

SHERIFFDOM OF LoTHIAN AND BORDERS AT EDINBURGH

2012 FAI 35

2B 1000/11

DETERMINATION

by

SHERIFF A W NOBLE

Sheriff of Lothian and Borders at Edinburgh

following a Fatal Accident Inquiry

into the death of

IAIN CAMERON BOYLE

Edinburgh, 31 July 2012. The Sheriff, having considered the evidence adduced and submissions thereon at the Inquiry under the Fatal Accidents and Sudden Deaths Inquiry (Scotland) Act 1976 (hereinafter “the Act”), Determines:

(a) in terms of section 6(1)(a) of the Act that Iain Cameron Boyle (hereinafter “the deceased”), born on 23 August 1971, of 21 Maryfield Place, Bonnyrigg EH19 3BG, died at about 2.47 a.m. on 10 July 2010 on the A1 Edinburgh to Newcastle road at a point some 422 metres south of the Castledykes roundabout, Cockburnspath, Scottish Borders, immediately following a collision between a Volvo articulated large goods vehicle registered number PO59 AEY which the deceased was driving in the course of his employment as a commercial driver, and a DAF articulated large goods vehicle

registered number FB57 ENH driven by James Cain in the course of his employment as a commercial driver;

(b) in terms of section 6(1)(b) of the Act that the cause of the deceased's death was multiple injuries sustained in the said road traffic accident;

(c) in terms of section 6(1)(b) of the Act that the accident was caused because the vehicle being driven northwards by the deceased crossed from the northbound carriageway into the southbound carriageway and came into collision with the vehicle being driven southwards by James Cain;

(d) in terms of section 6(1)(b) of the Act that the cause of the deceased's vehicle entering the southbound carriageway was driver fatigue.

NOTE

Introduction and Parties represented at the Inquiry

[1] This fatal accident inquiry was held in terms of section 1(1)(a) of the Fatal Accidents and Sudden Deaths Inquiry (Scotland) Act 1976 (hereinafter "the Act"). It was a mandatory inquiry because the deceased died in the course of his employment as a lorry driver. Four parties appeared. The Procurator Fiscal was represented by a procurator fiscal depute, Mr O'Reilly. Mr Manson, solicitor, Glasgow, appeared for Noble Foods Limited, the company whose foodstuffs Mr Cain, a self employed lorry driver, was engaged in delivering at the time of the accident. Ms Price, solicitor, Edinburgh, appeared for Iceland Food Limited

("Iceland"), whose goods the deceased had delivered prior to the accident. Mr Jackson, solicitor, Glasgow, appeared for DHL Exel Supply Chain Limited ("DHL Exel"), which operated the Livingston Distribution Centre (where the deceased's journey had originated) and the distribution of goods from it. The deceased's family were not represented, although they were present during the relatively brief proceedings before me.

Legal Framework

[2] The duties of the court at a fatal accident inquiry are set out in section 6(1) of the Act, which is in the following terms:

"At the conclusion of the evidence and any submissions thereon ... 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 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."

Procedural History

[3] I might note that this was the second attempt to hold a fatal accident inquiry into the circumstances of the deceased's death. An earlier petition was withdrawn as a result of investigations being undertaken by the Vehicle and Operator Services Agency ("VOSA") [the executive agency of the Department of Transport which has certain licensing, testing and enforcement functions relative to vehicles and their operators and drivers], following receipt by them of an anonymous letter which suggested that lorry drivers working out of Livingston Distribution Centre routinely adopted certain practices to enable them to

complete their duties more quickly, such as habitually exceeding the speed limit, and classifying as rest breaks periods when they were unloading their vehicles. In particular, the letter, the terms of which were agreed in the joint minute mentioned in the next paragraph, included the following (the spelling and grammar are the letter writer's own):

"Iain was employed as an Agency driver and employed almost entirely on the Iceland contract with DHL/Excel Logistics.
He was regularly engaged on what is known as the North East run, covering Durham Sunderland Washington Newcastle Middlesbrough etc
Iceland guarantee their drivers 13 and a half hours to complete the journey which involves two articulated trucks delivering to 3-4 stores in these particular areas, 1 has frozen goods the other chilled and or ambient, it is referred to as lock and drop.
The run is completed in 9½ to 10 hours the drivers are still paid 13½.
It is completed in this fashion an agency driver is teamed up with one of Iceland's own and designated a route they hammer down the A1 or A68 on full limit no 40 mph when they arrive at allocated shop to unload they set their tachometer to show a break whilst unloading this is repeated at all stores when they have finished making their deliveries they drive straight back up to Livingston to get the trucks back to be loaded to go out asap.
Although showing and registering a break on their tachometer there is no actual break being taken through out the whole period of the night shift, this takes place every night of the week and is encouraged and expected by Iceland.
An agency driver has to keep up with the Iceland driver to find the stores yes he has the right to say no it is illegal but if you want the work you have to comply.
It is 3 hours 25 driving time down same back that is at minimum 6 hours 50 minutes driving without a break add another hour driving round the stores and approx 20 min unloading at each store the maths speaks for its self.
Do these runs for any period of time and it is going to catch up on you, this was a tragic accident that could have been prevented since it happened nothing has changed at Iceland/Booker this practise still continues and is expected. If you do not comply or quote the regulations you are off site indefinitely. ...
I have done this run on two separate occasions both times I struggled, on the later I stopped on way back and took a break of an hour in a lay by. I have not been back at Iceland since."

The hearing before me

[4] As indicated, the hearing before me was a short one. No oral evidence was led. The parties tendered a substantial joint minute which agreed a number of matters. They also handed over written submissions.

[5] I will generally deal with the evidence later, but there are a few issues arising out of the joint minute which I might mention now. First, clause (9) of the minute was in the following terms:

“In so far as written statements are lodged in process in place of the parole evidence of any witness, the said written statements are true and accurate records of the evidence of the said witnesses to which they relate and are to be taken as being equivalent to oral evidence; and more particularly reference is made in this regard to the written statements of the following witnesses:”

There then follows a list of 34 witnesses. There were in fact no written statements from two of the witnesses listed, the police officers who had prepared the collision investigation report; no doubt the report sufficiently constituted their evidence. With the exception of a statement from a Beverly Stoner, a VOSA traffic examiner of five years' experience, who had provided her own statement, the 32 listed witness statements were all taken by the police. (I append the list at the end of this Note, with a brief description of what the witnesses speak to.) More significantly, within the papers are statements, or documents identified as statements, from another four witnesses, none of whose names appears on the list, and all of whom either had been or still were (at least when the statements were taken) lorry drivers operating out of Livingston Distribution Centre. In the case of these four statements, two of them might more properly be described as interview transcripts, since they contain both questions and answers, and the witnesses were cautioned, advised they could terminate the interviews at any time, and also advised that they could seek legal advice. These two interviews were conducted by Mrs Stoner, with a police officer also present. The other two statements follow the normal narrative statement structure. They were taken by police officers, in one instance with Mrs Stoner present. One of the question and answer

interviewees was William Wood Millar, the driver who had accompanied the deceased on the north east run during which the accident under consideration happened. By the time of the accident, all the deliveries had been completed, and Mr Millar's lorry was almost back at the distribution centre, the deceased, as I mention later, having stopped driving for a period of about 43 minutes in the vicinity of Alnwick. However, one would have expected that Mr Millar could have given information about what had happened at the various delivery stops, and it is perhaps surprising that no statement specifically dealing with these matters was taken from him, or at least was put before me, particularly given the allegations contained in the anonymous letter, together with the information obtained from the tachograph in the deceased's lorry, as mentioned later. In the interview Mr Millar was not questioned specifically about the north east run of 9/10 July, although he and the other three witnesses did deal more generally with the practices of drivers making deliveries out of the Livingston Delivery Centre. In relation to the contents of these interviews/statements, they seem to me to raise many more concerns than were touched on in the anonymous letter, but the question is whether I can have regard to them. I would not propose to do so. It is open to doubt that they are covered by clause (9) of the joint minute, and in any event, many of the practices that they describe are not relevant, or in any event cannot be demonstrably linked, to the deceased's driving on 9/10 July.

[6] Clause (11) of the joint minute narrates that the substance commonly known as mephedrone was added to Part 2 of Schedule 2 to the Misuse of Drugs Act 1971 when The Misuse of Drugs Act 1971 (Amendment Order) 2010 [2010 SI 1207] came into force on 16 April 2010. It states that Crown Production 10 – it should in fact be Crown Production 11 – is

a copy of that statutory instrument. Part 2 of Schedule 2 specifies those drugs which are subject to control as Class B drugs under the Act. The statutory instrument refers not only to mephedrone (the common name for 4-methylmethcathinone) but also to some other cathinone derivatives. Cathinone itself and yet other cathinone derivatives were already controlled under the Act. There seems to be no doubt that clause (11) was intended *inter alia* to have some connection with a foil packet containing a quantity of pale brown powder which was recovered from the deceased's trouser pocket following the accident. Clause (8) of the joint minute agrees the conclusions of Crown Production 8, a joint forensic report analysing the powder. In terms of that report:

“[t]he powder (1.15g) ... was analysed and the presence of a mixture of substituted cathinones was indicated. This could not be confirmed due to the non-availability of reference standards.”

The joint minute makes no reference to Crown Production 9, an apparent analysis by a single forensic scientist of blood samples taken from the deceased at the mortuary. I did ask about it without objection from anyone at the hearing. (I have to say I had not appreciated at the time that it was not covered by the joint minute, and it seems hard to see why it should not be. No one, as indicated, objected to me hearing about it, and in particular no one advised me of any reason why it had deliberately not been agreed.) According to Crown Production 9:

“Pentylone was found in the [deceased's] blood (unquantified). The blood was examined for other cathinones including mephedrone, piperazines and pyrovalerones with negative results.”

The report went on to state:

“Pentylone ... is a stimulant and a cathinone related compound. There is limited data or research available about pentylone. However, adverse effects associated with cathinones include reduced inhibitions, drowsiness, excited or paranoid states, insomnia, anxiety irritability, depression, hallucinations and panic attacks.”

According to Mr O'Reilly, pentylone was a stimulant not covered by the Misuse of Drugs Act 1971. On the basis of the agreed analysis of the powder contained in clause (8), and the very limited result thereof, it is difficult to see the relevance of clause (11). To complete the picture, the post mortem report, Crown Production 7, agreed as accurate in clause (1) of the joint minute, indicated that there was an unconfirmed indication of Ibuprofen in the deceased's blood, and that it was further examined for other acidic drugs, basic drugs, amphetamine related compounds, benzodiazepines, cannabinoids, cocaine, methylamphetamine and related compounds, methadone, morphine and opiates with negative results. (The report goes on to say "There is no indication that Mephedrone has been specifically tested for." However, Crown Production 7 is dated 19 January 2011, and Crown Production 9 is dated 20 July 2011. The latter report also records that the deceased's blood samples were received for examination on 11 February 2011.) I might finally say that the witness statements included a statement from a clinical scientist at the hospital to which Mr Cain was taken. She handed pre-transfusion blood samples taken from Mr Cain to two police officers, and their witness statements confirm that. No further mention is made of these samples, and I assume that nothing untoward emerged from any analysis of Mr Cain's blood, if such took place.

[7] As indicated, written submissions were tendered on behalf of all the parties at the hearing. I need not refer to them in detail. All the parties invited me to make findings only in terms of section 6(1)(a) and (b) of the Act. In relation to section 6(1)(b), all the parties, including the Crown, did not seek a finding in relation to the underlying cause behind the accident. The most that Mr O'Reilly for the Crown did was to suggest in his summary of

facts that “some unknown reason, most likely fatigue or some as yet unknown medical condition [caused the deceased] to lose consciousness and/or control.” Ms Price made reference in her written submissions to the case of *Black v Scott Lithgow Ltd* 1990 SC 322, and to comments made by Sheriff Principal J S Mowat QC in his determination following the fatal accident inquiry relative to the Lockerbie Air Disaster, reproduced in Carmichael, *Sudden Deaths and Fatal Accident Inquiries* (3rd ed), para 11.10.

The evidence and my conclusions thereon

[8] The one matter addressed in written and oral submissions by all the parties was the immediate mechanism of the accident. An issue arose because Mr Spedding, one of the listed witnesses, a lorry driver who came upon the accident immediately following its occurrence, although he did not witness it, had formed the following conclusion, as expressed somewhat tentatively in his statement:

“It’s hard to say what happened but I thought the guy heading southbound [i.e. Mr Cain] had lost control or overtaken somebody and I got the impression from the debris that he was in the right hand southbound lane, had the impact and then ricocheted right over to the left hand side of the carriageway.”

Mr Cain gave an entirely different account of the accident in his statement:

“I went round the roundabout (Cockburnspath Roundabout) and started up the hill. I know the speed camera is just round the corner, this is a slight right hand bend. I suddenly became aware of another lorry coming north towards me. I was in the nearside lane and I thought to myself, ‘Why’s he coming over the white lines into my side of the road?’, I would be lucky if I was doing 25 mph, he just kept coming, further and further and I knew I had to move NOW. I turned the unit into the verge and I thought I was going to be okay, but he still kept coming towards me. I heard the bang and I knew straight away that I’d been hit on the front corner on my driver’s side”

[9] I was satisfied, as submitted by all the parties, that I could resolve this issue on the papers. I mention first the road layout. As indicated, the accident occurred on a hill. The deceased was driving downhill, on a road which, for him, had a shallow left hand bend. Mr Cain was driving uphill. The southbound, uphill, carriageway had two lanes, including an inner "crawler" lane. The northbound carriageway had one lane. The northbound and southbound carriageways were separated by double white lines. Given that he had the benefit of two lanes going in his direction, there would appear to be no need for Mr Cain to encroach upon the opposing carriageway, were there a vehicle for him to overtake. Further, the accident was investigated by two very experienced police officers, Constables James Brunton and Malcolm Burt, both with many years' experience as road policing officers, and both based at police headquarters in Fettes Avenue, Edinburgh, the former in the Collision Investigation Unit and the latter in the Road Policing Unit. As mentioned earlier, a collision investigation report compiled by Constable Brunton and corroborated by Constable Burt is produced as Crown Production 1, and is agreed in clause (3) of the joint minute.

Examination of the accident scene indicated that the collision had taken place well within the southbound carriageway. The officers' conclusion was:

"the Volvo LGV has been approaching the locus from the south when he has failed to negotiate the shallow left hand bend, crossing the double solid white line and colliding head on with the southbound Daf LGV which had just negotiated Cockburnspath roundabout and had been accelerating up the hill towards the locus."

In relation to the last phrase, I should say that the speed to which Mr Cain had accelerated was 37 mph (as calculated from the vehicle's tachograph). As far as the speed of the deceased's vehicle was concerned, it was 53 mph, significantly in excess of the legal limit of 40 mph for vehicles of that kind on the road in question. The officers also note that the deceased's vehicle had been driving at a constant speed of 53 mph (85 kph) for a period of

time prior to the collision, which in their view “could indicate that the vehicle was being driven either on cruise control or at its limited speed” (which has a possible resonance with the allegations contained in the anonymous letter). Having regard to the evidence mentioned, I was satisfied that Mr Cain’s account of the accident was substantially reliable, and that Mr Spedding’s view as to how it occurred should be rejected. (As to why Mr Spedding reached that view, I suspect it may be because the deceased’s vehicle ended up diagonally across both carriageways, with the tractor unit in particular back in the northbound carriageway.) What I have said thus far obviously leaves aside the question of why the accident might have happened. Anticipating what I say more fully later, there are a number of factors suggesting that the deceased might have been so tired that he fell asleep or at least lost concentration at the wheel. Such an occurrence seems to me to fit quite well with the nature of the accident.

[9] The collision incident report records that the deceased’s vehicle and trailer (and also Mr Cain’s vehicle and trailer) were examined by a Constable Stephen Wilson and a VOSA vehicle examiner Douglas Pugh on 12 July 2010, and that no mechanical defects were found on either vehicle which could have contributed to the accident. The maintenance and testing record for the deceased’s tractor unit was produced as DHL Exel Production 3 and agreed in clause (15) of the joint minute. The last service of the vehicle was on 14 June 2010, on 15 June 2010 it passed a brake test undertaken by Volvo Truck and Bus, and on 16 June 2010 it passed a detailed brake test and inspection undertaken by VOSA and received a goods vehicle test certificate valid until the last day of June 2011. The vehicle’s tachograph was also tested on 16 June 2010. The maintenance record for the deceased’s trailer unit was produced

as DHL production 4 and agreed in clause (16) of the joint minute. The trailer was inspected on 19 May 2010 and passed a detailed brake test on 20 May 2010. It had a goods vehicle test certificate which was valid until 30 November 2010.

[10] The collision incident report records that the road surface at the accident locus was reasonable, with good road markings and nothing in the way of adverse camber or other physical feature which would inadvertently cause a northbound vehicle to deviate to the right. From the witness statements it appears that it was raining quite heavily around the time of the accident and probably at the time of the accident. In his statement, Mr Spedding is recorded as saying that “it was raining and very slippy, so much so that I lifted the 3rd axle, the lift axle on the road, which gives you extra grip on the road.” Another witness, Leanne Mair, who was following the deceased’s route and came upon the accident very shortly after it had happened, stated in her statement that it was raining really heavily, she was going slow, about 50 mph, the road conditions were quite dangerous, she was worried about aquaplaning, and had aquaplaned slightly on the way back up [in her Peugeot 206 Sport]. In his witness statement, Police Sergeant Neil Inglis, who arrived at the locus at 3.17 a.m., recorded that “the road surface was wet and actually greasy and slippery underfoot”, this being unrelated to any accident debris. All of that said, Constables Brunton and Burt also attended at the scene of the accident shortly after its occurrence, and were aware of the weather conditions. They did mention the rain in their report, but solely in the context that it and the darkness would not have created any sight restrictions. It seems reasonable to infer that they would have made an express reference to the wet and slippery nature of the road surface had they considered that it might have caused or contributed to the accident.

[11] In relation to the deceased, it is necessary to give some biographical information. He had been married twice, although both marriages had ended in divorce. There was one child, T, of his second marriage to J. In 2000 he had obtained a heavy goods vehicle licence. Latterly he had completed a law degree at Napier University in Edinburgh and at the time of his death he was about to start a master's degree in social work at the University of Edinburgh. He shared a house with Daniel Lansley, someone whom he had met while they were both undertaking law degrees at Napier University. Mr Lansley's statement, which was obtained on 13 July 2010, included the following information:

"Iain had been an agency driver with Search agency for the last three years to subsidise his studying. Iain continued to drive after he graduated. He had been accepted at Edinburgh University to do a masters degree in social work. Over the last few months, Iain has been working all the hours he could to save for when he was doing his masters degree. I noticed in the last few months that his sleep patterns weren't good.

He was working all types of shifts, sometimes surviving on a couple of hours sleep before going out to work again. He often talked about having lack of sleep, he once even mentioned blacking out because of lack of sleep. He even phoned NHS 24 and was told that he had had a mild psychotic episode due to lack of sleep. I told him to go to the doctor; he told me he just needed more sleep.

For the last three weeks, Iain has been complaining of a pain in his left shoulder, I think he did mention a pain in his chest too. He was generally quite a fit guy, he was in the paratroopers when he was 16 years old until he was 26 years old and he liked cycling and hillwalking. [In terms of the deceased's father's statement, this account of the deceased's military service is not quite right. According to him, the deceased did have a short, unsuccessful period in the army as a boy soldier, and then another period later, not as long as ten years, when the deceased was indeed a paratrooper. I do not think the difference is material. On any view, the deceased spent a period in the army, with the implication that has as to his state of fitness at the time.] ...

On Friday 9th July 2010, I was day shift (0700-1700) at [...]. Before I left for work, I heard Iain coming home from work. He went to his room and I left for work. I didn't speak to him.

About 1700 hours, I returned home. Iain was home with T his daughter. Iain had told me that J had dropped T off about 0930 hours and he had her all day. I asked him what he had been up to. He said T and him had been to Tesco and the play park. He said he had been doing stuff on his computer. About 1730 hours, Iain got ready for work, J was due to pick T up at 1800 hours. J didn't turn up till 1810 hours. Iain

was saying he couldn't be bothered going to work, but he said that all the time. We had planned to go out on Saturday, because we were both off. I picked T up at 1810 hours and then left.

About 1815 hours, Iain left for work he said "See ya later mate" and left. That was it till the next again morning."

[12] In relation to the mention of arm and chest pains in Mr Lansley's statement, the post mortem report identified the multiple injuries which the deceased sustained in the accident as the cause of his death. Nothing was discovered in the course of the post mortem examination which could have served as an alternative cause of death, or which could have provided an explanation for the accident. In relation to the deceased's cardiovascular system, one area of moderate atherosclerosis and a few areas of mild atherosclerosis were discovered during the post mortem, but the pathologists who undertook the post mortem specifically state that the moderate atherosclerotic disease was not thought to have played a role in the deceased's death.

[13] The other issues which arise relate to what happened in the course of the deceased's final north east run. As indicated, the deceased had been engaged in delivering foodstuffs to Iceland stores in the north east of England, in particular three stores in the Sunderland area, at Pennywell, then Pallion and finally Southwick. As suggested in the anonymous letter, the deceased had obtained this work through the mechanism of an employment agency. He had clearly carried out work for DHL Exel for some time. DHL Exel Production 5, as agreed in clause (17) of the joint minute, is the deceased's training and licence record, and *inter alia* records the deceased's completion of a health and safety induction package on 20 October 2009. The deceased's assessor was a Mark Wilkie, and DHL Exel Production 6, as agreed in clause (18) of the joint minute, confirms that Mr Wilkie was a qualified large goods vehicle

instructor and assessor. Clause (12) of the joint minute confirms that the tractor and trailer units used by the deceased on 9/10 July were owned or leased by Iceland at the time of the accident and were based at the Livingston Distribution Centre, which was managed by DHL Exel, in accordance with contracts between Iceland and DHL Exel. No Iceland employees were based at the Livingston Distribution Centre. As noted earlier, the other driver accompanying him on the run of 9/10 July was William Millar, a DHL Exel employee. The deceased's lorry was equipped with a digital tachograph, and analysis of the tachograph and driver card data receives mention in both the collision investigation report and Mrs Stoner's statement. I should say something about the regulations relating to drivers such as the deceased. These are found in EC Regulation 561/2006. They define daily and weekly rest periods during which a driver may freely dispose of his time, e.g. the "regular weekly rest period" means any period of rest of at least 45 hours. DHL Exel Production 8, as agreed in clause (20) of the joint minute, is the three page "agency control form" which the deceased was required to sign when reporting for duty on 9 July 2010. On page 1, the deceased has signed to confirm that he has read and fully understood all statements made on the form, and that he has answered questions truthfully. At heading 6e, he answers yes to the question, "Have you taken the necessary daily and weekly rest before reporting for duty with DHL today?" He also *inter alia* confirms that he has had no change in health which would affect his entitlement to drive. In addition to rest periods, the regulations define the break periods a driver must have in the course of his duties, "break" meaning "any period during which a driver may not carry out any driving or any other work and which is used exclusively for recuperation." To quote from Mrs Stoner's statement:

"A driver is permitted to drive for a total accumulative period not exceeding 4½ hours before a break of 45 minutes is observed. This 45 minute break can be split into

two breaks the latter of which must be a minimum of 30 minutes. The first break must be a minimum of 15 minutes and if the break has been split then both breaks must be taken within 4½ hours of driving. The recording equipment fitted to both of these vehicles [i.e. the deceased's and Mr Millar's – Ms Stoner was asked to analyse their driver's hours' records] is digital. The technical regulations governing the functionality and fitment of the digital recording equipment (tachograph) specifies that the vehicle will automatically record driving when the vehicle is in motion and when stationary the mode will automatically default to 'work' therefore a driver has to manually change the mode switch to record rest by physical action."

In the collision investigation report the following is stated:

"An examination of data stored on the now deceased Boyle's driver card reveal that he had commenced driving the previous evening at 18.07hrs UTC (19.07hrs BST) with his first rest break of 18 minutes duration at 21.44hrs UTC (22.44hrs BST) until 22.02 UTC (23.02hrs BST). [UTC stands for Universal Time Co-ordinated, the time measurement used in digital tachographs, equivalent to Greenwich Mean Time. I only quote hereafter the British Summer Time (BST) time. The deceased's tachograph was subsequently found to be one minute fast, which is why I have specified in my determination the time of the collision as 2.47 a.m.] He has then continued working/driving until another second rest break of 33 minutes duration at 23.28hrs BST till 00.01hrs BST. He has then continued working/driving from 00.01hrs BST through midnight until a power interruption is recorded at 0248hrs BST, which is accepted as being when the collision occurred. Damage sustained during the collision phase has interrupted power feeding the tachograph causing the unit to record a 'power interruption' malfunction. [After referring to EC Regulation 561/2006, the officers state:] As can be seen from the analysis of the data stored on the driver card, Mr Boyle has complied fully with the aforementioned regulation."

In her statement, Mrs Stoner places a different interpretation upon some of the data, as follows:

"Detailed analysis of the digital data for Iain Boyle shows that from the commencement of his duty on 9th July 2010 at 1907hrs he split the required 45 minute break, the first part of which was taken at Pallion for 18 minutes. The second part of his break is declared as 33 minutes at Southwick (the third delivery point), however this is inconsistent as there is no declared time at Southwick covering the time for unloading the eight pallets he delivered at that store. It would be fair to assume that some if not all of the 33 minutes recorded as rest at the Southwick store should have been recorded as 'other work' to cover the unloading of the vehicle. From Southwick the digital data then shows him driving for a period of 59 minutes, this is then followed by a period of 43 minutes recorded as 'other work', this is the mode the tachograph automatically defaults to when the vehicle is stationary, again it would be fair to assume that this was in fact a period of rest where the driver has forgot to change his mode switch to rest. It is at this point that the two vehicles become split.

Mr Miller drives from the Southwick store back to the depot recording a 3hrs 7 minutes driving arriving back at the depot at approximately 0311 hours on 10th July 2010.

“The digital data shows that Mr Boyle left the Southwick store at approximately the same time (0001hrs) as Mr Miller, however he only drives for a period of 59 minutes then stops. Using Autoroute calculations it is likely that he stopped somewhere near to Alnwick, Northumberland. The vehicle is then stationary for a period of 43 minutes, at the point of stopping he had been on duty for 6 hours 02 minutes. He had driven for a total of 4 hours 40 minutes. At 0145 hrs he commences what would turn out to be the last leg of this journey, driving for a period of 1 hour 3 minutes at which point the collision occurs at Cockburnspath. Using Autoroute calculations, this ties in with the distance from Alnwick to Cockburnspath. ...

“In relation to taking the required break or break(s) analysis of the tachograph data shows him to comply with the requirements. There is serious doubt as to the accuracy of the second recorded break period of 33 minutes, however even if we were to discount this period, it is clear that Mr Boyle observed a 43 minute break shortly thereafter. This would amount to a cumulative driving period of 4 hrs 40 minutes. When considered in conjunction with the drivers activities throughout the shift, it is my opinion that this could be considered negligible. Therefore I report that analysis of the digital data for driver Iain Boyle shows no evidence that lack of breaks or excessive duty or driving time played a part in the resulting road traffic collision.”

Both the police collision investigators and Mrs Stoner therefore express themselves satisfied with what the data shows, albeit the police may not have picked up two of the points noted by Mrs Stoner, that the rest time at Southwick did not allow for the unloading of the deceased's vehicle, and the “other work” period at Alnwick may have been a period of rest. In addition, it is noted in clause (13) of the joint minute that the rules on drivers' hours for goods vehicles in the UK and Europe specify a maximum daily driving time of nine hours which can be increased to ten hours twice a week. In clause (14), it is agreed that DHL Production 2 includes records of the driving route undertaken by the deceased on 9/10 July from 19 January 2010 to 31 July 2010. It is said that the records specify the driving time of each driver along with the actual hours spent working during the particular shift. On only one occasion, on 23 February 2010, did the driving time hours exceed ten. It is calculated that over 251 shifts from 9 [sic] January to 31 July that the average driving time for the route

was 7 hours 57 minutes with the average duty time being 10 hours 33 minutes. It was presumably some or all of the foregoing which led Mr O'Reilly to make the following submission:

"Following the receipt of an anonymous letter suggesting that Mr Boyle and others had been encouraged to falsify records and drive without appropriate breaks, an investigation of Mr Boyle's driving patterns was begun by VOSA. VOSA found no cause for concern in relation to his driving patterns."

I have already said that no witnesses were called. In the case of Mrs Stoner, Crown Production 10, as agreed in clause (10) of the joint minute, is a letter from her indicating that she will be unavailable for the fatal accident inquiry on account of her confinement. I do find her absence regrettable. A number of different elements are involved in the regulatory regime for goods vehicle drivers, *inter alia* the maximum number of hours a driver can work in the course of the day, the daily and weekly rest periods that must be observed, and the breaks that a driver must take in the course of his driving duties. Compliance with one element does not necessarily mean compliance with another element. There are a number of areas where I think it would have been useful to have heard more from Mrs Stoner. Mr O'Reilly has perhaps interpreted what Mrs Stoner says in her statement as meaning that the allegations in the anonymous letter have been disproven. It would have been helpful to hear Mrs Stoner confirm that, or otherwise, as well as deal with the other information she was given in the course of her investigations. In relation to the night of 9/10 July itself, it would have been helpful to know why Mrs Stoner does not appear to question the genuineness of the first 18 minute break taken by the deceased. If it was a genuine break period, and the deceased did have a 43 minute break in the region of Alnwick, then it may be that he did get the break minutes to which he was entitled in not much more than the correct time. However, the anonymous letter suggests that doing the run for any period of time catches up

on a driver, and it would have been helpful to know to what extent the previous runs had been considered. It appears plain that the runs could ordinarily be completed within the maximum permissible number of driving hours – I would accept that there must have been some exceptional occurrence on 23 February 2010 to prevent that – but it would have been helpful if Mrs Stoner had been able to clarify whether her analysis had extended to the speed of the vehicles and confirmation that what were shown as break periods were indeed break periods.

[14] Despite what I say in the previous paragraph, it is clear that my duty is restricted to assessing the evidence led by the parties participating at the inquiry, and reaching what conclusions I can upon that evidence. As noted, all parties invited me only to make findings in terms of section 6(1)(a) and, in limited form, section 6(1)(b) of the Act. When and where the accident and the death occurred were clearly established, and indeed were identical. (In terms of certain witness statements, life was declared extinct by an unidentified paramedic probably around 3.15 a.m., but it clear that the deceased would in fact have died in the accident, and I have so found.) In relation to the cause of death, it was multiple injuries sustained in the accident. So far as the cause of the accident was concerned, at the most basic level, it was the deceased's vehicle crossing from the northbound carriageway into the southbound and coming into collision with Mr Cain's vehicle. As to what caused the deceased's vehicle to do that, as indicated, no party invited me to make findings upon that question, Mr O'Reilly at best suggesting that the deceased lost consciousness or control due to "some unknown reason, most likely fatigue or some as yet unknown medical condition", a phrase repeated in the collision incident report. On the evidence before me, there is much to

suggest that the deceased would have been fatigued. He was working as much as he could to finance his studies, and during the day prior to commencing work on 9 July, the domestic duties he undertook seem to allow little time for rest. He in fact was working unloading his lorry during at least one of the periods identified as a break period. The stimulant drug which he had taken is perhaps a two edged sword. If it worked, it would have assisted in keeping him awake, but the fact that he was using it suggests that he was fatigued.

Conversely, there is little to suggest that some unexplained medical condition led to the accident. The post mortem indicates that the deceased was a healthy and comparatively young man. His moderate localised heart disease, in terms of the doctors' findings, played no part in his death. Assessing the matter on the balance of probabilities, there is much to support the inference that driver fatigue caused the accident. There is nothing to support the inference that it was caused by an unexplained medical condition, and there seems no need to add such a phrase as an alternative. I therefore simply find, on the balance of probabilities, that the accident was caused by driver fatigue. In relation to paragraphs (c) and (d) of section 6(1), I am constrained by the evidence which was led. I cannot positively find that reasonable precautions which might have prevented the accident and resulting death were omitted, or that defects in the working system contributed to the accident and death. So far as section 6(1)(e) is concerned, I do not think I need make any specific findings.

[15] At the inquiry, I and all the parties extended their condolences to the deceased's loved ones, and I would do so again.

APPENDIX

The following witnesses were on the list appearing in clause 9 of the Joint Minute:-.

- (i) Bryson Cameron Boyle: the deceased's father, he identified the deceased's body and provided biographical information about the deceased;
- (ii) James Cain: the driver of the other lorry, as set out in the determination;
- (iii) John Spedding: a lorry driver who came upon the accident shortly after it had occurred, as referred to in the note;
- (iv) Alexander Macdonald Wood: a medical doctor who also came upon the scene of the accident and who provided some assistance inter alia to James Cain;
- (v) Leanne Morag Mair:)
- (vi) Susan Elaine Coyle:) another three witnesses at the scene of the accident
- (vii) Gary Alexander Rutherford:)
- (viii) Steven Russell Best: a GP at the deceased's practice; no relevant link between the historical information he provided about the deceased's earlier attendances and the accident was shown;
- (ix) Susanne Poyner Simpson:) respectively paramedic and ambulance technician
- (x) Louise Sally Wilson Buglass:) in attendance at the accident;
- (xi) Matthew Reed:) respectively accident and emergency consultant, staff nurse
- (xii) Alison Hornell:) and charge nurse who attended the accident in Medic 1;
- (xiii) Joan Kane:)
- (xiv) Maria Helen Warner: clinical scientist at Edinburgh Royal Infirmary who handed blood samples from James Cain to the police;

- (xv) Thomas Kevin Blair: retained fire fighter watch manager, who attended with his crew and inter alia successfully removed James Cain from his lorry;
- (xvi) Daniel Murray Stewart Lansley: the deceased's housemate, as referred to in the Note;
- (xvii) Christopher Paget: off duty police sergeant who attended the accident, having heard it from his home;
- (xviii) Gregor Myles: police constable who obtained statements from witnesses;
- (xix) Gavin Liddle:)
- (xx) Neil Inglis:)
- (xxi) Stuart Tennant:) police officers who attended the accident
- (xxii) Kosmas Papakyriakou:)
- (xxiii) Iain McIntyre:)
- (xxiv) Alison Bell: police officer who informed Mr Lansley and the deceased's ex wife of the deceased's death;
- (xxv) Roger Park: police officer at the locus with follow up duties;
- (xxvi) Stewart Logan: police officer who accompanied Constable Bell;
- (xxvii) Edward Armour:) police officers who recovered the drugs from the deceased
- (xxviii) Alina Cowan:)
- (xxix) Sharon Lackenby:) police officers who obtained the deceased's blood and urine
- (xxx) William Angus:) samples and James Cain's blood samples;
- (xxxi) James Johnstone: police officer who attended at Livingston Distribution Centre;
- (xxxii) James Brunton: no statement;
- (xxxiii) Malcolm Burt: no statement;

(xxxiv) Beverly Stoner: VOSA traffic examiner, as referred to in the Note.