2013 FAI 18

Determination by

John A Baird Esq., Advocate

Sheriff of Glasgow and Strathkelvin at Glasgow

Into the death of

Terence Michael Griffin

Glasgow: 20 September 2013

Findings

1. Terence Michael Griffin, date of birth 16 February 1972, died on 29 May 2010 at about 04.58, immediately following an accident on the M74 Motorway, northbound, at about 100 yards east of Daldowie, Glasgow (this finding made in terms of section 6(1)(a) of the Fatal Accidents and Sudden deaths Inquiry (Scotland) Act 1976).

2. The cause of death was; 1a Head Injury due to 1b Road Traffic Accident (driver) and the cause of the accident resulting in the death was loss of control by the deceased of the vehicle then being driven there by him, causing the said vehicle to collide with the central reservation barrier there (this finding made in terms of section 6(1)(b) of the said Act).

3. Reasonable precautions taken by the now deceased which might have avoided his death and the accident which caused it were: advising the DVLA that he had been diagnosed as suffering from alcohol dependence syndrome and was therefore no longer fit to drive; heeding the signals being made by police officers to pull his vehicle over and stop when first approached by them; and causing his

vehicle to stop immediately after its collision with police car TM32 or at any time thereafter (this finding made in terms of section 6(1)(c) of the said Act).

4. Other reasonable precautions whereby the death might have been avoided were; the implementation by those in charge of the care of the now deceased at his General Medical Practice, at any time after 18 December 2009, of the steps contained in the guidance issued by the General Medical Council with regard to reporting concerns about the fitness to drive of patients to the Driver and Vehicle Licensing Agency (this finding made in terms of section 6(1)(c) of the said Act).

5. The following are other facts relevant to the circumstances of the death (in terms of section 6(1)(e) of the said Act: that the now deceased was on 28 and 29 May 2010 engaged to drive a minibus for hire and reward, and was so doing in Scotland; that at that time he was not the holder of a driving licence entitling him to drive that vehicle for that purpose; that at that time he had a diagnosed history of alcohol dependence syndrome extending back for a period of at least 15 years; that he had not reported the existence of that condition to the DVLA; that if he had done so at any time in that period they would have revoked his entitlement to drive; that in November 2009 he had been treated at a drug and alcohol treatment centre in London and told that he should not drive and should inform DVLA of his alcohol problems; that despite being given that information and advice he continued to drive and to do so vocationally and did not so inform the said DVLA; that on 18 December 2009 the specialist at the said treatment centre wrote to the now deceased's General Medical Practice and advised that the now deceased had been given such information and advice; that the GMC issues guidance to medical practitioners regarding the reporting of concerns about the fitness to drive of patients to the DVLA; that despite the now deceased having attended at his General Medical Practice on two occasions between 18 December 2009 and the date of his death, none of the steps detailed in the said guidance

were taken by those responsible for his care at his General Medical Practice and that the issue of fitness to drive was not raised with him at all; that after about 04.00 on 29 May 2010 the now deceased drove the said minibus northwards on the M74 all the way from Lockerbie to Hamilton and beyond and that the manner of his driving throughout the whole of the said journey was one which presented a persistent danger to other road users; that the police required to be alerted to the danger which his driving posed; that two police cars approached the rear of his said vehicle and clearly indicated to him that he should pull over and stop; that he chose not to do so; that at no time during the course of the involvement with the said police cars was there a pursuit taking place; that the now deceased deliberately caused the said vehicle he was driving to collide at high speed with one of the said police cars, causing it to crash off the road; that despite that, and despite his own said vehicle having lost a wheel in the said collision, the now deceased continued to drive the said vehicle under control at high speed on three wheels for a further 4½ miles; that during said journey he had ample opportunity to bring the said vehicle safely to a halt but chose not to do so; that he then caused it to swerve into the central crash barrier causing it to overturn and bring about his own fatal injuries; and that at the time of the said fatal crash, there was no other vehicle, and in particular no other police vehicle involved.

Note:

Background

1. The now deceased, Mr Griffin, was 38 years of age at the time of his death, having been born and lived his life in London. He had no connection with Scotland and is not known to have visited the country prior to the fateful trip which he was undertaking on 28 and 29 May 2010.

2. He had been engaged by a company in London which operated minibus hire to be the sole driver of a minibus which had been hired to take a group of passengers from London to Edinburgh. He did drive that group of passengers from London to Edinburgh on 28 May 2010 and dropped them as agreed in Edinburgh.

3. On the journey to Scotland, rather than travel north on the eastern side of the country, using the M1motorway and then the A1, he appears to have driven across to the western side and headed north up the M6 and M74 motorways, travelling over eastwards towards Edinburgh only after crossing the Scottish border. There was no return fare or hire, and his obligation then was to return from Edinburgh to London in the now empty minibus. He should have taken an overnight rest stop after dropping his passengers off and undertaken the return journey on 29 May 2010. It appears again that his intention was to return by the same route, which would involve him in travelling west from Edinburgh until he reached the M74, and then south on that motorway and the M6 before crossing over eastwards towards London. Even if he had never driven to or from Scotland previously, he appears to have had available an operative Satellite Navigation device (satnav).

4. However, at the critical time, and when he should still have been taking his overnight rest stop, he was discovered, between roughly 04.00 and 05.00 on 29 May, to be driving the minibus on the M74, but not southwards. Instead, he drove it northwards, in the northbound carriageway, all the way from Lockerbie in the south west of Scotland towards, and right into, the Glasgow area. The manner of his driving throughout that entire portion of the journey was so erratic and dangerous that it attracted the attention of many other motorists, who were so concerned that they used their mobile phones were to contact and alert the police. I will deal later with the necessary detail of this.

5. As a result, two Police Traffic Control cars were dispatched to follow the said minibus and take whatever action the officers involved thought necessary. Having caught up with the minibus, the officers made clear and persistent indications, by use of sirens, blue flashing lights and flashed headlights, to the driver, the now deceased, that he should stop. He failed to do so. Instead, he continued to drive, still on the M74 northwards, at very high speed and caused a collision between his own vehicle and one of the police vehicles, which caused the police vehicle to be forced off the motorway and crash over barriers into woods at the side of the road.

6. Despite the fact that the minibus had lost a wheel in the impact of that collision, and despite the terrifying nature of it, the now deceased continued to drive the minibus, on three wheels and at high speed for a further 4½ miles. Both immediately after the collision and during the subsequent four and one half mile long journey, the now deceased could have brought the minibus safely to a halt. He failed to do so. Eventually, he lost control of the vehicle and caused it to veer to the offside and into the central reservation barrier, with which it collided and overturned, throwing the now deceased clear of the wreckage but causing him the injuries which caused his instant death. He appears not to have been wearing a seat belt but it is unlikely that he would in any event have survived the crash. No other vehicle was involved in the collision with the crash barrier which resulted in his vehicle overturning, causing his death, and no action by any other driver contributed to that accident in any way. In the events which led to that specific incident, no other vehicle was in the immediate vicinity of the minibus, and in particular, no police vehicle was engaged in a pursuit.

7. Having regard to the fact that he had been engaged to drive this vehicle, which was being used commercially for hire and was, (or was at least supposed to be),

returning to London at the time of the accident causing his death, this Inquiry had to be held in terms of section 1(1)(a)(i) of the Act of 1976.

8. Against that factual background, a number of obvious questions arose, including, why had he not taken an overnight break? Why was he driving northwards and not southwards? What was his physical/mental condition during the course of this fateful journey? Why had he not stopped on first being signalled to do so by the Police? Why did he not bring the vehicle to a stop, but instead carry on driving, after the collision with the Police car? As it transpired, there was no trace of alcohol or drugs in the now deceased's blood at the time of this driving, but while that means that he was not at the relevant time driving while under the influence of alcohol or drugs, a much more complex explanation was to emerge which does involve the now deceased's history of alcohol misuse.

9. As it turned out, the evidence led raised a number of additional and quite fundamental questions, including a very basic one, which was: why was he driving at all?

The Conduct of the Inquiry

10. As a result of the various strands of enquiries which had to be made, it took some time to proceed to the holding of this Inquiry. Although the accident took place in Scotland, and in the Glasgow area, the now deceased had no other connection with this country. The involvement of the company which hired him to drive, and the circumstances surrounding that, and the question of his actual entitlement to drive a vehicle *of that type*, led to the need to advise his employers at the time to seek appropriate advice. As it transpired, they were not represented at the Inquiry, though their managing director gave evidence at it. Further, when the now deceased's medical history was enquired into, and it was discovered that it was of considerable importance to the question of whether he

ought, at the time of the accident, to have been permitted to drive *any* motor vehicle, that meant that his General Practitioner had to become involved, along with a number of other professional counsellors and advisers, all of whom of course were based in London. Finally, the impact of the discovery of the significance of all of this material was such that it became necessary to involve the making of representations to the Driver and Vehicle Licensing Authority (DVLA) and to the General Medical Council (GMC).

11. The effect of all of this was that the time span initially allocated for the holding of the Inquiry proved to be inadequate. The need to bring relevant witnesses from England, and the need to call witnesses to give evidence of opinion, meant that the Inquiry had to be heard in a number of different chapters, over a period of some months. Since the now deceased's sister had to travel from her home in London and no doubt incurred considerable expense in doing so repeatedly, that was unfortunate, but it must be said that the expense she incurred would in any event have had to be incurred, only perhaps in one block of a longer time span than in the shorter blocks which proved necessary. It should also be said that some of the additional evidence from witnesses giving opinion evidence became necessary as a result of the obvious impact of the evidence from those involved in speaking to the now deceased's medical history, and the completely correct reaction of the Procurator Fiscal who was leading the evidence, to the effect of that evidence and its impact on issues which were more general than just those which applied to the circumstances of this tragic case.

12. All of the evidence in the case was led by Ms Macfarlane for the Crown, and her presentation of it was completely thorough and undertaken in exemplary fashion. The other parties represented were; the family of the now deceased, the Chief Constable of Strathclyde Police (as it then was), whose officers were involved in the incident as it developed on the M74 motorway, one of the

individual police officers who had been driving one of the police cars involved, the police inspector who had become responsible for investigating the circumstances, and the now deceased's General Medical Practitioner in London. No other party who was represented chose to lead any witness in evidence.

The Circumstances Leading to the Fatal Accident

13. This was the first chapter of evidence, and the first aspect dealt with was the background of the now deceased and the circumstances by which he came to be hired to drive commercially.

14. It was clear from the evidence of the sister of the now deceased that her brother had an extensive employment history, but not much in connection with driving. He lived at home with their mother and had taken the job as a driver for the London Minibus Company a few months before the accident. She did not think he actually owned a car at the time, though he did hold a standard driving licence. The family was well aware that he was driving commercially. She described him as a "happy go lucky" individual, very kind and caring and bright and witty. He was unmarried with no children.

15. She stated that she had not been aware of any ongoing health difficulty which he had, and in particular that she was not aware if he had had a problem with alcohol. Their mother felt unable to attend the Inquiry or give evidence. It transpired that the now deceased did in fact have a very long and extensively charted history of problems with alcohol and of the consequences of over indulgence in it, and it became clear from his medical records that his family were aware of that too since they are mentioned in them. Further, he was living at home with his mother and his sister was in regular contact with him, so I am unhappily drawn to the conclusion that it seems a little difficult to accept, in retrospect, her contention that she knew nothing about any such problem.

16. She herself did not know he was taking a job which involved driving to Scotland but their mother did and he had told their mother that he would see her the following day. Of course, that was the plan: he was to take a party to Edinburgh and return in the empty bus the day afterwards.

17. The witness was upset at the fact that when she flew to Glasgow in the aftermath of the accident, she was taken to the scene in a marked police car and was asked a number of questions about any drink or drugs problem the now deceased may have had. She was also upset that the name of her brother as the person who had died in the accident was released to the media before it ought to have been. She has received an apology from the police about that last matter, which was repeated at the Inquiry, and it perhaps appears that the decision to escort her to the scene in a marked police car was a little insensitive. However, the scene was a motorway and it would have been necessary to protect the health and wellbeing of all those involved. The police were then investigating a fatal accident and two of their own number, and a number of other members of the public, had come close to disaster also, so one can see why they needed to make appropriate enquiries.

18. Mr Mahatma, the director of the London Minibus Company, gave evidence that his company had operated from February 2009. They were primarily a coach broking agency with what seemed the equivalent of a vehicle operators' licence restricted to two vehicles. They did own and operate two vehicles themselves in May 2010, though he said they now do not operate any. The vehicle being driven by the now deceased at the time of the accident was one he had bought only 3 days earlier. He bought it second hand and without having any mechanical inspection done of it. It was of an age which required it to have had an MOT certificate, which apparently it did. The company had a pool of drivers available for them to use. None of them was actually employed by the company; instead

they all offered their services on a self-employed basis and were free to take any job offered to them, on the basis of thereafter rendering an invoice to the company which the company would pay without making any deduction for tax or National Insurance.

19. This witness was, remarkably for someone operating in a highly regulated sphere, not able to produce any relevant paperwork. He said he could not put his hands on any contract which might have been signed by the now deceased, nor any copy of the driving licence he produced at the time he was interviewed for a job. He described having interviewed the now deceased and having been satisfied that he was entitled to drive "pretty much anything". As it emerged, that was far from the case, and the now deceased was not in fact entitled by the terms of the licence he did hold to drive the vehicle he was driving on 28 and 29 May 2010. Indeed, the witness said that he could not remember if he had even seen the paper part of the now deceased's driving licence, and hired him as a driver without doing so.

20. It is of course correct that at that time, the standard way to issue any driver with the "basic" driving licence was to issue it in two parts, a paper part and a "credit card" type plastic part. The plastic part contains a photograph of the holder and does list the categories the holder is entitled to drive and the expiry date of the licence. The paper part contains the full particulars of the holder and, significantly one would have thought in the case of a person being hired to drive commercially, a list of any previous endorsements or disqualifications, assuming they have not been removed as being spent.

21. Pausing there, it seems trite to say that a person who was considering hiring (whether as an employee in the traditional sense or on a self-employed, *ad hoc* contracting basis) a prospective driver who would be carrying passengers for

hire or reward, should actually know the various categories of driving licences and know what categories were required to be held by a person who would be driving the vehicles they owned. Further, one would surely expect such an "employer" to make the most rigorous enquiry of the prospective" employee" as to the category of licence such a person did hold, if for no other reason than that if a driver was driving a company vehicle when not the holder of the relevant category of licence, it would materially affect the company's insurance position. Unsurprisingly, this witness said that there had indeed been problems with his RTA insurers as a result of this situation and he had not recovered his losses from them. Also, it seems trite to say that a prospective "employer" would want to know if a prospective driver had any record of endorsements or previous disqualifications. Such a record, if it existed, could clearly affect a decision on whether or not to "employ", and could also again affect the "employer's" RTA insurance provisions.

22. It seems however that in this case, the witness made no enquiry about the now deceased's previous driving history as regards endorsements or disqualifications. He in fact admitted that he had not carried out a comprehensive check about the now deceased's record or entitlement to drive, and that was because they were a small company and the now deceased seemed to understand rules about use of tachographs and other important regulations about drivers' hours. I have to point out that this witness had previously been advised to take legal advice about his position, and that I also gave him a warning about the privilege against self-incrimination.

23. It is of course no answer to suggest that small companies do not have to be as rigorous in their procedures as large ones, nor that the now deceased may have actually demonstrated relevant knowledge about the rules relating to driving commercially.

24. In short, the actual photograph part of the licence held by the now deceased at the time did state, under reference to permitted categories of vehicles, that he was not entitled to drive for hire or reward the vehicle he was in fact driving on 28 and 29 May 2010. There are codes displayed on the photograph part of the licence which the now deceased had displayed to the witness at the time he was hired as driver, and the witness stated that he now knew the significance of this.

25. It was to emerge later that the now deceased also had a previous conviction for drink driving, in 1991. There is no evidence that the now deceased disclosed that to the witness. Since it is within a period of 10 years of the date of the fatal accident, it is my understanding that it would have remained disclosed on the paper part of the licence, since in the event of any subsequent conviction for an analogous offence occurring within 10 years, there is an enhanced period of disqualification which a subsequent court has to impose. He had served his period of disqualification in respect of that and of course the fact of that conviction by itself would not have prevented the company from offering him driving work, though again it may have had a bearing on their RTA insurance position.

26. It is not known whether the company would have agreed to use him as a driver if they had known all the relevant facts, and all one can say is that it appears they did not make a thorough enough investigation of them. Equally, even if they had known and "employed" him nonetheless, it is possible that he may well have been legally entitled to drive other vehicles on their behalf. Although the witness said that if he had known then what he knows now he would not have taken the now deceased on, one cannot make the bald statement that they simply should not have engaged him at all; but one can say that they should not have offered him this particular contract. In the event, I had to consider whether this set of circumstances might form the basis of a finding under section 6(1)(c) of the Act

("reasonable precautions…whereby the…accident resulting in the death might have been avoided"), but have come to the view that it is too remote to justify so doing. Also, I am not able to make any specific findings regarding the decision by the company not to arrange overnight accommodation for the now deceased in advance. The need to stay overnight was known to the now deceased, he had the means to pay for it (and would have been re-imbursed), and in the light of subsequent evidence, principally about the difficulties which the now deceased chronically had in sleeping anyway, as a result of his medical condition, it is not at all clear that the now deceased would have actually used any such accommodation as might have been provided. Further comment on the practices and procedures adopted by this company are a matter for the relevant regulatory authorities in England.

27. In the next chapter, the witness explained how this particular job had come about and the involvement of the now deceased in it. An extended family of 9 people from India were on holiday in the UK and required to be taken by minibus from London to Edinburgh. As I understand it, none of them spoke much in the way of English. The witness offered the job to the now deceased and he accepted. The witness met him at about 08.00 on 28 May. The now deceased seemed "fresh". He was given money for meals, told to drive to Edinburgh, ensure he had a clear break and rest, and bring the empty bus back to London on the 29th, the following day. There was no rush or pressure of time. He did not in fact arrange any overnight accommodation for the now deceased but left him to make his own arrangements in that respect. He was told to find one of the standard chains of inns and hotels. The vehicle had a satnav device. The journey should take between 8 and 9 hours with appropriate breaks. He did say in a remark which was to prove significant later, that the now deceased had no difficulty in accepting the job, and was the sort of person who would have no

difficulty in refusing if he felt he should not. He stated that in the past, the now deceased had on 3 or 4 occasions told him that "he had had a drink and was not going to be able to take" a job.

28. In the course of the journey north, on the 28th May, the now deceased telephoned this witness on 6 or 7 occasions. He seemed anxious. The passengers were conversing in their own language and he seemed to think they were commenting unfavourably on the manner of his driving. The witness said he spoke to the passengers, who denied to him that they were doing any such thing, and he tried to re-assure the now deceased accordingly. He also said he had spoken to him at about 10 or 11 o'clock at night, after the passengers had been dropped off, and that he told the now deceased to find a hotel for the night, which the now deceased said he would. He also spoke to the now deceased's mother who said the now deceased had spoken to her and said he thought that, during this journey north, he was being "followed".

29. What this means is that, assuming it is correct that the passengers were not in fact finding fault with the driving of the now deceased, he seemed to think they were. Such a belief, and that expressed by him that he was being "followed" (on the journey north on the 28th, when of course he was not), suggest an irrational basis for such beliefs amounting to a possible paranoid ideation. Again, the significance of that was to emerge later.

The Driving of the Minibus on the M74 on 29 May 2010

30. I turn now to consider the evidence relating to the driving of this vehicle by the now deceased in the early hours of the morning of 29 May 2010. It is of course correct that he should have been sleeping in overnight accommodation somewhere at that time. It was a holiday weekend in Edinburgh, and even if that meant pressure on the usual types of hotels he might have stayed at, he had

access to information which could have led him to suitable rest stop venue out of the city. It is known that he seems to have travelled as far down as the Carlisle area, and to have visited the places there where there are some suitable hotels, but no other information was forthcoming about actual attempts to book in anywhere. In any event, he was driving a minibus with extended length seats. Though perhaps not the most comfortable option, he could in fact have stopped at some discreet place, possibly in a car park, and slept in the minibus, and for all we know, may actually have done so, at least for a short time.

31. The fateful journey was in the early hours of 29 May 2010, and a number of witnesses spoke to the driving of the minibus, and to the manner of it by the now deceased, while it was on the northbound carriageway of the M74 motorway.

32. Perhaps it should simply be said at this point that there was no evidence to show why the now deceased was driving northwards. He appears to have been in the Carlisle area at some point but the distance from Carlisle to Glasgow north on the motorway is some 90 miles. We know that the now deceased was not familiar with that road. All entrance roads to motorways lead from a roundabout and while it is perfectly possible for a driver entering a motorway with the intention of travelling in one direction to find that he has come on at the wrong entrance and is in fact heading the opposite way, the alert driver will almost immediately realise that because of the existence of traffic direction signs and mileage indicators, and turn off at the next available exit point and head back the other way.

33. In fact, the actual motorway being travelled on in this case gives an even greater clue to the unfamiliar motorist. The now deceased chose to travel north on the 28th May by cutting across to the M6 motorway which starts in the east Midlands of England. We know he used that part of it which bypasses Birmingham as a toll

road and proceeded north to Scotland. Just past Gretna, that road changes its designation and number, to the M74, but is to all intents and purposes exactly the same road. It continues with its Scottish designation all the way to Glasgow. It is, I think, the only British motorway which actually changes its designated number without there being any actual change in the road characteristics or any break in it. The point is that when travelling on the road clearly marked as the M6, one knows one is in England. When travelling on the road clearly marked as the M74, one knows one is travelling in Scotland. If the now deceased had by mistake entered the M74 and travelled northwards when he meant to enter it and travel southwards, he would have very swiftly noticed that he was not on the M6 but still on the M74. In any event, the evidence is that the road is signposted regularly with mileage markers to major towns which are obviously in Scotland and not in England. We simply do not know why he was heading north when he should not have been, but later evidence was to point to a compelling reason why he failed to notice his mistake and react to it, assuming that is what it was. Also, and in any event, he had access to a satnav device which was operative and my understanding is that such devices, assuming a specified destination has been entered, give the clearest indication to the driver that he has taken a wrong turning or is heading in the wrong direction, if that is what he is doing.

34. A number of members of the public gave evidence that they had occasion to be travelling north on the M74 in the early hours of 29 May 2010 and saw the minibus being driven by the now deceased. They all commented on the manner in which it was being driven. To save repetition, it is fair to say that they all described the manner of driving as amounting to reckless and dangerous driving on the part of the now deceased. It is also important to point out that most of those who commented on it are actually employed as professional drivers.

35. Mr James Douglas, who was in fact driving home in his own motor car, is actually a highly qualified and experienced driver of heavy vehicles in connection with his employment in the armed forces. He is in fact qualified to drive armoured tanks, and does so. He became aware of the minibus coming up behind him at about junction 10 near Lesmahagow. He himself was travelling at between 65 and 70 mph. The minibus came right up behind him at great speed and right up to his back bumper, only pulling out to avoid him when there was a space between the two vehicles of only a few feet. He clearly feared he was going to be run into from behind. That was not the end of it though, for despite the fact that there was very little traffic on the road, the minibus immediately pulled back in ahead of him but so close to him that he thought it was going to take his front bumper off. Shortly afterwards, on coming up behind another vehicle, the driver of the minibus repeated an identical manoeuvre. At no time did he display brake lights. The minibus was rocking from side to side quite noticeably. He saw the bus drift into the fast lane as if going to hit the central reservation barrier. The driver of the bus then repeated this manoeuvre in respect of a car which the witness saw had a family in it, including children, whom he surmised might be headed to Glasgow Airport. He saw that all of the occupants of that car were panicking at the driving of the minibus. He said the minibus drove like that in overtaking trucks also, and that he saw him drive in that manner, driving right up behind a vehicle, pulling out suddenly at the last moment, and then immediately pulling back in front again, on over a dozen occasions. All this happened at considerable speed, more than 70 mph, and over a period of 5 to 10 minutes. Plainly, that means a journey of 6 to 12 miles. He was so alarmed that he used his mobile phone, on a hands free kit, to dial 999 and alert the police. He continued to follow the minibus, but at a safe distance. His call to the police is logged on the police incident report.

36. Mr Douglas was still behind the bus when he reached the Hamilton area, which is a very considerable distance from where he had first seen it. It was from Hamilton that the two police cars which became involved had been dispatched, and Mr Douglas saw them travelling south, and flashed his lights at them to alert them to the fact that the bus had passed that junction and was still going north. The two police cars responded to his signal by exiting at the next junction, turning round, and heading back north again, overtaking Mr Douglas. He saw the police cars approach the rear of the minibus, with one police car in the inside lane and the other beside it in the middle lane. Both were using their flashing blue lights and flashed headlights. Almost remarkably, at that point the driver of the minibus came up behind an articulated lorry and repeated his previous manoeuvre, pulling in so sharply in front of it that the driver of the lorry had to brake and almost jacknifed. The minibus driver was plainly ignoring the police signals to him to stop and came up behind yet another heavy goods vehicle. At that point, one of the police cars had pulled into the outside (of three) lanes and the minibus was in the inside lane, but the driver of the minibus pulled out from behind the heavy goods vehicle and right into the outside lane, striking the passing police vehicle and causing it to spin right round and travel right across from the outside lane to the inside lane, and pass, going backwards, right in front of the heavy goods vehicle, missing it by inches. The impact was massive. The police car, which had plainly been travelling at more than 70 mph, then struck the barrier at the side of the road and flew, backwards, over the barrier and into trees in woods off the side of the motorway. He described the actions of the driver in pulling the minibus over towards, and colliding with, the police car, as deliberate. He described these actions as crazy.

37. Mr Douglas, having witnessed this appalling accident, stopped his own car on the hard shoulder and went to see what had happened to the occupants of the

police car. The other police car and the heavy goods vehicle which was so nearly involved in the carnage also stopped. Mr Douglas commented, perceptively, that his automatic reaction to the manner in which the now deceased was driving was that he was either under the influence of something or something was affecting his state of mind. Of course, having stopped, Mr Douglas did not see what happened to the minibus thereafter, although he was aware that it did not stop. He only became aware of the fact that it crashed later on, and that the driver was killed in that second crash, when he heard about a fatal road accident while listening to his radio. He did not see the crash in which the now deceased was killed.

38. The driver of the heavy goods vehicle which so nearly became embroiled in the collision between the minibus and the police car was Michael Caballero. He was a very experienced driver of large and heavy vehicles, having been a bus driver himself at one stage. He was driving north on the M74 on his regular route. His vehicle consisted of the cab with a three axle trailer. He was approaching Hamilton when he was first alerted to the situation. He saw the two police cars travelling south with their blue lights flashing. The conditions were perfect and played no part in what subsequently happened. He was approaching the Bellshill junction (numbered 5) travelling at no more than 55 mph as his vehicle has a speed limiter. He then became aware of the flashing blue lights now behind him and coming north. He was in the inside lane and saw the white minibus move into the outside lane where it struck the passing police car. It was a side swipe as he described it and the effect was to set the police car into a spin, sending it across the road from outside to inside lane and passing, going backwards, right in front of him. It passed inches in front of him and onto the hard shoulder, (then going over the barrier). He indicated that of course there would have been nothing he could have done to bring his vehicle to a stop in the split second

available, so that if he had hit the police car, both of its occupants would have been killed. He would literally have run over the top of it. He stopped but the minibus carried on. He therefore did not see the subsequent fatal crash of the minibus. He thought the manoeuvre performed by the driver of the minibus which caused it to strike the police car was deliberate.

39. Remarkably, the two police officers who had been in the car which had gone off the road emerged from the wreckage and came up the slope back onto the hard shoulder, and astonishingly, one of them had had the presence of mind to ask him for his details as a witness, despite being shaken up as they had been "near to death". With massive understatement, he then said "I was a bit shaken too". Of course, as a result of this accident and then the subsequent fatal one, the road had had to be closed, and all of the drivers mentioned, including this witness, were obliged to remain at the scene of the first crash.

40. He was quite clear however that there had been no need for the minibus to have swerved into the police car, that the police obviously had wanted the driver of that vehicle to stop, and that he had had plenty of time to stop if he had really wanted to. Of course that means the now deceased had the opportunity to stop in response to police signals before the collision with the police car. Plainly, that collision need not have happened. If he had stopped then, the first accident would not have happened, and neither would the second, fatal, one.

41. One other motorist, David Bissett, gave evidence about seeing the driving by the now deceased which led to the first accident involving the police car. He also is an experienced driver and was working as a licensed taxi driver in the Lanarkshire area. He entered the M74 going north at junction 7 (the numbers count down as the motorist approaches Glasgow). He became aware of an articulated lorry (this seems to be the one overtaken by the now deceased before

he came up behind Mr Caballero), the minibus, driven by the now deceased, and the car which was being driven by Mr Douglas. He described the minibus as being driven erratically and swerving to the left and right. His immediate thought was that the driver must be drunk. He was so concerned for his own safety that he held back from the immediate vicinity of these vehicles, and then saw the minibus going very close to the back of the articulated lorry and then changing lanes into the middle lane. He then became aware of approaching police cars on account of the flashing blue lights behind him. They passed him and were side by side in lanes 1 and 2 (of three). He said it was obvious that they were intent on getting the driver of the minibus to stop, but they were still behind it. At that point, one of the police cars went into lane 3, the outside lane and tried to overtake the minibus, but it moved out from lane 1 right across to where the police car was and struck it, pushing it into the central reservation, which it rebounded from and then passed back across the three lanes off the road. His view was that the manoeuvre by the driver of the minibus was very sharp and that he thought that driver knew what he was doing and that he was trying to stop the police car getting past him.

42. This witness stopped also at the scene of the first accident, but not before he saw what effect the collision with the police car had had on the minibus. He saw sparks coming off the road at the back of the bus and then a wheel detached from it. The sparks of course were coming from the metal of the wheel hub dragging along the road surface, but nonetheless, the minibus did not stop and carried on driving, out of his immediate sight. The second police car stopped also but after seeing that their colleagues had managed to emerge from the wreckage of their car, they drove off again, after the minibus. Interestingly, when asked if he thought that the actions of the driver of the minibus looked as if he might have been affected by tiredness, he replied “No. You don’t drive like that when you’re

tired. He wasn't meandering – it was a purposeful pull in and out". He said he had never before witnessed driving like it. `

43. At this point, it is necessary to consider the evidence of the police officers involved, in the chronological chain of events.

44. As I have mentioned, calls were being made by concerned motorists regarding the manner of the driving of the minibus. As a result, Traffic Control despatched two police cars from the nearest depot to proceed to the motorway. These cars were assigned the call signs TM32 and TM34. TM32 was driven by Constable Graham Neilson with Constable Ronald Arnott as his passenger. TM34 was driven by Constable Andrew Brant with Constable Ian Thomson as his passenger. Although of course all four officers gave evidence individually, it is perhaps appropriate to discuss their evidence in two chapters, that relating to TM32 and that relating to TM34.

45. Constable Neilson is 43 and with 11 years of service. Constable Arnott is 31 with 10 years' service. They were the crew of TM32. Constable Neilson is a highly skilled and trained police driver. He has qualified as an Advanced Police Driver. He was familiar with all aspects of road policing, including the detailed rules contained in the instructions about road pursuits issued by the Association of Chief Police Officers Scotland (ACPOS).

46. This issue had been flagged up at an early stage of the investigation of this death since of course the minibus then being driven by the now deceased was known to have been approached from behind by two police cars, which had signalled it to stop, but which it had failed to do. It had itself then crashed, killing the driver, so it was important that the issue of whether the actions of the police cars had played any part in the fatal crash was looked into. As it emerged in the evidence, the question as to what constitutes a "pursuit" is dealt with in the ACPOS

manual, and it became obvious that in the situation which took place here, there were in fact two separate and distinct incidents. The first was the collision between the minibus and the police car, and the second one was the subsequent overturning of the minibus with the fatal consequences for its driver. If the situation had been that when the minibus had collided with the police car, it had overturned there and then, killing its driver, then of course it would have been necessary to see whether the ACPOS instructions were in point, and if so, were being complied with. As I have already made clear, however, that was not the situation. After the collision with TM32, the minibus kept on driving, on three wheels, for a very considerable distance and at a very considerable speed. At the point where it did crash and overturn, with its fatal consequences, the evidence clearly established that there was no question of there being a police "pursuit" taking place. I will of course deal with that issue later in regard to the first collision too.

47. Paragraph 1.1 of the ACPOS manual defines "pursuit" and says that a police driver is deemed to be in pursuit when "a driver indicates by their actions or continuance of their manner of driving that they have no intention of stopping for the police and the police driver believes that the driver of the subject vehicle is aware of the requirement to stop and decides to continue behind the subject vehicle with a view to either reporting its progress or stopping it. Pursuit may be spontaneous or pre-planned." As the next sub-paragraph makes clear, there is no place for the term "follow" in this context and that a police vehicle is either in pursuit or it is not.

48. The point here is that clearly, both TM32 and TM34, when they came up behind the minibus, were signalling the driver to stop and were, in the ordinary sense of the word, "following" it, since they were both behind it. However, that does not constitute a pursuit, as defined. The expression "stopping it" means taking active

steps to force a stop. That is not what was happening here, according to the evidence. What was happening was that the drivers of TM32 and TM34 were indicating to the driver of the minibus to stop, and, obviously, hoping that he would do so. The minibus was travelling at about 70 mph and there were, as indicated other vehicles in the immediate vicinity, so it is not realistic to expect a complete and sudden stop. Police drivers have to remain in contact with the subject vehicle and wait to see what develops. The manual goes on to indicate that the initial phase of a spontaneous pursuit has to be authorised by control room staff.

49. In any event, Constable Neilson confirmed that he set out down the motorway, heading south, driving TM32, in response to the call out, and became aware of a vehicle travelling north and flashing his lights at them (this was Mr Douglas). He exited at the next junction and headed back north, having been joined by TM34. They came upon the minibus as they approached another exit road from the motorway. They saw a HGV (which appears to be the first one overtaken by the minibus) and that the minibus was coming up right behind it. The minibus was doing about 70mph and they were travelling at about 80 to 90 mph at that point. Both police vehicles were displaying blue flashing warning lights, sounding sirens, and flashing headlights. The minibus moved out from lane 1 into lane 2 and back in again behind a lorry (this was the one driven by Mr Caballero). The two police vehicles moved in behind the minibus, with TM34 in lane 1 and Constable Neilson in lane 2.

50. At this point, Constable Neilson was aware that there was an approaching exit road at junction 5. He was concerned that the driver of the minibus, who plainly knew, in his opinion, that he was being signalled to stop, might seek to exit the motorway at that junction. That exit leads to one of the busiest and most complex junctions in the area. If this vehicle was to stop, it would have been much safer

and more manageable to keep it on the motorway. It was in the early hours of the morning and traffic was very light. Constable Neilson decided that he would overtake the minibus and get ahead of it to the exit so as to prevent the minibus from leaving there. That is an entirely understandable decision to have taken, and in accordance with training and procedure.

51. He moved TM32 into the outside lane, lane 3. Even if the driver of the minibus had decided to overtake the articulated lorry driven by Mr Caballero, lane 2 was available for that purpose. At that precise moment, the driver of the minibus pulled out from lane 1 right across to lane 3 and struck the side of TM32. Constable Neilson thought that this was a deliberate action by the driver of the minibus. He rejected the suggestion that this might have been an inadvertent manoeuvre of a driver who was fatigued. He thought that the minibus was trying to force the police car through the central reservation. It was the front offside of the minibus which struck them. Constable Neilson lost all control of the police car which spun right round, travelled backwards across lanes 2 and 1, passed right "under the nose" of the HGV, hit the embankment at the crash barrier side of the hard shoulder, flew up into the air, still travelling backwards, and down the slope off the road into a plantation of trees and bushes, stopping about 30 feet down the slope.

52. Miraculously, neither he nor his colleague was seriously injured as a result. They managed to extricate themselves from the wreckage and became aware of Constable Thomson, the driver of TM34, coming to their assistance, along with the other motorists already mentioned who had also stopped. He then became aware that TM34 left the scene, in order to see where the minibus had gone to, since it had not stopped despite the severity of this collision.

53. At this point, the information about the minibus was coming from only TM34. For the sake of completion, the log of the relevant radio traffic was produced and showed that the first call about the driving of the minibus was received at 04.46, that Constable Neilson (TM32) got the message to investigate at 04.48.16, with the suspicion obviously being that there was an alleged drink driver, that TM32 and TM34 turned round at junction 7 and headed north at 04.51.55, that they reported being behind the minibus at 04.54.41, and that the collision with TM32 was 11 seconds later. At 04.56.26, TM34 confirmed that they were now continuing and that so was the minibus, despite having lost a wheel in the collision with TM32. It is clear that no authorisation was given to TM34 to commence what would have been a pursuit. Constable Thomson was in fact an appropriately trained driver but was told at 04.56.43 to wait for directions. He did so. Constable Thomson then radioed that the minibus had hit the central reservation at 04.58. In all, 1 minute and 47 seconds passed between the report of the collision with TM32 and the report of the fatal crash of the minibus.

54. As it happens, Constable Arnott, who was the passenger in TM32, is also a very experienced police driver and is also trained as an advanced police driver and in the details of the ACPOS manual regarding pursuits. Although it was his colleague who was in fact driving at the material time, it does of course mean that both officers were appropriately trained and both completely aware of what might be required of them in the situation as it developed. Constable Arnott, who was of course making the radio communications with control, was also in a position to make acute observations about the manner of the driving of the minibus in the seconds which elapsed before the first collision. He described it as very erratic, and that the driver was swerving violently from lane 1 to lane 2 and back again. He described it looking as if the driver was trying to topple the bus over. This was in fact consistent with a description given earlier by Mr Douglas.

This witness too had to relive the experience of describing how he thought the HGV being driven by Mr Caballero was going to travel right over the top of them as they passed right in front of it when exiting the road backwards. When he got back up to the road on foot, he said he had expected to see the minibus but was told it had not stopped. He came upon the other motorists who had stopped, and, remarkably in the circumstances, began to take their details as witnesses.

55. Constable Andrew Brant was the driver of TM34, and he was also an extremely experienced police driver, being an advanced police driver, trained in the techniques of pursuit, and a qualified vehicle examiner. It intends no disrespect to the evidence of this witness and his passenger, Constable Thomson, to say that in broad terms, they confirmed all that I have already set down up to an including the details of the collision with TM32. Constable Brant was another witness who said that, before the collision with TM32, he saw the minibus "fishtailing", i.e. moving in a swaying manner which upset its balance. He saw the minibus overtaking the first HGV and doing about 70 mph as it did so. It then pulled back in. He then saw TM32 overtaking them, in the outside lane, and doing about 90 mph. As it did so, the driver of the minibus pulled out across to the outside lane and struck TM32 in the manner already described. He also stated that he regarded the actions of the driver of the minibus as having been deliberate on account of the speed he moved at and the accuracy displayed in striking the passing car. He was horrified at what he saw.

56. He then of course had to brake and pulled up, in order to see what had happened to his colleagues. The minibus however, did not stop. In fact, he said that it did not even brake or attempt to slow down and just carried on up the road. He saw that it had been badly damaged. It was down at the driver's side and there were sparks coming off the road (it had of course lost a wheel). When he realised to his relief that his two colleagues had not in fact suffered serious

injury and had emerged from the wreckage of their car, he decided to press on after the minibus. At that stage, as he drove away, he noticed substantial debris on the road, obviously caused by the collision. It included the whole of one of the wheels from the minibus.

57. Photographs taken during the subsequent investigations while the motorway was disclosed amply confirm all of this. Those showing the rest position of TM32 at the foot of the embankment in a thicket of tress demonstrate just how astonishing it is that both occupants were not killed. The wheel had six retaining nuts and they were all found later on the carriageway. The wheel itself is seen lying on the road. This witness also said that not only was the vehicle giving off a shower of sparks as it drove on, from the metal of the wheel hub scraping along the road surface, it would also have been making a substantial noise. The result is that there is no possible basis in which the driver cannot have known that his vehicle had been seriously disabled in a crash.

58. It is however significant to note that the scrape made by the metal of the wheel hub of the minibus is clearly shown on the road, and demonstrates that the driver was driving it in the middle lane of three and was actually keeping it under control and in a straight line. It is completely clear that he could have stopped at any time in that journey, either by pulling over to the hard shoulder, or just by ceasing to operate the accelerator, which would have meant that the vehicle would gradually simply slow down and stop. Indeed, when TM34 caught up with the minibus again, the driver was still travelling at between 60 and 70 mph and still had it under control. The photographs show that the scrape line gives the clearest picture of the vehicle's progress. Further up the road, the inside lane becomes a dedicated exit lane for the M73 motorway and the M74 continues on with 2 lanes and a hard shoulder, but round a sweeping right hand bend. The driver not only managed to negotiate the junction with the exit to the

M73, but he kept it in what then became the inside lane of two lanes, making it even more obvious that he could have stopped the vehicle at any point in that journey.

59. What then happens in the road is that it becomes three lanes wide again, as the onramp from the M73 joins it, and after that point, TM34, which was not engaged in a pursuit but was sitting about 100 metres behind the minibus and simply observing its progress, saw it drift over towards the central reservation and strike the barriers, somersaulting over on itself and coming to rest across the barriers between the two carriageways, and throwing the driver out, apparently through the windscreen, onto the road. TM34 prevented any other vehicle from encroaching on the scene of the fatal crash, and of course the road was closed, in both directions.

60. Constable Thomson, the passenger in TM34, was also an experienced police officer, though not qualified as an advanced driver in the manner of the other three officers involved. He of course confirmed the details given by his colleague, and in addition said that Constable Brant said in terms, when he had resumed his journey after stopping for the first collision with TM32, that he was not going to try to effect a stop of the minibus but was instead simply going to drive at a safe distance behind it, holding back any other traffic behind him. That is what he did, so once again it can be clearly seen that in deciding to proceed after the minibus and following the first crash, Constable Brant in TM34 was not engaged in a pursuit. Constable Thomson described the driver of the minibus as keeping it on the road and under control, albeit it was swerving and swaying. Significantly though, the driver made no attempt or effort to stop, which he could easily have done.

61. The final eye witness was Mr Patrick Cullen, who had also been working as a private hire driver in the Lanarkshire area. He had dropped off a fare and was heading back to his depot via the M74 motorway. He entered the road at the on ramp from the junction which is after the place where the collision with TM32 happened. As soon as he did so, he became aware of the minibus travelling in front of him with sparks flying off the road. He said he thought the driver of the minibus ought to have seen the sparks. He said it was in the middle lane, which is confirmed by the photographs showing the scrape marks, and was waving about. He could see there was a wheel missing, though his initial thought, understandably, was that maybe the bus had had a blowout of a tyre. It was however travelling at about 60 mph and not attempting to stop. He was so concerned for his own safety that he eased off and kept well back from it. He then became aware of blue flashing lights and a police car, which was TM34, passed him. The road then passes under a bridge, and Mr Cullen slowed down even further, since it was clear that the police wanted to keep any other cars behind them, and when he got under the bridge, saw that the minibus had indeed crashed and overturned.

The Investigation of the Circumstances of the Fatal Accident

62. Sergeant Scott Sutherland, yet another vastly experienced officer who is also trained in pursuit techniques and as an advanced driver, was on duty and responded to the ongoing incident. He entered the M74 and passed where TM32 had crashed, and went further up after TM34. He found TM34 parked on the motorway, blocking the road, just beyond the Maryville junction, and situated some distance behind the wreckage of the minibus straddling the central reservation. As was the protocol in those days when there were a number of separate Scottish police forces, the actual investigation was initially carried out by Strathclyde Police and then reviewed independently by Lothian and Borders

Police. This witness had to deal with the distressing aftermath of the fatal crash and arrange for relatives to be contacted.

63. He also collected the information which was subsequently set out in the report, including details of relevant timings. Some of this was obtained from an examination of the tachographs taken from the minibus. In summary, it is known that the now deceased was in Edinburgh after 20.00 on 28 May. As previously stated, he was expected to stay there, or at least in the vicinity, overnight and drive back down to London in the morning of 29 May. Instead, he was found to have been driving *south* on the M74 at Lockerbie, which of course is not far short of the border with England, at 23.49 on the 28th. He seems to have carried on driving till 01.30 on the 29th. There is then a break recorded until 04.00 on the 29th, when he started to drive again and is recorded as travelling *north* on the M74 at Lockerbie at 04.11 on the 29th. He gave the opinion that even if the decision to drive north instead of south was initially a mistake, it is simply not possible for a driver to drive all the way from Lockerbie to Hamilton without realising that he was travelling in the wrong direction. There are numerous signs and direction and mileage indicators. In any event, the vehicle had a working satnav device. That, and the now deceased's mobile phone Sim card were analysed.

64. There are messages on his mobile which confirmed that there was some turmoil in the now deceased's private life at the time of this death. There are messages from his mother on the 20th May which indicate that he was having relationship difficulties with a woman which seemed to cause difficulties in turn between the now deceased and his family. There is another one from his mother dated 27 May, the day before the trip north, in which she obviously knows he is leaving on a journey, but says "Will always care about you but have problem living with you". There are details extracted from the satnav device which show that after leaving Edinburgh in the late evening of 28 May, he visited the sites of three

hotels or inns in the Carlisle area. No information was forthcoming as to whether he had stayed in any of these inns, or even attempted to book in, and the period of three or so hours up until just after 04.00 on the 29th May remains unaccounted for. The opinion of this witness was that it would be highly unusual for fatigue by itself to be the cause of then driving on the 29th because it does not usually manifest itself like that.

65. Constable Ewan Thomson was yet another vastly experienced police officer who gave evidence about the subsequent investigation into the two crashes. He has been involved in such work for over 8 years. He, and his colleague who assisted him also, is highly qualified in the appropriate range of skills required for investigation, as well as being an advanced police driver. Of the greatest initial significance is that his measurements show that the fatal collision of the minibus with the central reservation barrier took place 7 kilometres further along the motorway from the scene of the first collision between the minibus and TM32. That means that the now deceased, despite being involved in a major collision with a police car at very high speed, and despite losing the front offside wheel of his vehicle as a result, continued to drive the minibus, at speed, further along the motorway on three wheels, with the front offside corner scraping along the ground and throwing off a shower of sparks as it did so, for a distance of 7 kilometres, which is approximately 4½ miles. From that fact alone, it can be said that he could have brought the vehicle to a stop at any point in that journey, and if he had done so, the fatal accident would not have occurred. Nothing about the condition of the road or the weather contributed to the fatal accident. The now deceased was not wearing a seat belt at the time of the fatal crash. Significantly also, there were no mechanical defects present on the minibus (or indeed on TM32 either) which could have contributed to the initial collision with TM32.

66. Suffice to say that the real evidence examined from tyre and scrape marks and positions of debris on the road confirm the eye witness evidence already set out, and that TM32 was in the outside lane of three when struck by the minibus. Analysis of tyre marks left by the minibus on the road surface at the exact point of the fatal collision with the central reservation shows that the minibus was travelling at a speed of 70 mph ± 10%. It was the force of the collision with TM32 which caused some of the wheel nuts of the front offside wheel of the minibus to shear, but as the driver did not stop and carried on driving at speed, the remaining nuts would have been prone to excess loading and would then have sheared also. They were all recovered at the locus of the first collision and subsequently further up the road, along with the wheel, which came to rest 800 meters further on from the scene of the first collision. In due course, the effect of driving with the brake discs on the wheel hub scraping on the road caused the brake calliper to become detached and the brake pads to fall off, from that wheel, but this witness stated that the braking system was still operative despite the damage and the vehicle could still have been braked to a halt. In any event, simply ceasing to use the accelerator would eventually cause the vehicle to slow down and stop also as it lost momentum. He said it would have been impossible for the driver not to know that there had been a collision and that his front offside wheel had been at least seriously damaged.

67. Inspector Simon Bradshaw was at the time in charge of the appropriate Roads Policing Unit at Lothian and Borders Police, and was tasked with the need to carry out an independent review of the Strathclyde investigation. The conclusions of the independent review were that no blame could be attributed to any actions by either of the police drivers of the vehicles TM32 or TM34 in respect of either the first collision with TM32 or the second fatal one involving only the minibus.

68. Of course it is no part of the function of a Fatal accident Inquiry to attribute "blame" but it is important therefore to highlight that the effect of the independent police review is to say that no criticism can be attached to either of the drivers of TM32 or TM34, that neither of them was engaged in a police pursuit, as that concept has earlier been discussed, and that neither of them took any action which caused or contributed in any way to, nor played any part in, the fatal accident which occurred in this case.

69. Interestingly, Inspector Bradshaw did discover, and commented on, a potential reason for the nature of the driving of the minibus by the now deceased in this case, and that is that he was believed to have been suffering from mental health issues resulting from alcoholism and alcohol withdrawal affecting his judgement. It is also the case that the now deceased drove the vehicle for a total of 13 hours in the period of roughly 19 hours between 10.00 on the 28th and 04.45 on the 29th. The maximum permitted under Drivers' Hours legislation, about which the now deceased was knowledgeable, is 10 hours out of 24, and so he had driven considerably in excess of the maximum permitted. The review concluded that driver fatigue was not a significant or contributory factor in this incident. This is based on experience of investigating incidents where it is known that a driver has fallen asleep at the wheel. Speed will decrease slowly and the vehicle will undergo a slow change of direction, which is the complete opposite of what happened here.

The Relevant Medical History of the Now Deceased

70. The next chapter of the Inquiry looked at this aspect in detail, following up on the observations mentioned above which raised the issues of a possible explanation, based on an alcohol problem, for the driving behaviour of the now deceased on the 29th May. As already pointed out, there was no alcohol found in

the system of the now deceased after the fatality, but as was to be the subject of intensive scrutiny thereafter, that fact did not give the full picture.

71. The now deceased had been registered with a General Practitioner whose practice is based in a Health Centre in London. It had been discovered in the course of the investigation which followed this incident that there was highly relevant material in the now deceased's medical records, and that as a result, evidence was required from his GP, and from two other General Practitioners who had seen him at that practice on a locum basis. Further, other medical and health care professionals were discovered to have been involved in counselling the now deceased, and they too gave evidence about their involvement.

72. His registered GP was at all material times the principal of that practice, though she had a partner at some stage. She first saw the now deceased in the late 1980's but he had been registered before then. She described him as a patient who did not attend frequently, was difficult to engage with, and was a diffident young man. She said that in the early days it was quite clear that he had a problem with excess alcohol consumption. Sometimes he would admit to that and sometimes he would not want to discuss it. That problem increased over the years and he began to present with gastro-intestinal problems relating to alcohol consumption. She had in fact seen him with acute psychosis in the 1990's and said he had been admitted to hospital in 1995 with acute psychosis in the context of alcohol withdrawal. In October 1994, he presented with abdominal problems and in September 1995 complained of being confused over a period of days with paranoid ideas that his room had been bugged and that he was very agitated and was hearing voices. The diagnosis was possible alcohol withdrawal and he was admitted to hospital.

73. The Community Mental Health report following that admission shows that it was prompted by the consumption by the now deceased of a vast quantity of alcohol followed by the suffering of *delirium tremens*. He was recorded as having suffered auditory and visual hallucinations of a florid nature with some passivity phenomena, combined with what was said to be a positive family history of schizophrenia. He was discharged on medication but had not complied with that. At review, he claimed to be not drinking in order to avoid withdrawal phenomena. That means that as long ago as October 1995, the now deceased was a person who suffered the effects of alcohol withdrawal, was aware of them, and knew that by continuing to binge drink and then have periods of abstinence, the risks of recurrence of withdrawal symptoms remained.

74. In September 1996 he admitted to drinking 10 pints a day but did not think his drinking was a problem and was not prepared to discuss it. He had a peptic ulcer caused by alcoholism, in the witness' view. Two months later, he reported paranoid feelings of seeing spiders in his room and of not sleeping, all of which started after heavy drinking over the weekend. On that occasion he reported no auditory hallucinations but realised he had a drinking problem. A referral was made to the Community Alcohol Service. He had an endoscopy for abdominal problems caused by drinking in the mornings. In early 1997 he seems to have taken help and gone to Alcoholics Anonymous.

75. However, in January 1998, he was again complaining of not sleeping and said he was drinking 10 – 12 pints a day, and was not interested in trying to stop. By July 1998, he admitted to drinking 16 pints a day, 6 days per week, and had done for years. He said he was not eating and could not do his job. There was said to be a strong family history of alcoholism. He suffered from hallucinations and shakes and was vomiting blood. In the entry for 30 July 1998 there is recorded "he has a problem of alcohol dependence". The now deceased himself recognised that his

drinking pattern prevented him from working. In August 1998, the impression of those at the Alcohol and Drug Addiction unit at the Community Mental Health Resource Centre was that he had a schizotypal personality disorder rather than primary alcohol dependency syndrome.

76. The Community Psychiatric Nurse who dealt with him at that centre then reported on 21 August 1998 that his drinking pattern was to binge for a few days followed by a few days abstinence. His mother was well aware of his problems as were other members of his family as he still lived at home. Significantly, he described the days of abstinence as "unbearable". He suffered from sweating and paranoia, believing that people were talking about him. (It will be remembered that on the journey north on 28 May 2010, he reported that he thought the passengers were talking about him, when apparently they were not.) He was described as being "clearly dependent on alcohol". A reference was made to the locally available alcohol counselling service, known as the Gatehouse.

77. He was still being treated by specialist clinics in March 2000. He had required then to be admitted to hospital after suffering from an alcohol withdrawal seizure. He was then drinking 12 pints per day, every weekday, and 18 pints per day at weekends, but denied regular withdrawal symptoms though giving a history of alcoholic blackouts. He was having sleeping problems and said he had been feeling paranoid on and off for a number of years. There was a substantial family history of drinking and problems caused by it. He did have a drink driving conviction in 1991. The plan was to get him to reduce consumption. In October 2000 he was referred to a consultant neurologist, having reported yet another fit, despite not having had a drink for 4 days. He had been assaulted in 1999, but of course his alcohol problem long predated that.

78. The neurologist reported back to the GP on 13 August 2001, and that report contains information which is both significant and worrying. For the first time, the now deceased is described as having been working as a delivery driver. No diagnosis of epilepsy was made regarding the history of blackouts though an EEG was arranged. The consultant reported that the now deceased's employers were aware of his history of blackouts (which is certainly not the case with the "employer" who had engaged him at the time of his death), but the now deceased told him he drove only on private sites (which is actually irrelevant – an accident can happen just as easily on private sites as on the public road). The consultant then records that he discussed the driving regulations with the now deceased in detail and told him that he should "NOT" (sic) drive on public roads for one year following the last episode.

79. However, it looks as if no one took the initiative at that stage of passing on this information to DVLA.

80. By June 2002 he reported to the GP that he had stopped going to the Community Addiction Resource, and in July of that year that he had reduced his intake to 6 pints per day. On 19 September 2002 he reported to his GP that he had abstained from alcohol for 5 weeks but had started again. He reported that he had been hearing voices and feeling paranoid. He reported drinking, getting hot sweats, and the DT's and having hallucinations. On 28 February 2003, the GP practice was written to and advised, by the same CPN who had seen the now deceased before, that he was being discharged from the Community Alcohol Service back to the care of his GP as he declined further contact with them. He is described as having "a major alcohol dependency" and then drinking 30 units daily. His GP referred him back in April 2003, because he had complained again of suffering paranoid feelings following heavy drinking but he did not respond to offers of appointments.

81. On 28 August 2003, he wrote to his GP a letter which makes it clear that he was driving in the course of employment. He said that in connection with his company's insurance requirements, he needed to tell them if he could "drive correctly on the medication that I am taking". He was not actually then taking medication. The witness noted in manuscript on the letter she received that she spoke to the now deceased on the telephone on 1 September 2003 and thought it was an unusual request, and that he should write with his signed consent (which he did not in fact do). Of the greatest significance though is the last sentence she has written, which reads "I did not think he should be driving with his history of alcoholism".

82. It looks as if, once again, no report was made to DVLA. The witness said she took no further action.

83. In June 2004, the practice was advised by an ophthalmic surgeon that the now deceased was working as a driver/loader and was drinking heavily and had been advised to seek their advice regarding that. In November 2004 he was referred by the practice to a gastroenterologist, and noted as drinking 104 units of alcohol per week. In July 2005, he reported to the practice that he was having auditory and visual hallucinations, panic attacks, feeling he was being talked about though there was no one there and was agreeable to an alcohol detoxification. He failed to attend at the Gatehouse in August 2005 and in December of that year he told the practice he had no interest in getting help. This witness then referred him again to the Gatehouse in January 2006, and again he failed to engage. In March 2007, he referred himself to casualty after vomiting blood, and reported the same thing in February 2008 to a locum GP. He attended on that occasion after persuasion from his mother and sister.

84. On 4 March 2008 he self-referred to Accident and Emergency and complained of auditory hallucinations. He said he had been suffering this for 13 years. He also reported paranoid feelings of people watching him and following him. He was referred again to Gatehouse. This of course also is consistent with what he reported on the journey north on 28 May 2010. In May 2008 he reported to the same locum GP that he had suffered yet more very unpleasant withdrawal symptoms. In July of that year he reported to the same doctor that he had gone "on a bender" after losing his job. He did attend at Gatehouse in July 2008 and they reported back to the GP. On 12 August 2008 that doctor has recorded that he has alcohol dependence syndrome. She did so again on 7 May 2009. These entries are the last in the computerised medical notes immediately below the attendances by the now deceased with the other locum GP, and clearly there to be seen.

85. The next development drawn to the attention of the GP practice is one of the highest degree of significance. By November 2009, the now deceased was co-operating, at least to a certain extent, with the alcohol counselling service at the Gatehouse and with an employment support worker at a sister agency, TASHA. TASHA referred him to the Gatehouse and on 27 November 2009, Naomi Friel, who was the Dual Diagnosis Lead at Gatehouse, wrote to the GP and advised her that the now deceased was reporting drinking 110 units of alcohol per week. On 18 December 2009 she reported to the GP the outcome of her assessment on 27 November 2009. She reported that the now deceased had told her he was working as a temp and that that sometimes involved driving as a courier. Just as had been done 8 years earlier in 2001, Naomi Friel advised the now deceased of the DVLA rules. The next three sentences read "Given his history of alcohol dependence and his current pattern of binge drinking, he was advised that he should not drive and that it was his duty to inform the DVLA regarding his

alcohol problems. Mr Griffin was also advised that he would need to achieve a period of abstinence from alcohol of one year before he could apply for reinstatement of his licence. Legal implications and risk to the public discussed."

86. From the terms of that letter, it is completely clear that if the now deceased had done what Naomi Friel had told him to do, he would not have been driving in Scotland on 29 May 2010.

87. When asked what action she had taken on receipt of that letter, the GP replied that the letter was scanned into the practice's electronic system and was there to be seen in his records. Such a scanned letter requires only to be opened by any subsequent user in order to be read. She took no further action regarding it. She did not call the patient in to discuss its terms, nor advise DVLA of its contents. She thought the letter was clear and that it indicated that the now deceased had been made fully aware, by Naomi Friel, of his responsibilities. She indicated that if she personally had seen him in the practice thereafter, she would have reminded him of his obligations in terms of driving or not driving, but in fact she did not see him after receipt of it. She had last seen him personally in 2006. She thought it unlikely that he would have acted on the advice given, which is perhaps an even better reason to report the matter to DVLA.

88. In fact, the now deceased was seen at the practice after receipt of that letter, and twice, on 25 February and 12 April, both 2010. On both occasions he was seen by a different locum GP from before, but the same person on both occasions. The entry relating to the attendance on 25 February is the first one after receipt of the letter from Naomi Friel. Any doctor attending to the now deceased on 25 February would have seen the computerised notes and would have seen that the very latest entry was a scanned in report from the Gatehouse drug treatment centre. All that was required to see its contents was to click on the entry to open

it. What the doctor has recorded for the attendance on 25 February is "Alcohol dependence syndrome 60 [units] per week. Now tasting blood in the mouth. Increase in dyspepsia symptoms." He also recorded that the patient was requesting a referral to TASHA having been initially referred there by Gatehouse in December 2009. That entry of course contains a direct reference to the very organisation which had reported in its letter of 18 December 2009, and which was there to be seen and read.

89. The same comment applies to any doctor who attended to the patient on 12 April 2010, when the now deceased attended complaining on an unusual injury; that of having burned his wrist, hand and forearm secondary to a fall in the bath 6 days earlier. A later witness was to attach significance to that report, since it is unusual for an adult of full capacity to have run a bath so hot that he runs the risk of burning himself.

90. What however the entry of 25 February 2010 indicates is that, just 3 months before the fatal accident took place, there is a written note that the now deceased had a history of alcohol dependence from at least 1995 and for a continuous period of 15 years.

91. When his GP was asked now what action she felt ought to have been taken following receipt of the letter from Naomi Friel in December 2009, she said that she should have acted on it and had a discussion with the patient. She of course stressed the need to have the patient's consent before reporting the matter to DVLA but was aware that in certain appropriate circumstances it could be reported without the patient's consent. She said she was aware that the issue of fitness to drive regarding the now deceased had been raised before, as it had in 2001, and pointed out that there were substantial gaps in his record of attending,

and that there is a substantial risk that a patient may disengage and under report if suspecting that the matter is not kept in confidence.

92. There is however guidance available to General Practitioners on this matter. The GMC issues Guidance to doctors on the specific issue of confidentiality and the reporting of concerns about patients to the DVLA. Paragraph 1 of that says that personal information may be disclosed in the public interest without patients' consent and in exceptional cases even where patients have withheld consent, "if the benefits to an individual or to society of the disclosure outweigh both the public and the patient's interest in keeping the information confidential." The doctor has to balance the harm likely to arise from non-disclosure against the possible harm from the release of it to the patient and to the relationship of trust between doctor and patient. Paragraph 7 tells doctors "If you do not manage to persuade the patient to stop driving or you discover that they are continuing to drive against your advice, you should contact the DVLA…immediately and disclose any relevant information, in confidence, to the medical adviser". Paragraph 8 advises the doctor to tell the patient first of an intention to report to DVLA and after doing so.

93. The witness agreed that the guidance was clear and helpful as far as it went, but again stressed that patient's expectation of confidentiality and possible disengagement with treatment if these matters were to be reported. She expressed the view that the GP was not the patient's guardian. She did acknowledge that this guidance was available to doctors and that she had actually been aware of its terms. She also acknowledged agreement with the advice given to the now deceased by Naomi Friel and recorded in her letter of 18 December 2009. She was of the opinion that the now deceased had the capability to have acted upon that advice by himself advising DVLA of this condition, but thought he may have taken fright on account of the consequences for him. She

accepted that the GMC took the view that doctors may well acquire a duty to inform DVLA of such matters. She acknowledged that if she had advised DVLA of the situation relating to the now deceased, particularly after receipt of the letter from Naomi Friel, they may well have revoked the now deceased's licence which would have prevented him from driving vocationally.

94. The DVLA issues a Guide for medical practitioners on the current medical standards of Fitness to Drive (FTD). Chapter 5 relates to Drug and Alcohol Misuse and Dependence. Both of the terms "Alcohol Misuse" and Alcohol Dependence" are terms of art defined in the International Classification of Diseases (ICD). The definitions are repeated in the Guide. The quoted definition of Alcohol Dependence is "A cluster of behavioural, cognitive and physiological phenomena that develop after repeated alcohol use and which include a strong desire to take alcohol, difficulties in controlling its use, persistence in its use despite harmful consequences, with evidence of increased tolerance and sometimes a physical withdrawal state. Indicators may include a history of withdrawal symptoms, of tolerance, of detoxification(s) and/or alcohol related fits".

95. Pausing there, the now deceased had of course been diagnosed as suffering from alcohol dependence for years before 2010, but even if no such formal diagnosis by that name had previously been made, there is no doubt from the history extensively set out above that he was suffering from that condition. That being the case, the Guide provides that for a person who has that condition, the effect on his entitlement to hold an "ordinary" driving licence (i.e. for private use) is that the licence requires to be revoked or refused until a one year period free from alcohol problems has been attained. Abstinence is normally required, with normalisation of blood parameters if relevant. Of course, it was known that the now deceased had never managed a year free from alcohol problems from at

least 1995 onwards and had never been abstinent, apart from for very short periods. Of greater significance though is that for those whose entitlement was vocational, which in December 2009 applied to the now deceased, and who was still driving vocationally at the time of the fatal accident in May 2010, is that vocational licensing will not be granted [by DVLA] where there is a history of alcohol dependence within the past three years.

96. All of that means that if DVLA had known at the beginning of 2010 that the now deceased had the history he had, they would not have allowed him to drive vocationally, or in fact at all, due to the lack of abstinence.

97. Evidence was then heard from both Anita Charles, who had been with TASHA, and Naomi Friel, who had of course been at Gatehouse, as to the significance of their contacts with the now deceased. TASHA was a charity which supported clients who had substance misuse issues, depression and mental health problems and provided aftercare, particularly in employment support after they had stopped using harmful substances. Ms Charles had been there since 2006. He was referred by the Drug Alcohol Information Service and she had worked with him on and off over a long period. He had been seen in June 2008 where he reported sessions of binge drinking and had experienced paranoia, and again on 3 July 2008 where he reported still experiencing paranoia. She offered an appointment in August 2008 but he did not keep it. After persuasion by his mother, he contacted them for an appointment in September 2008. She said his co-operation was intermittent. He would come in and attend workshops for a few weeks and also attended one to one counselling. The purpose is to get reformed addicts back into work. She described him as open and honest. She arranged a training course for him in customer service, which he completed. His follow up attendance was sporadic however.

98. In 2009, she had contacted Naomi Friel at Gatehouse due to concerns about his drinking again. He told her that he felt that people were talking about him and that everyone was whispering about him and that he was quite anxious. The intention was to have a session of dual diagnosis with Naomi Friel at the Gatehouse, which was a separate organisation but with the same processes. If he had relapsed, TASHA would need to feed him back to the Gatehouse. This witness felt that the now deceased was not being as open to Naomi Friel as he was to her. The record of the dual diagnosis assessment shows that it took place on 25 November 2009. It shows the reported pattern of heavy drinking for one week followed by a week's abstinence. It also shows a long history of not sleeping. The information about being advised not to drive and about the DVLA requirements is clearly recorded.

99. Although there was a follow up appointment with Naomi Friel, Ms Charles had no further one to one contact with the now deceased as he failed to contact her despite requests. She did encourage him to go to his GP but was aware that he did not do so. She said he seemed very anxious and "was not in a good place – he knew how ill he was". She even offered to accompany him to his GP but he declined. She referred him back to Gatehouse but he did not attend, even when she chased the matter up.

100. Naomi Friel was the person who was mainly responsible for the interviews in November and December 2009. She is trained as a Mental Health Nurse and as a Clinical Nurse Specialist and had been working for some years at the Gatehouse, which, as before, is the specialist alcohol and drugs addiction unit available to persons who lived in the same area as the now deceased. When she got the reference from TASHA in November 2009, it was clear to her that the now deceased was no longer in recovery. He reported still hearing voices and was paranoid. She thought he was pleasant and amicable.

101. She discussed clearly with him the issues which arose if he chose to drive. She was very experienced in this work and always brought the matter up with clients, as she did here. She said she made him fully aware of the DVLA guidelines and that it was his responsibility to advise DVLA. In her view it would have been illegal for him to drive. She advised him not to. He had told her that he had only an "ordinary" driving licence. She obtained a printed copy of the Guidelines to give to him at the follow up appointment. In some cases, she would discuss with the consultant Psychiatrist who is attached to the Gatehouse whether DVLA should be contacted by them direct. She was aware that that could be done without the client's consent, though they should be told both before and after it has been done. The first stage is to make every effort to persuade a client not to drive. The now deceased did not in fact attend his follow up appointment, but this witness then wrote the critical letter of 18 December 2009 and sent it to the now deceased's GP. She received no response.

102. She confirmed a previous referral from Gatehouse to TASHA for the now deceased in March 2008 and also that letters of appointment sent to the now deceased from Gatehouse in March and May 2008 had enclosed with them a leaflet which gives details of substance abuse and the DVLA implications already referred to. The Gatehouse records show the admission by the now deceased of having auditory hallucinations on 3 March and 5 March 2008, of the assessment on 12 June 2008, when he said that he suffered auditory hallucinations following periods without sleep, and of the admission by him on 3 July 2008 that he was still experiencing paranoia. On 23 June 2008 he had completed a form showing that in a single week he had drunk 186 units of alcohol. This witness said that there was an occasion when, after consultation with colleagues, she had in fact taken the step of advising DVLA that a client was continuing to drive when he should not have done so and despite being told not

to. She regarded the critical information she needed was that a client was continuing to drive despite being told not to. In this case, the now deceased had not of course attended the follow up appointment. Her line manager had thought that the criteria for reporting had not been triggered.

103. The first of the two locum GP's involved worked at the practice run by the registered GP as a salaried GP from about 2008 till 2011. She saw him on a number of occasions and remembered him as a person with low mood and suffering from drinking problems. She was the doctor who saw him on 11 February 2008 when he attended after being persuaded to do so by his mother and sister. He was drinking heavily but did not think there was a problem. He had vomited blood but did not want counselling, having had it before. She arranged liver function tests and an ultra scan of the liver. She saw him again in May 2008 and recorded that he had an appointment then at the Gatehouse. He had suffered very unpleasant withdrawal symptoms and his mother was aware of his difficulties. By October 2008 the witness had in fact spoken to the mother of the now deceased and was satisfied of a diagnosis of alcohol dependence syndrome. She recorded that exact expression for her entry of 7 May 2009, which is the last entry of an actual attendance by the now deceased before the one in February 2010. She said the diagnosis was clear. She said she was aware that if such a diagnosis was made and the doctor knew that the person was driving, that should be discussed with the patient. She knew that advice should be given to such a person to stop, but that if the doctor became aware that the patient had not advised DVLA and had not stopped, then the doctor could inform DVLA. She was aware that such a step is obviously preferable with then patient's consent, but that it could be done if consent was not given. She was aware of the terms of the guidance issued by both the GMC and the DVLA. She had in fact reported a patient on one occasion to the DVLA because of her concerns about

that patient's eyesight. She had never discussed the issue of driving with the now deceased and it had never occurred to her to raise it, although she was clear that he satisfied the criteria for the syndrome and that that meant he should not be driving at all. She now accepted that she would bring up such a matter herself with the patient in similar circumstances.

104. The second of the two locum GP's worked as a locum at the practice from about 1998. When he did, he was booked simply to do a surgery of two hours duration. He was not involved in administration or correspondence. His view about correspondence received was that if a patient wanted to discuss it, then he would. He said he would not habitually review the last consultation as he was interested principally in the present reason for the patient's attendance. He confirmed seeing the now deceased on 4 April 2007 when he had attended 5 days after suffering injuries in a fall, and issuing him with the document (Med 3) which certifies unfitness for work, but admitted that he had not in fact asked him what work he was then doing.

105. The next time he saw him was the critical attendance on 25 February 2010. As already mentioned, the words "alcohol dependence syndrome" appear in the last two entries on the electronic record which actually record an attendance and are completely obvious. Further, the entry immediately before he saw him shows that a report had been scanned into the records form the Gatehouse drug treatment centre. In order to see what that said, all that he had to do was click on it to open it. In fact, the now deceased told him that he was now tasting blood in the mouth, and the entry created by the doctor starts with the words "Alcohol dependence syndrome". He considered that blood tests should be done and asked the now deceased to return the next day, which he did not. He has recorded that the now deceased was requesting a referral to TASHA having been initially referred there by the Gatehouse in December 2009, yet despite that, he

chose not to open the scanned report from Gatehouse which is clearly dated in December 2009.

106. This witness then saw the now deceased again on 12 April 2010 when he was complaining of having suffered burns in the bath 6 days earlier. He did not think that an unusual complaint for a man of the age of the now deceased. Once again, he chose not to open the scanned report from the Gatehouse, and said it would not have occurred to him to open it. He said his concern was to treat the presenting symptom.

107. That of course means that although the now deceased did in fact attend at his GP practice twice after the letter of 18 December 2009 was received by them, the opportunity to discuss the contents of it with him and give advice not to drive or ask any questions as to whether he was in fact driving was simply not taken. With the benefit of hindsight, the witness accepted that if he had looked at the letter, he would have asked the now deceased if he was working as a driver and advised him that he should not be driving at all. He pointed out that the patient has to be prepared to talk about it. He said that now, in a similar situation, if he saw a patient driving, he would speak to the patient first and then tell DVLA. He recognised the impact of such a course of action on the doctor/patient relationship. In hindsight, he said he would have given the patient two weeks to disclose it himself, and then if not, he would have disclosed it.

Evidence of Opinion Based on the Material contained in the Records

108. This came from Dr Benjamin Wiles, the Senior Medical Adviser to the DVLA, Dr Iain Smith, a Consultant Addiction Psychiatrist at Gartnavel Royal Hospital Glasgow, Dr Ronald Neville, a GP specialist, and Mr Niall Dickson, the Chief Executive of the GMC.

109. The DVLA operates a Drivers' Medical Group with a large group of medical advisers, responsible for deciding on issues of Fitness to Drive (FTD) and fitness to hold licences in the UK. It liaises with the GMC and has a separate Policy Group advising on appropriate medical standards. Dr Wiles has been with them since 2007 and is the Senior Medical Adviser.

110. On the straightforward issue of the actual type of driving licence held by the now deceased at the time he was driving in Scotland on 28 and 29 May 2010, he confirmed that in order to be allowed to drive a minibus of that capacity, the now deceased would have needed to have applied to the DVLA for a vocational licence, which of course he had not done. (This also is a requirement of which one could reasonably have expected Mr Mahatma to be aware and to have checked before engaging the now deceased as a driver.) Anyone applying for a vocational licence entitling him to drive a minibus of the capacity which the now deceased was in fact driving would need to apply and read the leaflet issued by DVLA. That says clearly that there is a medical component involved and medical examination would be required before the person could be issued with such a licence. It is made plain to prospective applicants that an application is likely to be refused if they have suffered from alcohol misuse in the past 1 year or alcohol dependence in the past 3 years. From that alone, it is clear that if the now deceased had applied for such a licence, his medical history, if disclosed, would have prevented DVLA from issuing him with one. It is of course the applicant's responsibility to disclose relevant conditions, all of which are clearly set out in accompanying material. As with all similar documents, the making of false statements or the withholding of relevant material in such applications constitutes a criminal offence.

111. The DVLA also operates a scheme known as the High Risk Offenders Scheme, which is designed to deal with those drivers who have had a criminal conviction under the drink or drug/driving provisions of the Road Traffic Acts.

112. There are of course two principal offences involved there; driving while the amount of alcohol or drugs in the breath exceeds the prescribed statutory limit, and driving while the person's ability is impaired through drink or drugs. Such drivers will have been disqualified by court order upon conviction, but usually, such orders are limited to a specified time period, after which the person is entitled to apply to have the licence restored. The scheme applies to those with a single conviction where the reading provided was more than 2½ times the prescribed limit, or where there are two or more of such convictions within 10 years, or where there was a failure to provide specimens for analysis. (The consequences in terms of penalties for failure to provide specimens for analysis are of course the same as for providing specimens which exceeded the limits). Such drivers will be asked to submit to medical examination when they apply to have their licences re-instated. Although the now deceased did have a relevant conviction for a drink driving offence in 1991, which was within a period of 10 years of his death, the records available did not show the figure involved in any analysis which had then been carried out.

113. All of the material which is provided by DVLA in relation to driving licences, standards, types of different licences and medical requirements is publicly available in leaflet from and online on the DVLA website. It is updated regularly and expert panels convene to discuss any necessary additions or amendments required. The medical conditions which are of concern to the DVLA are listed in all of this material and the descriptions and definitions of relevant conditions are taken from ICD definitions and classifications. The material is all standardised.

114. The DVLA also issues guidance for medical practitioners as to the current medical standards of FTD. The edition in force at the relevant time here was issued in September 2009. Attention has already been drawn to the content of Chapter 5 of that guide relating to drug and alcohol misuse and dependency. Examination of the equivalent editions of the guide going back to 1994 shows no material change in the applicable standards or consequences for the driver who is suffering from a relevant condition. Indeed, the GMC has issued similar guidance to medical practitioners, and an excerpt from that guidance is quoted with approval at the beginning of the DVLA guide. While making the point that it is the DVLA which is legally responsible for deciding if a person is medically unfit to drive, they need to know when licence holders have a condition which may affect their safety as a driver.

115. It is stating the obvious that the only way that DVLA can discharge that aspect of its function is if someone tells them relevant information in relation to a particular driver.

116. Alcohol dependence syndrome is one of the relevant conditions specified by both the DVLA and the GMC. The GMC guidance provides that the medical practitioner should make sure that patients understand that the condition may impair their ability to drive, and that the medical practitioner should explain to patients that they (i.e. the patients) have a legal duty to inform the DVLA about the condition. The rest of the guidance by the GMC proceeds in steps:- if the advice is not accepted, invite the patient to seek a second opinion, but advise them not to drive in the meantime; if they continue to drive when not fit to do so, make every reasonable effort to persuade them to stop; if that is unsuccessful and the doctor becomes aware that the patient is continuing to drive contrary to advice, the doctor should disclose relevant medical information immediately in confidence to the medical adviser at DVLA; but before doing that, the doctor

should tell the patient of the decision to do so, and after it has been done, write to the patient confirming it has been done.

117. Of course in the present case, information was provided in December 2009 to the GP practice attended by the now deceased that he was working vocationally as a driver when he clearly was still suffering from alcohol dependence syndrome. The fact of his vocational "employment" is of course merely additional information. The prohibition is not merely on driving vocationally, it is on driving of all kind.

118. The evidence of Dr Wiles was that this system does operate in such a way that DVLA is given relevant information on FTD. The guidance DVLA issued to medical practitioners does contain details on where and how a medical practitioner can seek advice from the DVLA. The DVLA does not regard the existence *per se* of the normal doctor/patient relationship as sufficient justification not to disclose relevant material on FTD.

119. As to self-notification by drivers, there is a form issued by DVLA which can be used by drivers, and the version to be used by those with vocational licences and the version to be used by those with standard licences both actually have a provision whereby the person submitting it can tick a box disclosing the existence of the precise condition under discussion here. If DVLA receive such a form, they contact the driver and ask for consent to a medical examination. Needless to say, the now deceased neither submitted any such form to DVLA, nor advised them in any other manner, that he did indeed suffer from alcohol dependence syndrome at any time during the period of his entitlement to hold a driving licence. Further, it was the evidence of this witness that if accurate information had been received by DVLA about the relevant recent medical history of the now deceased, DVLA would have had sufficient information to

justify revoking his standard entitlement to drive. And again, the evidence from this witness was clear that if DVLA receive a communication from a GP disclosing material which raised the question of FTD due to alcohol dependence, DVLA would treat that as a priority and act immediately to notify revocation of the entitlement to drive. If the communication is received over the phone, DVLA give a fax number to the GP and ask for confirmation in writing.

120. This witness was also clear in recognising that most doctors were not as knowledgeable on the contents of the guidance or the need to notify as they ought to be. They also have concerns about the breaching of patient confidentiality. All doctors are issued with copies of both the DVLA and GMC guidance, but this witness was clear that they do have a difficulty in complying with it at least in so far as it relates to the issue of drugs and alcohol and how that may affect FTD. In his view however, the wording of the guidance is clear cut, and applies every bit as much in cases of alcohol dependency as it does in the perhaps more obvious cases of epilepsy or dementia. He was also aware, being of course medically qualified himself, that doctors could turn to the GMC for guidance if they were concerned about the breach of confidentiality aspect.

121. The GMC have produced supplementary guidance for doctors which relates specifically to the issue of reporting concerns about patients to the DVLA. All doctors have access to it. It contains the exact text which is thereafter reproduced in the DVLA guidance and has already been quoted, and itemises the steps, also already set out above, to be taken in dealing with the matter with the patient. The contact details for the GMC are of course contained in the leaflet.

122. In fact, in January 2010, a project team from the University of Warwick headed by Dr Carol Hawley produced a report for the Department of Transport on the Attitudes of Health Professionals to Giving Advice on FTD (Road Safety

Research Report No 91/2010). They examined all aspects of this, including whether sufficient attention was paid to it at the stage when medical students were being trained. They found that the teaching of medical aspects of FTD was inconsistent across UK medical schools and that while most health care professionals were aware of the DVLA medical standards on FTD, they showed poor knowledge of how the standards applied to specific conditions. They found that most of those professionals were reluctant to notify DVLA about patients who were unfit to drive. They identified that the main barriers to advising patients on FTD were given as: not considering FTD as an issue within the clinical context, not remembering to discuss driving with them, over-complex DVLA guidelines, uncertainty about roles and responsibilities for giving FTD advice to patients, patient resistance or denial, the risk of negative effects of loss of licence on the patient's wellbeing or livelihood, and the risk of jeopardising the clinician/patient relationship.

123. The witness agreed that it would be helpful if the standard software now used by practitioners had a drop down prompt regarding the need to discuss the range of conditions in respect of which FTD is an issue. The evidence was that most practitioners automatically react to a diagnosis of epilepsy and some other obvious disabling conditions, but not to conditions such as the one in issue here, yet it was just as significant in connection with FTD. The Report also suggested that DVLA should hold training courses on the subject for relevant health professionals, as part of their CPD. Apparently they did use to do so, with the last one being in 2008.

124. The witness recognised that one of the concerns voiced by doctors was they may be made the subject of a complaint to the GMC for disclosing confidential material, but he took the view that there was guidance from the GMC on that

and that if the GMC guidance had been followed, then the doctor should be protected.

125. Critically, he also expressed the view that the guidance was exactly the same for alcohol dependence syndrome as it was for epilepsy, with exactly the same consequences, and for exactly the same reasons. The rules had been unchanged for years, and it appeared to him that there had been "a long window of opportunity for DVLA to have been notified" of the existence of a relevant condition which would have led to revocation in the present case. The point he stressed was that this was a public safety issue and that that can justify the breach of confidence. The figures show that there is no shortage of reporting of relevant conditions overall; over 750,000 such reports were received in 2012/2013, some 15,000 to 20,000 of which came from doctors, and in fact of those, very many were in respect of alcohol issues.

126. Dr Iain Smith is a highly qualified and experienced consultant psychiatrist, operating in the field of drug and alcohol addictions. *Inter alia*, he is the current chair of the Scottish Addiction Specialist Committee. He sees and treats perhaps 600 patients per annum with alcohol addiction problems. Although he of course had never treated the now deceased in life, he was provided with all of the extensive material which had been collected by the Crown relating the circumstances of the driving of the now deceased on the 29th May 2010 and of what had become known about the medical history of the now deceased and asked to provide a psychiatric opinion on the circumstances leading up to his death.

127. He said this was a clear case of long standing alcohol dependency, and that the GP practice had been aware of it. In his opinion, the description of the driving by the now deceased on the journey north on the M74 on the morning of 29 May

2010 was consistent with the strong likelihood that the now deceased was suffering from a paranoid reaction and in all likelihood was fleeing from some imaginary pursuer or pursuers believing his life was in danger, as is often seen in alcohol withdrawal delirium. This was completely consistent with his history of suffering withdrawal symptoms and of alcohol related psychosis during withdrawal periods. In his view, the now deceased ran the risk of suffering psychosis every time he drove.

128. He regarded the advice given to the now deceased by Naomi Friel in November 2009 as being clear, correct and reasonable. There could be no doubt that he ought to have reported himself to the DVLA that his FTD was impaired. He did not think that the now deceased's personality had caused him to drink or the psychotic reaction to it and dismissed notions of any long term psychotic illness such as schizophrenia. Such psychosis can settle with long periods of abstinence, but unfortunately, there were no such periods here.

129. In the view of this witness, the now deceased possessed the capacity to take advice and had no alcohol related brain damage. It was clear that he had responsibility for himself and was capable of exercising it.

130. As to the practice of reporting such matters to DVLA by doctors, he recognised that doing so may deter the patient from seeking, or continuing to take advantage of, treatment. He himself had made such reports when he had become aware of patients who were continuing to drive contrary to advice, but acknowledged that very few doctors do make such reports. He thought that the GMC could make their guidance more directive, rather than leave it as a matter of judgement. He knew that both the DVLA and the GMC were able to give telephone advice to doctors. He also thought that other health professionals might make such reports, and that in this case, it may have been possible for

Naomi Friel to have given the now deceased a deadline for notifying DVLA, failing which she would have done so.

131. Dr Neville is a GP who is heavily involved in the processes by which continuing assessment is undertaken of those in general practice. He has been asked to comment in a number of court cases on aspects of general practice and compliance with the norm. In particular, the present re-validation programme requires doctors to demonstrate familiarity with GMC guidelines. He participates in training for GP's including situations where ethical considerations are manifest. This includes situations where confidential material may have to be disclosed. He had been made aware of all of the relevant medical material which has already been mentioned.

132. As already documented, the now deceased suffered from alcohol dependency from at least 1995 until the time of his death and probably from 1991 onwards. In his clear view, the now deceased should not, at the time of his fatal journey in Scotland on 29 May 2010, have been the holder of a driving licence. This witness felt that the issue was in fact clear cut as far back as 1991 and that there was no episode or history after that which would have caused the diagnosis to be doubted. He was also clear that the relevant DVLA guidance in force meant that this issue should have been raised with the patient with a view to DVLA being told. If they do not know, they cannot act, and of course the Inquiry does know that they would have acted to revoke the licence. The matter was well documented in the patient's GP notes, along with correspondence from hospitals and other relevant medical professionals. Even the summary of it, he thought, showed the severity of the now deceased's condition. His view was that any GP would identify that condition as at the severe end of the spectrum and persisting.

133. He thought that he could identify a series of opportunities over a long term where there could have been intervention involving advising the DVLA. His named GP had recorded in 2003 that she did not think then that he should have been driving. He felt that she should have then followed the DVLA guidance. He explicitly recognised that his experience, in common with other medical witnesses, was that GP's had a greater degree of reluctance to inform with regard to this condition than they had with other ones on the list from the DVLA. He felt that there was an issue of awareness for both GP's and the rest of the general public of the significance of this condition. Everyone knows that you should not drink and drive, in the sense that that means drive immediately after consuming a large amount of alcohol, but the condition under discussion here goes much further than that, and the now deceased had not been drinking at all prior to driving on this occasion.

134. Of course, this witness thought that the letter from Naomi Friel on 18 December 2009 was highly significant. It was there to be read and it contains the clearest message. He felt that at the very least, the content of that letter should have been logged and marked to be actioned at the next contact with the patient. As it happens, there were two more contacts with the patient after that, but the content of the letter was not raised or discussed at either of them. His view was that more should have been done with the letter than simply file it. When the now deceased was in fact seen next, in February 2010, by a locum, this witness was clearly of the opinion that such a locum should take the time to familiarise himself with recent entries and he would have expected him to read recent correspondence, particularly since it was the last entry on the file when the patient attended then. Since the patient then brought up the issue of the Gatehouse, and since the scanned letter was from that very place, this witness thought that the letter should have been looked at both before and during that consultation. He did not

accept that there was any presented condition which would have prevented proper consideration of the issues raised in that letter, which principally raises the question of FTD. This witness also thought that a person in the position that that doctor was, as a locum, could have attempted to deflect any concerns about the harming of the doctor/patient relationship by saying that all he was doing was following up on concerns expressed by others. It is easier to confront an issue if it has already been raised, which of course it had been with the patient by Naomi Friel.

135. Interestingly, this witness took the view that the presenting complaint at the consultation on 12 April 2010 was so unusual that it merited much further investigation by the doctor. It is unusual for an adult of full capacity to be burned in those circumstances. A real clue as to why that might have happened is found, and is to be found immediately, in the records. Failure to recognise how hot bath water was might well be explained by reference to the person's sobriety at the time. Further, since there was no emergency then being treated, there was the opportunity to raise the matter contained in the letter of 18 December from the Gatehouse, but once again it was not taken.

136. This witness was satisfied that there were a number of missed opportunities to have raised with the now deceased the advice given to him by Naomi Friel that he should not be driving and that DVLA ought to have been informed. He felt that the first locum GP should have told him that in 2008, as she was seeing him for relevant medical problems.

137. He felt that doctors had a duty to be proactive about this. He felt that if a doctor was consulting with an adult in his 30's, they should specifically ask if he held a driving licence and was actually driving, and not just vocationally. He said that the rules relating to not driving when alcohol dependence has been diagnosed

were as clear cut as if the diagnosed condition was, e.g. epilepsy. He agreed with the suggestion made earlier about then use of software prompts for doctors.

138. Mr Dickson had been in post at the GMC for some 3½ years at the time of this Inquiry. He explained that there is a system of re-validation for doctors which requires them to be reviewed on a regular basis, and that the review includes assessing familiarity with GMC guidance on a range of issues. Of course, the GMC has issued guidance on the precise issues which were dealt with in this case. The status of that was that it was guidance and not a code or a set of rules. Doctors were expected to follow such guidance but still of course exercise their own judgement. The existing guidance was drafted by appropriate experts and was used with the permission of the GMC by DVLA. Such matters, and the appropriate terms of guidance issued, are kept under constant review. Hard copies of such guidance are sent to every doctor and it is also available on the GMC website. In addition, the attention of doctors will be drawn to it from time to time if a specific issue arises where there has been some publicity or public concern. This can be done in the GMC Bulletin. Advice and assistance is available to doctors from a number of sources. They can contact the DVLA, and contact the GMC who would advise them who they should contact. That may be a professional colleague, such as a partner in practice, or the British Medical Association (BMA) or a Medical Defence organisation such as the Medical Defence Union.

139. His understanding of the thrust of the guidance issued in relation to the subject under discussion here was that the matter should be raised with the patient who should be encouraged to report it himself to DVLA. Efforts should continue to be made to that end. He recognised the need to reconcile the issue of patient confidentiality with the need to protect the public. That may ultimately involve the doctor revealing the information to the DVLA albeit it was made clear that

the patient should be told that is going to be done and again after it has been done. He was aware from case studies done that there might be a need to raise awareness amongst doctors of the significance of this particular condition, and that it appeared that specialists were more aware of it then GP's. He was acutely aware that even raising it with the patient may discourage the patient from engaging with treatment. Steps have been taken to ensure that medical undergraduates are made aware of the issue during their training.

Determination

140. The taking of the evidence in this Inquiry was lengthy and prolonged. The time taken was however necessary as there were issues raised of considerable public importance beyond the investigation of the circumstances of the individual death, tragic though that undoubtedly was for the family of the now deceased. It is also important to record at the outset that the scope of any determination made at the conclusion of any Inquiry held under the Act of 1976 is constrained by the terms of section 6 thereof, and must confine itself to a consideration of the circumstances of *that* actual death and of facts relevant to the circumstances of *that* actual death.

141. All parties represented took the opportunity to tender their submissions in writing, and I am grateful to them for their assistance in that matter. These submissions are with the papers, and have been fully considered, but it should also be recorded that as an Inquiry such as this requires to be held in public, the content of these documents was read out in open court at its conclusion. I should also record once again my gratitude to the Procurator Fiscal who actually conducted this Inquiry, not just for the manner in which it was done, but because it became obvious that she had been personally responsible for much, if not all, of the extensive investigation and preparation for it which was undertaken.

142. In what follows I have attempted to stress that although there were two accidents here whose circumstances were investigated: the one in which the minibus driven by the now deceased collided with the police car, and the one in which the same minibus, still being driven by the now deceased, collided with the central reservation of the motorway and overturned, bringing about the death of the now deceased, it is only the second of those which can be described as the accident resulting in the death of the now deceased.

143. The most obvious conclusion from the evidence led in this case is that the death of the now deceased, caused as it was by the overturning of the minibus he was driving at about 04.58 on the M74 northwards, need not have happened. That *accident* need not have happened and was avoidable. In the findings I have made under the terms of section 6(1)(c) I have set out those factors which on the evidence constitute reasonable precautions whereby this accident might have been avoided and whereby the death of the deceased as a result of this accident might have been avoided. In fact, if the now deceased had heeded those precautions which pertain to him, it can be said with certainty that the accident causing the death *would* have been avoided, but for the purposes of the subsection, it is necessary to hold only that the death *might* have been avoided.

144. Concentrating for the moment only on the proved circumstances surrounding the actual driving of the minibus by the now deceased on the morning of 29 May 2010, it is completely clear that throughout the time when the bus was observed to be driving north on the M74 from Lockerbie onwards, the manner in which it was being driven was dangerous, using that word not only in an ordinary sense but also in the sense of its definition in the Road Traffic Acts. It presented very considerable risks to all other road users. It was being driven at very high speed and in a manner in which the driver, the now deceased, continually and continuously drove far too close to the rear of other vehicles prior to cutting out

suddenly and too late and overtaking them and immediately cutting back in again when far too close to the overtaken vehicles. It is completely understandable that other drivers witnessing this might have formed the view that the driver of the minibus was perhaps drunk, though that proved not in fact to be so. It is completely understandable, and to be commended, that other drivers alerted the attention of the police to what they were witnessing. It was completely correct for the police to have responded in the manner in which they did by sending two patrol cars to investigate these reports and take whatever action might subsequently be deemed necessary.

145. Once that had happened, attention has to focus on the reaction of the now deceased. It is completely clear that the officers in charge of the two police cars were highly and appropriately trained. It is completely clear that they at all times complied with the instructions and directions which are incumbent on them when attempting to deal with a report of a motorist who, as here, is continuing to drive in a dangerous manner. In approaching the situation, they were well aware that they were placing themselves in a position of considerable danger. The decisions they made in approaching the rear of the minibus were entirely in accordance with approved practice and procedure. It is completely clear that they were not in a "pursuit" of the minibus as that term is defined, but at that stage merely indicating, by all appropriate means, that they wanted the driver of the minibus to pull over and stop. It is completely clear that the now deceased would have been well aware of that but chose not to comply.

146. While the evidence provides an explanation, based on the presence of a paranoid reaction to the onset of withdrawal symptoms suffered by a person with alcohol dependence syndrome, for the nature of his driving, it does not mean that he was not in conscious control of the vehicle. On the contrary, he had chosen to drive the vehicle, he had chosen not to stop and sleep somewhere for

the night, he was not affected by fatigue, and kept the vehicle under control all the way from Lockerbie to Hamilton and beyond. It is completely clear that he could have stopped at any time in the course of that journey. It is completely clear that he could have pulled over and stopped on the hard shoulder of the motorway when signalled to do so by the two police cars. If he had done so, it is completely clear that none of what followed would have happened.

147. He chose not to pull over and stop. It is completely clear on the evidence, and I accept it, that instead of doing that, he pulled the minibus out from behind the lorry then in front of it and caused it to cross over the middle lane into the outside lane and deliberately caused it to collide with the overtaking police car (TM32).

148. That having happened, he chose to drive on at high speed for another 4½ miles, despite being aware that he had been involved in a major collision in which another car had left the road and despite having lost a wheel in that collision. It is again completely clear that he was aware that his vehicle was badly damaged, but nonetheless he managed to drive it, under control, and with lane discipline, and at a time and for a distance during which he could have brought it to a halt by using the handbraking system, which was undamaged, or simply by ceasing to apply power via the accelerator. It is completely clear that if he had done that, the accident which subsequently took place and which brought about his death would not have happened. It is also completely clear that at the time of the accident which caused the death of the now deceased, there was not a "pursuit", as that term is defined, of the minibus by any police vehicle.

149. Turning then to other matters which were raised in the course of this Inquiry, the whole question of whether the now deceased should have been driving at all was brought very sharply into focus. The short answer to the question is that at the

time of the accident which caused his death, the now deceased should not have had any entitlement to drive, at all, never mind just vocationally.

150. There are of course a number of different aspects to that last comment. It is completely clear that although he was the holder of a driving licence, that licence did not entitle the now deceased to drive for hire or reward the vehicle he was driving at the time of his death. That death occurred at a time when he was engaged by the London Minibus Company to drive passengers to Edinburgh and bring the vehicle back to London and was of course an enterprise carried out for hire or reward. What that means is that for that reason alone, the now deceased should not have been engaged by the London Minibus Company to carry out this particular assignment. It is not possible for me to say that that company should not have engaged the now deceased at all, since it is possible that they may have had access to vehicles which he would have been entitled to drive in terms of his licence. What I can say though is that that company made no proper check to ascertain his entitlement, or whether he was the holder of any vocational licence, and had no proper understanding of the requirements for licences to be held by those they engaged to drive for hire or reward. Since they apparently held an operator's licence, it must be a serious question whether that company complied with the terms of it then, or since then. It is a matter of concern that they appeared to have retained no documents relating to the status of a driver engaged by them to carry members of the public for hire or reward. Such compliance issues are however best dealt with by the appropriate regulatory authorities in London.

151. Next, there is the evidence, which is completely clear, that in November 2009, the now deceased had been told by a qualified counsellor in alcohol addiction (Naomi Friel) that he should not drive. He was told that in the clearest terms. The reasons for her saying that to him have been fully set out in the narrative of the

evidence. He ignored that advice. Even if he had not done what she also told him and advised the DVLA of the situation, it is an inescapable conclusion that if he had simply acted on the advice not to drive, he would not have accepted the particular engagement which brought him to Scotland on 28 May 2010.

152. I can of course make another finding which is completely clear on the evidence, and that is that if the now deceased had applied to DVLA for any kind of vocational licence which would have granted him the entitlement to have driven the vehicle he was driving on 29 May 2010, his application would have been made subject to medical investigation, and given what we know of his medical history, would have been refused. Of course, we know that he did not ever make any such application.

153. That then brings me on to the question of whether he ought to have been the holder of any kind of driving licence as at 29 May 2010. It is, once again, completely clear that if DVLA had been notified of the diagnosis made in respect of the now deceased of alcohol dependence syndrome, they would have revoked his entitlement to drive. That would have happened at any time between at least 1995 and the beginning of 2010. They were not so notified and therefore not able to take the action which would have been manifestly appropriate. In particular, if he had done what Naomi Friel told him to do on or after November 2009 and notified DVLA himself of the diagnosis, they would have revoked his entitlement to drive and he would not have been legally in a position to do so. Of course, every court knows that some persons who have no entitlement to drive, or who have had their entitlement to do so removed by order of court, nonetheless do so, but the standard I am discussing here is only that of precautions which might have prevented the accident.

154. And that brings me onto the final question I have to answer, which is whether the DVLA ought to have been notified that the now deceased suffered from a diagnosed condition which would have led to his entitlement to drive being revoked by them. The answer to that question is "yes". As was stressed by a number of the witnesses who gave opinion evidence at this Inquiry, there was a series of missed opportunities to advise the relevant authority of a matter which affected the safety of the general public.

155. The way in which the relevant guidance is framed is that it makes it clear that the primary responsibility for advising the DVLA of a matter which would affect a licence holder's continuing fitness to drive rests on the licence holder himself. The issue here is medical FTD. It therefore must be obvious that when an issue involving medical FTD arises, the information pertaining to it will be held by members of the medical profession, and that of course brings into focus the question of confidentiality. But that question has been anticipated by both the DVLA and the GMC. The guidance in place recognises the difficulties in disclosing such information. It provides a series of steps to be taken by any medical practitioner in connection with ensuring that information which affects the safety of the general public is provided to the relevant decision maker (which in this context is the DVLA).

156. As I emphasised some time ago, my determination in terms of section 6(1)(c) of the Act can be concerned only with the reasonable precautions, if any, whereby the death being investigated and any accident resulting in the death being investigated might have been avoided. Telling the DVLA that the now deceased had been diagnosed with alcohol dependence syndrome would have resulted in them revoking his entitlement to drive. The now deceased did not tell them that, though it was his obligation to do so. He should have done that, either of his own

responsibility or after encouragement from his family, who plainly knew of his long and continuing struggle with alcohol and its associated consequences.

157. There were however other opportunities for this information to have been given to the DVLA. It is plain that at least by 1995, the now deceased suffered from alcohol dependence syndrome. It is equally plain that he never at any time since managed to deal with his problem and abstain from drinking and from excessive drinking for any appreciable period of time. It is equally plain that the effects of that syndrome are not limited to those times when the sufferer is actually under the influence of alcohol. The pattern disclosed here is of a repeated series of alcohol binges, followed by a short period of abstinence, during which the effects of withdrawal symptom are suffered, and these include sweats, inability to sleep, auditory and sometime visual hallucinations, and paranoia. I should say at this point that I do not regard it as significant that no overnight accommodation for the now deceased had been arranged in advance. All the evidence now shows that even if that had happened, the probability was that he would have had considerable difficulty in actually sleeping anyway.

158. That means that it is plain that person who is susceptible to the effects of withdrawal symptoms as described presents as a clear and obvious danger to other road users by virtue of his mere presence on the road. And that means he should not be on the road. The now deceased here was well aware of the effects of alcohol withdrawal. He had suffered them often. He knew that they tended to follow in the days after he had been on a drinking session. He chose to drive on this occasion in the full knowledge of the potential effects of such withdrawal symptoms.

159. He had been told not to drive in November 2009 by Naomi Friel. She wrote on 18 December 2009 to the now deceased's GP practice and told them that she had

done so. His GP read that letter but simply filed it without taking any further action. She had formed the same conclusion in relation to the now deceased as long ago as 2003, but had not then taken any step towards advising the DVLA of the information. As it happened, the now deceased attended at the practice both in February and April 2010, when on both occasions he was seen by a locum GP. That locum had the letter available to him but did not take the opportunity to read it, on either occasion. He said that his concern on both occasions was to treat the presenting symptom, but with the greatest of respect, his duty is to treat the patient, not just the symptom, and in any event the letter was highly relevant to the presenting symptom in February and in April there was no emergency or urgency justifying deflection from considering the letter and its import. It appears that no inquiry at all was made to see if the now deceased was complying with the direction given by Naomi Friel. That is an aspect of the stages in procedure recommended by the guidance issued by both the DVLA and the GMC.

160. The list of medical conditions which can have an effect on person's continuing FTD is not especially lengthy. They are all, in both a medical and in a common sense, self-explanatory, by which I mean that it should be obvious that a person diagnosed with any of these conditions will have his FTD compromised and that for such a person to continue to drive represents an unacceptable risk to the general public. Doctors have every opportunity to be aware of what those conditions are and what may be expected of them if they have to deal with a patient diagnosed with any one of them. That is particularly important since it may well involve the doctor in having to disclose material which would otherwise be medically confidential. The evidence was that doctors are generally aware of this issue of FTD and have no real difficulty in raising it with patients in the case of some of the prescribed conditions. The evidence is however that there

appears to be amongst doctors a lack of appreciation perhaps of the significance of alcohol dependence syndrome and a reluctance to begin the process of reporting on FTD in respect of that condition. I am sure that increased publicity to and education of doctors in that regard would be beneficial, as would the suggestion of prompts on software used, but that must be a matter for the GMC to determine. If they are looking for a case study to use in that process, none could be more illustrative of the effects of driving while suffering from the effects of alcohol dependence syndrome than this one, involving as it did the driving by the now deceased in a manner which caused his own death, almost caused the deaths of two police officers, and could have caused the deaths of several other members of the public.

161. With all of that in mind then, I have come to the conclusion that in order to attempt to avoid the happening of any such situation on account of the driving of a person whose fitness to drive was so obviously impaired, it would have been a precaution for those to whom the report by Naomi Friel was made on 18 December 2009 to have taken the matter further and implemented the guidance which specifically relates to that issue. Such a precaution would have been reasonable. If it had resulted in a report being made to DVLA, his entitlement to drive would have been revoked. As I have said before, while even that step might not necessarily have made the now deceased stop driving, it is certainly a precaution whereby his death might have been avoided.

162. There are no findings which can be made in terms of section 6(1)(d) of the Act.

163. It is not for me to make recommendations to the GMC as to how they might proceed in future; the court has no statutory power to make recommendations in any event. It does occur to me thought that there was merit in the suggestion that the guidance issued to doctors on this issue might be made more directive. I

completely understand that it is an extremely delicate matter, for all the reasons already set out, to consider a course of action which involves breaching confidentiality. Some of the difficulty may however be removed if the doctor was able to say to the patient that he was acting under instructions which were binding on him. If the guidance was to the effect that a doctor in the situation under discussion here *had* to advise the patient that he must not drive and that the patient was obliged to advise the DVLA of that *and* that the *doctor* was obliged to do that also, it would shorten the whole process and take it out of the hands of the patient who simply refuses to co-operate. It would also mean that it would not matter if the patient did not attend or provide information as to whether he was continuing to drive. It means that the doctor is being proactive and not the patient. No doubt some appropriate process can be built into the DVLA system which would allow the patient to challenge the decision to revoke by appeal or by presentation of contrary medical evidence. After all, when a court disqualifies a driver from driving, it does not wait for the driver to notify the DVLA; the court does it. It may well be thought that the system ought to be that where a diagnosis of a relevant condition is made which affects FTD, relevant medical professionals should be able to say to the patient that while they appreciate the difficulties which may be caused to that person's livelihood and family life by not being able to drive, they are obliged to report that diagnosis to the body (DVLA) which will then decide whether to revoke the entitlement to drive. This is matter for the GMC to discuss.

164. The final comments I should make are directed to the police officers who formed the crews of the two cars involved here, TM32 and TM34. It is utterly miraculous that Constables Neilson and Arnott were not killed in the course of this developing incident. It became clear on listening to the evidence in this case just to what extent the public rely on the professionalism of police officers who

undertake this kind of work on behalf of the public. Quite properly, they require to be trained and skilled to a very high level. They put their own lives at risk in investigating incidents such as this. They require not only to possess the requisite driving skills and abilities which involve them in operating at very high speeds, but also the capacity to remember and follow relevant protocols in the course of dangerous and developing incidents. Distressingly, they also require to have the professional detachment necessary to cope with and deal with the aftermath of serious and fatal road crashes.

165. It is completely to the credit of all of the police officers involved in this incident that they not only discharged those responsibilities and duties completely in accordance with prescribed procedure, but that they continued to do so after the first frightening accident involving TM32. It was astonishing to learn that on emerging from the wreckage of their car, Constables Neilson and Arnott engaged themselves in taking statements from witnesses. I have no doubt that the circumstances of their accident were such that both of those officers have suffered some dark moments since, when they have subconsciously relived it, and no doubt that observation applies also to all those others, police and lay witnesses alike, who also witnessed it, but all of these officers are to be congratulated for having the courage to continue in service after it and for being willing still to discharge these heavy responsibilities on behalf of the general public.