Gordon would be prescribed a Continuous Positive Airways Pressure (CPAP) machine. Mr Gordon was reviewed on 2 February 2012 at the sleep clinic. Use of the CPAP machine had reduced Mr Gordon's Epworth Sleepiness Score to 1/24. A follow-up appointment was arranged for 6 January 2013. Mr Gordon failed to attend this appointment. A further appointment was arranged for 11 March 2014. Mr Gordon failed to attend this appointment. Mr Gordon was noted to have returned his CPAP equipment on 20 May 2013.

4.5 Dr Stephen Banham, Consultant Respiratory Physician, was employed by Greater Glasgow Health Board as the Lead Consultant for the Sleep Clinic in 2011 and he retired from this role in 2012. The role as Lead Consultant was subsequently taken up by Dr Christopher Carlin, Consultant Respiratory Physician. Neither Dr Banham nor Dr Carlin offered any concerns regarding the medical treatment that Mr Gordon received while under the care of the Sleep Clinic within Greater Glasgow Health Board. The Crown did not introduce appropriate expert evidence which suggested any concerns regarding the medical care which was provided by Greater Glasgow Health Board.

4.6 In the absence of any evidence which suggests that Mr Gordon suffered from a significant medical event which may have contributed to the road traffic accident, and in the absence of any criticism of the medical care offered, it is submitted on behalf of Greater Glasgow Health Board that there were no reasonable precautions

which could have been taken, no defects in any system of working, and no other facts relevant to the circumstances of Mr Gordon's death.

APPENDIX 16 – SUBMISSIONS ON BEHALF OF THE DRIVER AND VEHICLE LICENSING AGENCY (DVLA)

The DVLA submits that the following facts have been proved on the balance of probabilities:-

1. The circumstances of the road traffic accident on 2 July 2014 as set out in the joint minute and the evidence of Richard Clifford, Denis Gallacher, Malcolm Newlands and PC Scott Simpson.
2. Mr Gordon met the DVLA standards for fitness to drive when his application of November 2013 for a Group 2 licence was processed by Ms Tamplin – see the evidence of Ms Tamplin.

The following facts have not been proved on the balance of probabilities:-

1. The cause of the road traffic accident on 2 July 2014 – there is no evidence to support a finding that the road traffic accident had a particular cause. It is possible to speculate that Mr Gordon might have been distracted by something at the cab, he might have decided to reach for something in the cab such as his mobile phone, or he might have become unwell for some reason, but there is no evidence to support a suggestion that on the balance of probabilities a possible cause can be identified.
2. That Mr Gordon did not meet the DVLA standards for fitness to drive at the date of the accident.

It is important to note that the standards that the DVLA apply in assessing fitness to drive were not an issue within the scope of the FAI. The DVLA submits that in the circumstances

of this FAI the Crown's decision not to include this issue within the scope of the FAI was entirely appropriate. In the lead up to the FAI there was no evidence to suggest that the advice on fitness to drive given to the DVLA by the Secretary of State's Honorary Medical Advisory Panels, consisting of doctors eminent in the fields of Cardiology and Neurology together with lay members, was incorrect. Nor in the course of the FAI did any party lead any evidence to suggest that the advice was incorrect.

The DVLA submits that because the cause of the road traffic accident cannot be determined the court is limited in the findings that it can make in terms of section 6 of the Fatal Accidents and Sudden Deaths Inquiry (Scotland) Act 1976.

The DVLA submits that the court should make the following findings:-

- (1) S.6(1)(a) Where and when the death and any accident resulting in the death took place

The DVLA concur with the Crown's proposed finding:-

Douglas Brian Gordon died at Southern General Hospital, Govan Road, Glasgow. His life was formally pronounced extinct at 13.15pm on 2 July 2014. The road traffic accident resulting in the death of Mr Gordon occurred at around 11.30am on 2 July 2014 on Sanderling Road, Paisley, approximately 36 metres west of the roundabout junction with Whitecart Road.

- (2) S.6(1)(b) The cause of causes of death and any accident resulting in the death

The cause of death was chest injury caused by the road traffic accident. The cause of the road traffic accident cannot be determined.

There is no evidence before the court that entitles the court to make any finding about why, on the balance of probabilities, the accident occurred.

“The first task of the FAI is to determine what facts have been proved on the balance of probabilities. Only if the FAI is satisfied that there are facts which have been proved can the FAI go on and make comments and recommendations based on those facts if it appears to be in the public interest to do so in terms of Section 6(1)(e) – see Sheriff Kearney in the FAI into the death of Mildred Allan” –*Carmichael: Sudden Deaths and Fatal Accident Inquiries*, 3rd ed, para 11-07.

The evidence before the FAI was that Mr Gordon:-

- (1) drove at excessive speed when he drove round the roundabout,
- (2) Mr Gordon caused Mr Clifford, the taxi driver, to brake on the roundabout to avoid a collision,
- (3) Mr Gordon looked at Mr Clifford with an apologetic expression on his face,
- (4) on exiting the roundabout Mr Gordon’s vehicle drove onto the opposite carriageway and collided with the HGV being driven by Mr Gallacher at an angle, approximately 36 metres from the roundabout,
- (5) Mr Gordon’s view of the HGV would have been blocked by trees on the roundabout,
- (6) the damage to Mr Gordon’s vehicle suggested that Mr Gordon was travelling at over 30 mph at the moment of impact,

- (7) the distance from where Mr Clifford saw Mr Gordon to the point of impact was between 70 and 80 metres,
- (8) if Mr Gordon had been driving at 30 mph he would have covered 36 metres in approximately 2.68 seconds,
- (9) if Mr Gordon had been driving at 30 mph he would have covered 78 metres in 5.82 seconds, and 74 metres in 5.52 second.

The Crown suggests that there are two possible 'reasons' for the accident:-

(First) that Mr Gordon was distracted by something in the cabin, or

(Second) that Mr Gordon had been taken ill.

There are other possibilities. Mr Gordon might have made a conscious decision to reach for something, for example his mobile phone because he wanted to make a call, rather than being distracted. Mr Gordon's actions might have been an instinctive reaction to take some form of avoiding action when he saw that the collision was inevitable. Given the manner of Mr Gordon's driving at the roundabout, the application of Occam's razor – entities must not be multiplied beyond necessity, or alternatively, among competing hypotheses, the one with the fewest assumptions should be selected, would suggest that the accident was caused by manner of Mr Gordon's driving. However, that suggestion is not the same as evidence which would entitle the court to find that on the balance of probabilities one possibility should be preferred over any other.

- (3) S.6(1)(c) The reasonable precautions, if any, whereby the death and the accident resulting in the death might have been avoided

As the cause of the road traffic accident cannot be determined there are no reasonable precautions whereby the accident resulting in the death might have been avoided.

It is trite to state that if Mr Gordon had not been driving that vehicle on that date at that place he could not have been involved in the road traffic accident that caused his death. The purpose of a Fatal Accident Inquiry is, however, to make recommendations that might prevent such an accident from occurring in the future. Regrettably because we do not know what caused the accident there are no recommendations that can be made under s.6(1)(c).

The Crown's submissions:-

'That it would have been a reasonable precaution for the DVLA when assessing Mr Gordon's health for the purpose of issuing a group 2 licence for the purpose of considering his previous blood pressure readings and not have accepted the preferable of two high blood pressure readings recorded on form D4 on 22 November 2013, both of which had been taken on the day of the examination, 5-10 minutes apart, and one of which was above the 180/100 threshold for high blood pressure readings.'

is not supported by the evidence led before the FAI.

Ms Tamplin's evidence, which is supported by the current version of the D4, and the terms of the Fifth Joint Minute is that her decision to grant a Group 2 licence on the basis of the information contained in the November 2013 D4 was correct that the DVLA would grant a Group 2 licence on the best of the readings on the D4. There was no evidence to suggest that Ms Tamplin's decision, which implemented the advice of the Secretary of State's Honorary Medical Advisory Panel on Cardiology, was incorrect.

Dr Parry was asked by Mr Reid in cross-examination if he would have granted a licence if he had been aware of Mr Gordon's blood pressure history before he was granted a Group 2 licence in December 2013 referring to the Crown Production 38, the chronology of blood pressure readings. Dr Parry was, of course, not working for the DVLA in December 2013. The hypothetical position that was put to Dr Parry was whether or not on the basis of that information alone he would have granted a Group 2 licence? Dr Parry said that he would not, but he clarified in re-examination that he would never have made a decision based solely upon a history of blood pressure readings and that he would have sought further information had the case come to him. There are two important points to bear in mind:-

- (1) A large part of the history related to the period before Mr Gordon's blood pressure was put on his final regime of drugs by the Blood Pressure Clinic on or about February 2012 – see Blood Pressure Clinic Records Crown Production 13, P294 and P203. On 18 April 2012 Mr Gordon's blood pressure was 151/88 mm Hg. There was no evidence about how the blood pressure readings were taken

after that date other than those taken on 22 November 2013 by Dr Somerville for the D4 medical who found that the first reading was high – 176/106 mm Hg, but it dropped after 5 minutes to 172/94 mm Hg. All we know is that Dr Taylor did wonder if there was an element of ‘white coat’ syndrome. We also know that Dr Dawson when he was asked on Thursday, 11 February 2016 at about 12.25 if he had any concerns about Mr Gordon discharging himself from the Blood Pressure Clinic said ‘In this setting [when he was] on maximal treatment, [with] good control and had access to primary care it was not my practice to follow up reasons [for a patient discharging himself].’ We also know that Mr Gordon’s most recent reading before the date of the accident was 160/90 mm Hg.

- (2) It is speculation to try and say what the outcome of further investigations by the DVLA would have been. They may well, for example, have shown that Mr Gordon’s blood pressure was adequately controlled below the level of 180/100 mm Hg and that there was an element of ‘white coat’ syndrome. There was no evidence in the FAI that would support a finding that on the balance of probabilities if further information had been provided to the DVLA in relation to Mr Gordon’s application in November 2013, Mr Gordon’s application for a Group 2 licence would have been refused.

- (4) S.6(1)(d) The defects, if any, in any system of working which contributed to the death or any accident resulting in the death.

As the cause of the road traffic accident cannot be determined there are no defects that can be identified in any system of working that contributed to the accident resulting in the death.

(5) S.6(1)(e) Any other facts which are relevant to the circumstances of the death

There are no other facts relating to the DVLA that are relevant to the circumstances of the death.

So far as the Crown's proposed findings are concerned:-

(i) *inconsistency of the DVLA approach to ascertaining fitness to drive (and continuing to drive)*

The Crown state that the DVLA At a glance guides are inconsistent with the DVLA Operating Instructions. The At a Glance Guide is not inconsistent with the Operating Instructions. It is different from, but not inconsistent with the Operating Instructions.

The Crown misunderstands the purpose of the At A Glance Guide – see the Introduction:-

“The information contained in the booklet is intended to assist doctors in advising their patients whether or not they should inform the DVLA of their medical condition and what the outcome of the medical enquiries is likely to be...

It is emphasised that this booklet is for use as guidance only. Whilst it provides some idea of the anticipated outcome of a medical inquiry, the specific factors of each case will be considered before an individual licensing decision is reached.”

The primary purpose of the Guide is to assist doctors in advising patients whether or not patients should advise the DVLA of their medical condition. The decision as to whether or not to grant a licence is made by the DVLA on the basis of the Operating Instructions that are prepared on the instructions of the relevant panel. The DVLA expect that they will be advised of medical conditions by drivers who, once their case has been considered by the DVLA, are fit to drive. The At a Glance Guide is not designed to allow or encourage doctors

to second guess the decision that the DVLA will make. It is designed to ensure that doctors give appropriate advice to their patients about reporting conditions to the DVLA, and whether or not they should drive while a decision is pending.

The Crown's complaint that the two differ is, in reality, a submission that the Operating Instructions are wrong and that the At a Glance Guide which are approved by the Secretary of State's Honorary Medical Advisory Panel on Cardiology is wrong. There has been no evidence that the Secretary of State's Honorary Medical Advisory Panel on Cardiology have got it wrong.

If the wording of the At a Glance Guide and the Operating Instructions was to be the subject of criticism by the Crown it would have been appropriate for the Crown to have led evidence from those responsible for the drafting of the documents. Dr Parry did not have responsibility for, and was not able to give any evidence about why the various documents were drafted in the way that they were. In these circumstances the court should not make the recommendation sought by the Crown.

(ii) *Lack of clarity of definition of 'consistently' in blood pressure guidance*

This is a complaint that there is no definition of 'consistently' in the At a Glance Guide. It is correct that there is no definition. Dr Parry was asked about this on Thursday, 18 February 2016 at about 12.15. He gave evidence that the DVLA receive regular feedback from doctors and that the meaning of 'consistently' did not feature in the feedback that had been received. There is no evidence that the absence of a definition causes any difficulty in practice. It is

clear that the doctors who were asked about what they meant by 'consistently' gave what they considered to be its ordinary meaning. They were not suggesting that there was a technical or medical meaning of the word consistently. Their practices varied. The Crown did not lead any evidence that the word 'consistently' should be defined in any particular way. The Crown did not lead any evidence that the different interpretations might lead to an incorrect decision on whether or not a person was fit to drive. The DVLA's practice in 2013 according to Ms Tamplin was to grant a licence if one reading on the D4 was below 180/100. The current D4 (Crown Production 43) page 5 box g provides:-

"If blood pressure is 180/100 mm Hg systolic or more and/or 100mm Hg diastolic or more, please take a further 2 readings at least 5 minutes apart and record the best of the 3 readings in the box provided."

The Crown did not lead any evidence that the DVLA's practice, which is in accordance with advice from the Secretary of State's Honorary Medical Advisory Panel for Cardiology was wrong. If the Crown had wished to explore this matter then the Crown could, and should have led evidence from a member of the Panel.

(iii) *Completion of form D4 without access to medical records*

The Crown did not explore this issue with the witnesses. Parliament has provided in The Motor Vehicle (Driving Licences) Regulations 1999/2864 (MVDLR 1999), 10 (5) that the D4 examination must be performed by a qualified medical practitioner. Parliament has not provided that the qualified medical practitioner should have access to the driver's medical records before completing the D4 examination. The Crown did not lead any evidence about

the practicality of such a requirement. The Crown did not explore the necessity of such a requirement. The Crown did not explore whether or not there might be any difficulties in the implementation of any such system. The Crown did not ask Dr Parry for his views on such a requirement. The only evidence about this came from Dr Somerville, Tuesday, 16 February 2016 who was asked at by your Lordship if she had any observation on a suggestion that a system should be set up whereby the D4 should not be completed without accessing the patient's notes. Dr Somerville said that from the point of view of the GP such a system would be very difficult. BP readings could be accessed easily but the GP might not be available at the time of the request. Her evidence was that it would mean that a D4 could not be completed in one sitting. In the absence of any evidence about the relative advantages and disadvantages of changing the system of completing D4's without requiring access to medical records, it is not appropriate for the court to make the finding sought by the Crown.

The DVLA have no observation to make on the Crown's fourth proposal as it does not relate to the DVLA.

In conclusion, on behalf of the DVLA I would like to express their condolences to the family and friends of Mr Gordon.