

**SHERIFFDOM OF SOUTH STRATHCLYDE, DUMFRIES AND GALLOWAY AT
HAMILTON
UNDER THE FATAL ACCIDENTS AND SUDDEN DEATHS INQUIRY
(SCOTLAND) ACT 1976**

2015FAI 11

DETERMINATION

By

SHERIFF ALASDAIR LORNE MacFADYEN

INTO THE SUDDEN DEATH OF

JOHN ROBERT McQUADE

HAMILTON, 19 MARCH 2015

[1] The sheriff, having resumed consideration of the evidence and productions, Determines in terms of the Fatal Accidents and Sudden Deaths Inquiry (Scotland) Act 1976, section 6(1) that:

- (a) John Robert McQuade, born 6 June 1964, of Livingston, West Lothian died at Wishaw General Hospital, Wishaw at 0830 hours on 1 February 2012.
- (b) The cause of death was a severe head injury sustained in a road traffic accident. The accident occurred at about 7am on the M74 motorway about 1 mile north of junction 7, near to Larkhall, South Lanarkshire, when a large goods vehicle, registered number X6 BBT, being driven by George Smith struck him.
- (c) Reasonable precautions whereby the accident might have been avoided would have been:
 - (i) for the deceased to have parked his vehicle closer to the nearside verge of the hard shoulder, thus allowing more room on the offside of the vehicle, which would have enabled the deceased to avoid

stepping out on to the live motorway lane in order to examine the offside of his vehicle.

- (ii) for the deceased not to have stood on or to allow any part of his body to encroach on to the live motorway lane at all.
 - (iii) the wearing by the deceased of high visibility clothing when outside his vehicle.
 - (iv) for the deceased to have proceeded slowly and to leave the motorway at Junction 7 and to pull in at a layby on the A72 public road, situated 1.8 miles from the location of the accident, in order to safely check his vehicle and load there.
- (d) There was no defect in any system of working which contributed to the death or the accident resulting in the death.
- (e) There are no other facts relevant to the circumstances of Mr. McQuade's death.

[2] Findings in fact

1. John Robert McQuade ('the deceased'), born 6 June 1964, of Livingston, West Lothian, was a driver by occupation.
2. He was the owner manager of a limited company, IMS Limited.
3. He was licenced to drive a Large Goods Vehicle ('LGV'). He was an experienced LGV driver.
4. In the course of his business the deceased drove a Large Goods Vehicle delivering large items of machinery in Great Britain.
5. On 1 February 2012 the deceased, accompanied by his son, Barry McQuade was driving an LGV, namely a Scania 460 T wagon, registration number B15 CNC ('the Scania'), south on the M74 motorway in Lanarkshire.
6. The Scania was a flatbed lorry.
7. They were engaged on the delivery of a large machine, known as a CNC machine, to a customer's premises in Birmingham.
8. At about 0655 hours on said date the deceased drove on to the M74 motorway, joining it from the Bellshill bypass.

9. The occupants of a passing vehicle made the deceased aware that there was some problem with his vehicle.
10. The deceased pulled into the hard shoulder of said motorway about one mile north of Junction 7 (Larkhall) in order to examine his vehicle and its load.
11. He brought his vehicle to a halt with the offside of the vehicle being approximately 0.2 metres east of the edge line between the hard shoulder and the carriageway of said motorway and the nearside of the vehicle being approximately 0.5 metres west of the kerb of the hard shoulder.
12. The inside lane of the motorway was approximately 3.2 metres wide.
13. The hard shoulder was 3 metres wide.
14. The Scania was 11.8 metres long and 2.4 metres wide.
15. There was nothing to prevent the deceased parking the Scania further east on the hard shoulder.
16. George Smith was employed as a driver by Billy Bowie Special Projects.
17. On 1 February 2012, in the course of his employment, he was driving a Renault rigid large goods vehicle, registration number X6 BBT ('the Renault') south on the M74 motorway.
18. He was driving at approximately 55 to 56 mph. His vehicle's speed was subject to a speed limiting device and was incapable of exceeding 56mph.
19. The Renault was fitted out as a tanker, with a vacuum pump and a tank.
20. Mr. McQuade exited from the cab of the Scania by the passenger door on the nearside of the vehicle.
21. He walked round to the offside of the Scania in order to check on the load.
22. It is likely that Mr. McQuade was engaged on the tightening of a strap on the offside of the Scania restraining the load.
23. At least the upper part of Mr. McQuade's body was encroaching into the live carriageway of the motorway.
24. It is at least possible that he was standing on the live lane of the motorway.
25. Mr. McQuade was not wearing any form of high visibility clothing, notwithstanding his having a high visibility jacket in the cab of the Scania.
26. There was no street lighting on that stretch of the M74. It was dark at 7.00am.

27. Although the Renault was positioned somewhat to the left of the inside lane of the motorway, no part of the Renault encroached into or over the hard shoulder.
28. Mr. Smith's view ahead was impeded by a large LGV ahead of him on the motorway.
29. Mr. Smith did not notice the Scania or Mr. McQuade as he approached them from the north.
30. Even if Mr. Smith had had a clear view ahead of him, it is unlikely that he would have seen Mr. McQuade, given his lack of reflective clothing and the darkness.
31. The nearside wind deflector situated at the front of the Renault and the bodywork surrounding the front nearside wheel arch thereof collided with Mr. McQuade's left side.
32. Mr. McQuade was thrown against his own vehicle and his head was then struck by the flange of a pipe carried on the nearside of the Renault.
33. That caused a serious head injury to Mr. McQuade.
34. Other vehicles came to a halt and drivers and passengers assisted Mr. McQuade by removing him from danger and making him comfortable.
35. The emergency services were called and attended.
36. Mr. McQuade was conveyed to Wishaw General Hospital, Wishaw, Lanarkshire.
37. His injuries were not survivable and he died at 0830 hours in that hospital.

NOTE

[3] The purpose of a fatal accident inquiry is to determine the place and cause of death of the individual in respect of whom it is held, to identify any reasonable precautions whereby the death might have been avoided, to identify the defects, if any, in any system of working which contributed to the death or any accident resulting in death and to narrate any facts relevant to the circumstances of the death.

[4] Such an inquiry is held to find facts, not fault. However, it allows the family of the deceased person and any other interested parties to hear in public the circumstances of

the death. It is to be hoped that the exercise will reduce the possibility of similar accidents occurring in the future.

[5] This fatal accident inquiry was held in terms of section 1(1)(i) of the Fatal Accidents and Sudden Deaths Inquiry (Scotland) Act 1976 in respect that, at the time of the accident leading to his death, John McQuade was engaged in the course of his employment or self-employment.

[6] Representation at this inquiry was as follows:

- The Crown: Ms. Arias, procurator fiscal depute,
- The family of the deceased: Mr. Blessing, advocate, and
- Billy Bowie Special Projects and George Smith: Ms. Carla Fraser, solicitor, Edinburgh.

[7] The Crown led evidence from the following witnesses:

1. Police Sergeant Alexander Andrews
2. Police Sergeant Steven Pollock
3. James Connolly
4. George Smith
5. Ian Henderson
6. Police Constable Kenneth Beeby.
7. Michael Clelland
8. Police Constable Sean Owen.

[8] Barry McQuade, the son of the deceased gave evidence by way of affidavit. The Crown relied on documentary productions, including photographs, a scale plan drawing of the location of the accident and a crash investigation report written by PC Gary MacKay and PC Owen, both of the Road Policing Department of Strathclyde Police.

[8] The family of the deceased led evidence from the following witnesses:

1. Colin Burton

2. Graham Greatrix.

[9] The family relied on a report on the circumstances of the accident written by Mr. Greatrix.

[10] The narrative of the circumstances of the accident which led to Mr. McQuade's death is set out in the findings in fact above. What happened was clear and not really the subject of any controversy. Put simply, during the hours of darkness Mr. McQuade was standing on, or at least allowed the upper part of his body to encroach over, the unlit live carriageway of the M74 motorway near Larkhall, Lanarkshire, that is to say a lane of the motorway on which motor vehicles were legitimately travelling at speeds of up to 70 miles per hour in the case of cars and 60 miles per hour in the case of LGVs, attending to a problem on the offside of his LGV and was struck by the front of another LGV, referred to in evidence as a tanker, being driven by Mr. George Smith, an employee of Billy Bowie Special Projects. Mr. McQuade suffered a serious head injury from which he did not and could not recover and shortly thereafter died in Wishaw General Hospital.

[11] The issues upon which there was concentration in this inquiry were:

1. Did the deceased activate the hazard warning lights on his vehicle when it was parked on the hard shoulder?
2. What was the position (i.e. left to right) of the tanker, driven by Mr. George Smith, in its lane of the motorway as it approached and passed the deceased's vehicle?
3. Whether Mr. Smith was driving so close to the vehicle in front of his tanker as to allow his view of the deceased and his vehicle to be obscured?
4. Whether the issues raised by questions 2 and 3 played any part in the cause of the accident?
5. Were there any reasonable precautions which, if taken, might have avoided the death of Mr. McQuade?

I shall deal with each of those in turn.

Did the deceased activate the hazard lights on his vehicle?

[12] There was conflicting evidence on this point. In his affidavit Barry McQuade says that his father 'put on the hazard warning lights' after pulling over and stopping on the hard shoulder. James Connelly, the driver of the vehicle immediately in front of Mr. Smith's, recalled seeing the sidelights of the deceased's trailer in the distance. He was not sure if the hazard warning lights were on.

[13] George Smith, the driver of the LGV which collided with the deceased did not notice anything to his left at all at the location of the accident.

[14] Ian Henderson, a passenger in the lorry being driven by Mr. Smith, who happened to be another experienced LGV driver, did not recall seeing any lights at all to his left. He did not notice the deceased's lorry before the accident, although he added that it was difficult to remember.

[15] Michael Clelland, another experienced LGV driver, was driving his lorry immediately behind that driven by Mr. Smith. Mr. Clelland's recollection was that he saw the sidelights of what must have been Mr. McQuade's vehicle on the hard shoulder but that it did not have its hazard warning lights switched on.

[16] The evidence of Mr. Barry McQuade junior was not subjected to cross-examination. On the balance of probabilities I have decided that Mr. McQuade's vehicle was displaying its side lights but not its hazard warning lights after it pulled into the hard shoulder.

What was the position (i.e. left to right) of the tanker, driven by Mr. George Smith, in its lane of the motorway as it approached and passed the deceased's vehicle?

[17] The relevance of this issue lay in the fact that the deceased chose to park on the hard shoulder of the motorway in order to check his load, having seen warnings from other

vehicle drivers that something was amiss on his vehicle. It seems that he decided to pull over immediately after seeing those warnings.

[18] At the point at which the appellant pulled off the live carriageway, the hard shoulder consisted of only the hard shoulder itself. There was no further room to the left of the hard shoulder on to which a vehicle could have pulled.

[19] The space between the offside of the deceased's vehicle and the live carriageway was 0.2 metres.

[20] Mr. Smith was driving along the nearside lane of the M74 as he approached the parked vehicle. There was traffic in the adjacent lane (lane 2). Mr. Smith did not consider that he was 'too far' to the nearside of the lane. It was the view of Mr. Clelland, the driver of the vehicle immediately following Mr. Smith's that Mr. Smith was driving to the left of his lane. However, he was not critical of that.

[21] What is of importance in this respect is that no collision took place between Mr. Smith's vehicle and any part of Mr. McQuade's vehicle. For example, there was no collision between the wing mirrors of the two vehicles.

[22] Accordingly, while it seems that Mr. Smith was driving his tanker somewhat to the left of the inside lane as he approached Mr. McQuade's vehicle, nevertheless all parts of Mr. Smith's tanker were within his lane. No part of it encroached on to or over the hard shoulder. In that situation, it cannot be said that the position of the Billy Bowie Special Projects tanker from left to right caused or contributed to the cause of the accident.

Whether Mr. Smith was driving so close to the vehicle in front of his tanker as to allow his view of the deceased and his vehicle to be obscured?

[23] The potential relevance of this issue was the suggestion made on behalf of the family of the deceased, based on the evidence of the expert witness led on their behalf, Mr. Greatrix, that Mr. Smith had driven his vehicle behind the vehicle in front of his at

such a close distance that by the time the deceased came into Mr. Smith's view, a collision was unavoidable.

[24] It is important to consider exactly what the evidence was. When giving evidence about his driving at the time of the accident, Mr. Smith said that he was driving on the M74 at about 55 to 56 miles per hour. His vehicle was subject to a device limiting its maximum speed to 56 miles per hour. He was in the nearside lane, i.e. the lane adjacent to the hard shoulder. He could not recall any detail of the vehicle in front of his beyond the fact that it was a lorry.

[25] He said that customarily he drove a safe distance behind any preceding vehicle, normally up to two lorry lengths. He might choose to shorten that if about to overtake the preceding vehicle but on this occasion he had no intention of performing an overtaking manoeuvre.

[26] He emphatically denied that he was engaged in 'tailgating' the preceding vehicle.

[27] Mr. Smith was accompanied by a colleague, Ian Henderson, who was sitting in the passenger seat of Mr. Smith's vehicle. Mr. Henderson was an experienced LGV driver himself. He noticed nothing that caused him any concern in Mr. Smith's driving that morning. He had no recollection of the nature of the vehicle immediately in front of Mr. Smith's. He could not recall if it was a lorry, van or car.

[28] Mr. Henderson said that Mr. Smith was not 'tailgating' the vehicle immediately in front. He said that, as a passenger, he would not put up with a driver doing that.

[29] James Connelly was the driver of an LGV. It is probable, although not necessarily certain, that his was the vehicle immediately in front of that being driven by Mr. Smith. Mr. Connelly could not say how close behind him the vehicle immediately behind him was. He recalled seeing headlights in his mirrors.

[30] While Mr. Connelly said that he saw both Mr. McQuade's LGV and Mr. McQuade, he could not recall whether the vehicle preceding him on the road was a car or a larger vehicle. A car would not have obstructed his view to the front and a larger vehicle might have done, depending how far ahead of him it was.

[31] When Mr. Connelly saw the deceased and his vehicle, he pulled over to his right. That was his normal practice if he saw a vehicle on the hard shoulder. He was unable to change lanes due to traffic volume to his right.

[32] Michael Clelland, the driver of the vehicle immediately behind Mr. Smith's, expressed the view that Mr. Smith was positioned behind the large LGV preceding him 'a little bit close'. When pressed to say how close, he said that he thought Mr. Smith's vehicle was roughly half a lorry length behind the preceding vehicle or closer.

[33] When considering this evidence, it is important to bear in mind the dimensions of the vehicle being driven by Mr. Connelly. It was referred to in evidence as a 'double decker'. It is self-evident that such a large vehicle would impede the forward visibility of the driver of any vehicle following it.

[34] Similarly, it is self-evident that the further back Mr. Smith was driving his vehicle, the better view he would have of the road and hard shoulder ahead.

[35] It is impossible to come to any fixed conclusion as to how far behind the preceding vehicle Mr. Smith was driving his LGV. Impressions must have been fleeting. Distances between vehicles vary from time to time, according to Mr. Clelland. On the other hand, Mr. Smith accepted that he did not see the deceased or his vehicle at all before the collision.

[36] What can be concluded is that Mr. Smith's forward visibility was impeded to some extent by the large articulated LGV immediately preceding him. On the assumption that Mr. Smith was keeping a proper lookout (and there was no evidence to the contrary),

that was confirmed by his agreement in evidence that he did not in fact see Mr. McQuade or his vehicle until after the impact occurred.

[37] It is no part of the function of a Fatal Accident Inquiry to attribute fault. Accordingly, no conclusion of fault should be drawn from the fact that Mr. Smith did not see Mr. McQuade before the collision.

Did the position from left to right of Mr. Smith's vehicle on the carriageway and his position behind the preceding vehicle have any bearing or causative effect on the accident?

[38] The answer to these questions relied on my assessment of analysis of the circumstances of the accident by, respectively, Police Constables Gary Mackay and Sean Owen in the Crash Investigation Report and Constable Owen's evidence, and the report and evidence of Mr. Greatrix.

[39] In his report and evidence, Mr. Greatrix expressed the view that if Mr. Smith had been driving further back behind the preceding vehicle, then he would have been able to see Mr. McQuade's vehicle and Mr. McQuade.

[40] PC Owen in evidence and his report disagreed. He expressed the view that although the vehicle might have been seen, it is unlikely that Mr. McQuade himself would have been seen given his clothing, by which I understood him to mean non-reflective clothing. I preferred the analysis by the police officers to that of Mr. Greatrix. Of particular significance were the following two factors:

- At the time of the collision, Mr. McQuade was standing on the live carriageway of the motorway, dressed in dark clothing. It is very likely that he would not be seen by any passing driver, no matter how far ahead his vision might have been.
- Although Mr. Smith's vehicle was said to be close to the edge line dividing the live carriageway from the hard shoulder, there was no collision between his

vehicle and Mr. McQuade's. The inference to be drawn from that fact is that every part of Mr. Smith's vehicle was within the live carriageway of the motorway and no part of it intruded into the hard shoulder.

[41] In my view, Mr. Smith had no reason to apprehend that a person would be standing in or moving along the live carriageway. While he may have pulled over to the right, had he seen Mr. McQuade's vehicle, there was no certain evidence as to the amount of traffic to his right at the time of passing the deceased's vehicle. It therefore cannot be said with any certainty to what extent, if any, he might have been able safely to pull to the right. It is not appropriate for the court to speculate on that matter when considering the question of cause of the accident.

[42] The absence of reflective clothing made the deceased highly unlikely to be visible to an approaching driver. The position of Mr. McQuade on the live carriageway of an unlit stretch of motorway in dark, non-reflective clothing rendered the outcome of collision with a passing vehicle a probability.

Were there any reasonable precautions which, if taken, might have avoided the accident or the death of Mr. McQuade?

[43] The outcome of a collision between a fast moving LGV and a human being is almost inevitably going to be the death of the individual involved. Accordingly, the focus in this chapter of my note is on steps which might have avoided the accident, as opposed to steps which might have avoided the death.

[44] In the first place, for reasons already explored, I confirm my view that the positioning by Mr. Smith of his vehicle in a different position behind the preceding vehicle or in a different position from left to right in the carriageway cannot be characterised as reasonable precautions whereby the accident might have been avoided.

[45] At the inquiry the Crown suggested that there were five reasonable precautions which, if taken, might have avoided the accident. I am grateful to the procurator fiscal

depute for listing those in her submission. It seemed to me that three of them were easily capable of being characterised as such and amounted to reasonable steps to avoid foreseeable risk.

[46] Accordingly, I have firstly decided that if Mr. McQuade had parked his vehicle closer to the nearside of the hard shoulder, then that would clearly have left more space on the offside so that when he was out of the vehicle, there was at least the possibility that he would not have had to step on to the live carriageway.

[47] Secondly, it was self-evident that if Mr. McQuade had not stood on the live carriageway of the motorway, then the accident would not have occurred.

[48] Thirdly, with regard to high visibility clothing, it seemed to me that if Mr. McQuade had donned his high visibility jacket, then that might have alerted the drivers of all vehicles proceeding south. It would be likely that they would then have pulled over to the right and that might have alerted Mr. Smith to the fact that something unusual was happening ahead. Accordingly, the conclusion reached by Mr. Greatrix that the wearing of high visibility clothing would have made no difference is flawed in my view. It would have provided a general alert of danger ahead to all south bound drivers. I was therefore persuaded that the wearing of such clothing was a reasonable precaution.

[49] The other two matters involved an element of hindsight being applied, if they were to be characterised as reasonable precautions. It is however settled that in the context of a fatal accident inquiry, it is appropriate to apply hindsight when considering the issue of reasonable precautions. That is because an important function of an inquiry is the identification of risks and reasonable precautions in the hope that similar accidents might be avoided in the future. That is clearly the case in an inquiry such as the present one which arises out of circumstances likely to be encountered frequently on motorways.

[50] Whether these matters are classified as reasonable precautions or as 'any other facts which are relevant to the circumstances of the death' (in terms of section 6(1)(e) of the Act is perhaps of little significance. However, in light of comments made by PC Owen regarding best and common practice by experienced LGV drivers, I have decided to include the following as a reasonable precaution.

[51] North of the location of the accident was a sign indicating that Junction 7 was about one mile ahead. At junction 7 was a slip road leading on to the A72. On that road, about 1.8 miles away from the location of the accident was a layby. At that layby the deceased could safely have inspected his vehicle and the load with no risk whatsoever of any collision with a moving vehicle. PC Owen was of the view that an experienced LGV driver who had received a warning regarding his vehicle could and should safely proceed off the motorway altogether to such a layby. He suggested that it would be possible to proceed at an extremely slow speed such as 10mph. He had personally previously accompanied an LGV which had suffered a burst tyre off a motorway. An experienced driver, after a cursory inspection presumably, would not have been apprehensive about, for example, the load shifting.

[52] Paragraph 275 of the Highway Code includes the following:

'If your vehicle develops a problem, leave the motorway at the next exit or pull into a service area. If you cannot do so, you should:

- pull on to the hard shoulder and stop as far to the left as possible, with your wheels turned to the left
- try to stop near an emergency telephone (situated at approximately one-mile intervals along the hard shoulder)
- leave the vehicle by the left-hand door and ensure your passengers do the same
- do not put yourself in danger by attempting even simple repairs
- ensure that passengers keep away from the carriageway and hard shoulder
- walk to an emergency telephone on your side of the carriageway...

- return and wait near your vehicle (well away from the carriageway and hard shoulder)’

[53] PC Owen was of the view that there was no reason to prevent Mr. McQuade complying with that advice. The question obviously arises as to why it would be reasonable for a driver to remain on the live lane of a motorway, having been alerted to some problem with his load. Considerations of safety for all road users on the motorway might dictate that immediate departure from the live lane on to the hard shoulder would be the best course of action. As he put it, other options (than stopping on the hard shoulder and attending to the problem) were open to the deceased. That seemed to be a reasonable analysis of the situation faced by the deceased. The problem most likely was the coming loose of a strap over the load. That, in my view, could have been seen clearly by way of visual inspection after parking as far to the left as possible on the hard shoulder. The vehicle could then have been driven slowly off the motorway and a full inspection and remedial action carried out on the layby on the A72.

[54] Accordingly, I decided that a fourth reasonable precaution would have been for the deceased to drive on for less than one mile and proceed to the layby on the A72 and there attend safely to whatever problem had occurred.

[55] Another reasonable precaution suggested by the Crown, based on the evidence, was for the deceased to have driven forward a matter of metres and to pull into an area of hard standing lying south of an emergency telephone. That area of hard standing provided more room for the parking of an LGV. However, it seemed to me that to include that manoeuvre as a reasonable precaution is unnecessary. The critical factor is that, having decided to park at all on the hard shoulder, the deceased failed to park sufficiently far away from the live lane of the motorway. That would apply whether he had parked where he in fact did or on the area of hard standing. In addition it was not clear whether the deceased was in fact aware that a wider off-road area was so nearby in his direction of travel. The identification of parking as far to the left as possible as the reasonable precaution is the important factor, not where on the motorway that should have been done. Accordingly I have not identified that as a reasonable precaution.

There is no need to mention it as another fact relevant to the circumstances of the accident either.

[56] I have not lost sight of the following: when the accident took place, Mr. McQuade was endeavouring to make sure that his load was secure, no doubt for the safety of all present on the motorway. It is a tragedy that he lost his life when engaged on that activity. I extend my personal sympathy to his family.