

DETERMINATION
of
SHERIFF I R ABERCROMBIE Q.C.
in
FATAL ACCIDENT INQUIRY
Into the circumstances of the death of
MR KEVIN MYKOLIW
In terms of Section 6 of the Fatal Accidents and Sudden Death Inquiry
(Scotland) Act 1976

Procurator Fiscal Depute; Ms. Fiona Murray
Tulloch Transport Ltd; Mr Greg S. MacDougall
D. & E. Coaches Ltd; Mr John Maillie
Highland Council; Mrs A. Watt

(a) Where and when the death and any accident resulting in
the death took place

Mr Kevin Mykoliw, 14 Neil Gunn Crescent, Inverness, who was then

aged 37, and employed as a mechanic by D & E Coaches Limited,

Inverness died on 17th October 2008 at about 7.20 am. He died at

Longman Drive, Inverness, close to the junction of said Drive with Henderson Drive.

(b) The cause or causes of such death and any accident resulting in the death

The cause of Mr Mykoliw's death was a major and irremediable head injury.

Mr Mykoliw's death was caused when the midi bus owned by his employers, registration number SK07 FCF, collided with a stationary montacon flat bed trailer (identification number C260569) owned by Tulloch Transport Limited, Inverness.

The trailer was unlit. It was parked, facing the oncoming traffic, by Mr Ronald Barlow, an HGV driver employed by Tulloch Transport, between 5 and 6 pm on 16 October 2008 in Longman Drive, Inverness.

The midi bus was being driven by Mr Mykoliw's colleague, Arthur Botterill. Mr Mykoliw was conducting brake tests on the vehicle using a Bowmonk Brakemeter. The meter was placed on the engine cover at the front of the bus by Mr Mykoliw. The engine cover was about one foot above floor level of the bus. Mr Mykoliw was probably kneeling on the floor, immediately behind the meter, in order to calibrate it. It is possible, although less likely, that he was seated.

The brake tests required Mr Botterill to inform Mr Mykoliw when the bus had attained a speed of 30 mph. Mr Mykoliw set the brakemeter dial to zero. An emergency stop was then performed. After the bus was brought to a halt, a meter reading was obtained by the mechanic.

After performing the first brake test at the southern end of Longman Drive, the bus was driven around the corner towards the long

straight section of that Drive, so that it was travelling in a northerly direction towards the Beaulieu Firth. It was intended to carry out the second brake test on this straight section of the road.

Just after negotiating the corner, Mr Botterill became aware that there was a large white Mercedes articulated lorry, registration number MB54 FNN, parked on the nearside carriageway. Said vehicle had been parked there by Mr Bradley Meade. He was waiting in his cab to drive this vehicle into the delivery yard of Booker Cash & Carry on the opposite side of the road. This lorry was readily visible and had its headlights on.

After Mr Botterill drove round said vehicle, he returned to the nearside carriageway. He was travelling at a fraction less than 30 mph when he became aware of the Tulloch Transport trailer immediately in front of him, facing the oncoming traffic. It had its landing legs down, which meant that it was angled upwards at its

front end. It did not have any front reflective signs, apart from two small white reflective discs. It was painted dark blue. Mr Botterill immediately applied the bus brakes. The bus collided with the trailer. The front of the trailer entered the bus, just missing the driver, at a height of about 5 feet. The trailer hit Mr Mykoliw causing the extensive injuries already noted. The bus came to rest when the front of the trailer was almost half way down the length of the bus.

At the time of the accident it was dark. Dawn was about to break. The street lighting was on. It had been raining and the road was damp. At the time of the accident it was not raining.

(c) **The reasonable precautions, if any, whereby the death and any accident resulting in the death might have been avoided.**

First Reasonable Precaution

The first reasonable precaution whereby the accident resulting in Mr Mykoliw's death might have been avoided, would have been for Tulloch Transport not to park its unhitched trailer in Longman Drive.

It was a condition of the Company's Operator's Licence that the trailer should, when not in use, have been parked in an Authorised Operators Operating Centre or at an officially designated off-road trailer park.

Tulloch Transport's Operating Manager, Mr Henderson, despite his attempts to confuse the Inquiry when giving his evidence, was fully aware of this condition. He chose to ignore it – as a “matter of expediency” - in an attempt either to save the costs involved in drivers taking trailers overnight to the Company's nearest Operating Centre, which was in Nairn, or to avoid the small charges which would be incurred if the trailer had been parked in an officially

designated park. Mr Barlow, who parked the trailer, was unaware of the location of his Companys' Operating Centre in Nairn. He had not been there since commencing employment with the Company in March 2008.

Moreover, Mr Barlow had, prior to the accident, voiced concerns to Mr Henderson about the safety of leaving unlit and unhitched trailers overnight on Longman Drive. Notwithstanding these warnings, Mr Henderson directed his drivers to park trailers there. This practice had started in at least March 2008, when the company lost its off-road, but non-designated parking premises.

Unfortunately, Mr Henderson was not the only transport manager to instruct or condone this practice. Many unhitched and unlit trailers were parked overnight in Longman Drive, over a period of several years, prior to the accident. It is tragic to record that it took the death of Mr Mykoliw to stop this practice.

If Mr Henderson had complied with the conditions of his Company's Operating Licence, this accident would have been avoided.

I recommend that operators should be reminded to comply with their operator's licence and that positive steps should be taken swiftly to enforce such compliance.

Second Reasonable Precaution

If the trailer was to be parked in Longman Drive it should have been properly lit in accordance with Regulation 24(3)(b) of the Road Vehicles Lighting Regulations 1989, which provides:-

"Save as provided in paragraphs (5) and (9), no person shall allow to remain parked, or cause or permit to be allowed to remain parked between sunset and sunrise –

a trailer to the front of which no other vehicle is attached and which is not required to be fitted with front position lamps, unless a pair of front position lamps is fitted and kept lit and unobscured.”

Third Reasonable Precaution

If the trailer was to be parked overnight in Longman Drive, it should have been parked facing the flow of traffic. If it had been so parked, it would have been easily visible to any oncoming driver. The rear of the trailer had two large fluorescent red and yellow reflective rectangles, together with two red triangular reflectors.

Mr Barlow said that he had never been instructed how to park trailers and that this was not “something brought up when doing the HGV test”. However, Constable Martin, the police expert road traffic witness, reminded the Inquiry that the Highway Code stipulates that vehicles should not be parked facing the flow of

traffic and that when carrying out a HGV test all applicants have to pass a theory test which includes the Highway Code.

Fourth Reasonable Precaution

This accident would have been avoided if the brake test had not been carried out, when it was dark, at this particular locus.

It was well known to employees of D & E Coaches, including Mr Botterill, that trailers were frequently parked in Longman Drive overnight. They also knew that trailers were, on few occasions, parked the wrong way round, with their front facing the flow of traffic. While the density of trailer parking was greater in the section of Longman Drive, north of its junction with Henderson Drive, there was clear evidence that trailer parking also occurred south of that junction in the vicinity of the locus.

While I make no recommendations about the general practice of carrying out brake tests in Industrial sites, I find that it was folly to carry out such a test at this particular locus while it was dark, knowing that unlit trailers were frequently parked in the area.

No one in D & E Coaches appears to have given this matter any consideration. There was no evidence of any elementary risk assessment being carried out. Moreover, this Industrial Estate was used by several companies who were then operating twenty four hours a day. The estate was also used regularly at all times of the day and night by employees driving to their place of work. While the street lighting at the locus was equivalent to that found on many similar estates, there was evidence that there was a pooling effect between the lamp standards which had the effect of creating areas of shadow.

I recommend that operators be reminded when carrying out brake tests on public roads to carefully assess the proposed locus prior to commencing their tests. I also recommend that operators should be warned of the dangers of conducting such tests when it is dark.

Fifth Reasonable Precaution

Mr Mykoliw should not have been required to carry out the brake test while either sitting, without restraint, or more probably, kneeling or hunkering down on his haunches, also without restraint. Such positions should not have been adopted during a test which involves an emergency braking procedure from a speed of 30 mph.

It is not certain on the evidence before me that the accident would have had the same consequences if Mr Mykoliw had been sitting, restrained by a seat belt, more than three rows back from the front, on the offside of the bus, or if the test had been carried out at the lesser speed, in accordance with the manufactures guidelines, of 20

mph. Nevertheless, I determine that the system of working had obvious defects, which if drawn to vehicle operators' attention, would limit the scope for future accidents of this kind.

I am fortified in the view I have reached by the fact that D & E Coaches now use an electronic device for the carrying out of such tests. This can be operated by the bus driver alone. In addition, the Company now carry out brake tests at an off street location. (A rolling road brake test is also available).

In reaching this determination, I have interpreted the word "might" in S6(1)(c) of the Fatal Accident & Sudden Death Inquiry (Scotland) Act 1976 as meaning "possibly" rather than probably. In my view this interpretation is in keeping with the spirit of the legislation which has at its heart the prevention of similar accidents (McPhail: Sheriff Court Practice 3rd Edition 28.17 at page 998; cf Carmichael: Sudden Death and Fatal Accident Inquiries, 3rd Edition, page 174).

I do not consider that there is sufficient general information before me to make any determination regarding the carrying out of brake tests by other means – such as the electronic brakemeter mentioned above or by using a “rolling road”. This is because circumstances vary from location to location, and from transport company to transport company - particularly in an area as remote and diverse as the Highlands of Scotland, where the availability of alternative testing mechanisms is an issue.

However, I do consider that transport operators should be reminded, if using a brakemeter device, such as that used in this accident, of the importance to carefully assess how the device is used, particularly where it is placed and where the operator should be positioned when carrying out a brake test.

- (d) **The defect, if any, in any system of working which contributed to the death or any accident resulting in death.**

I have nothing to add to what has already been covered under this head in the previous section.

- (e) **Any other facts which are relevant to the circumstances of the death.**

- 1) The fact that unhitched trailers were frequently parked in Longman Drive was known to Northern Constabulary and to Highland Council Traffic Wardens from, at least, early 2007.
 - a) This problem had come to their notice because such parking had impeded vehicular access to industrial and business premises on the Estate.

- b) No policeman or traffic warden gave any consideration to the safety implications resulting from the parking of such trailers.

- c) The evidence indicated that the traffic wardens did not know how to go about locating the Ministry of Transport plates on trailers or the process of identifying trailer owners.

- d) In this respect, P.C. Hier informed the Inquiry that, the parking of unlit trailers was only dangerous if they were parked close to junctions or parked the wrong way round for approaching traffic. PC Neil Martin stated that if he had come across the trailer parked in the course of a routine patrol he would not consider it to be parked dangerously. He further stated that the way in which the trailer was parked was against the advice of the Highway Code, but it was parked under street lights and away from a bend.

- e) Chief Inspector Coats considered that the problem of access being impeded by trailers had been resolved. A safety issue had not been flagged up because there had been no reported collisions there.
 - f) In my view, both the police and traffic wardens should have been aware of the safety implications arising from trailers being parked on public roads. I recommend that the regulations regarding parking of trailers on public roads be emphasised in police and traffic warden training.
2. The difficulties inherent in identifying owners was not a contentious issue before the Inquiry.
- (a) There is no straightforward way for the police to identify the owner of a trailer which is unhitched.

- (b) Unlike motor vehicles, an unhitched trailer does not require to carry a distinct registration number identifying its owner.
- (c) While the trailer is required to carry a Ministry of Transport plating certificate, its owner cannot be readily identified from that.
- (d) If the trailer is over a year old and displaying a Good Vehicle Test Certificate, VOSA can be contacted to find out who has presented the trailer for its last test. VOSA has to consult its records to ascertain which garage issued the certificate. The garage has then to be asked who presented the trailer for its last test. The individual or company so identified, has then to be traced and contacted to find out whether the vehicle was presented for its test by them directly, or on behalf of someone else. The problems of identification are further complicated when the trailer has been sold after its annual

test, or where the trailer is less than one year old, in which case a test certificate is not required. Furthermore, it is more difficult to contact VOSA outside normal working hours and many test centres and garages are closed at weekends. Accordingly, at night and during weekends it is even more difficult to establish the identity of an owner of an unhitched trailer.

- (e) I have little doubt that had there been an established and workable system in place for the identification of such trailers, steps would have been taken by traffic wardens and the police to stop unlit trailers being regularly parked overnight in Longman Drive. Once operators were aware that enforcement procedures were being taken – regardless of the fact that they were being taken for access control purposes - then the widespread practice of using Longman

Drive as an overnight trailer park would have stopped before this accident took place.

- (f) It would have been helpful if a VOSA “Policy” official could have been made available to assist the Inquiry on this particular matter. (I make no complaint about the evidence of Elizabeth Haddow who helpfully considered the practical suggestions put to her regarding the identification of trailers but who conceded that these matters were outwith her area of expertise).

- (g) The need for such assistance was identified early in the Inquiry. Despite the Inquiry being continued on two subsequent occasions – no appropriate witness was identified. Just before the Inquiry was closed, a statement was obtained from Mr T. Roberts, Senior Policy Advisor,

Department of Transport. This statement was then converted by parties into a Joint Minute. ⁽²⁾

(h) I do not consider this procedure to be a valid or proper substitute for the giving of evidence at a Fatal Accident Inquiry where this issue could, and in my view, should have been properly explored and tested.

(i) No reason was given to the court why a policy official did not attend the Inquiry. I was told that the Procurator Fiscal had used her best endeavours in this regard.

In this respect I make the following recommendations:

⁽²⁾ cf Rule 10 of the Fatal Accidents & Sudden Deaths Inquiry Procedure (Scotland) Rules S.1. 1977/191.

- 1) That the appropriate Government Departments and Enforcement Agencies give consideration to a system for trailer identification, so that the owners of unhitched trailers can be quickly and easily identified.

- 2) That local representatives of VOSA, the police, and traffic wardens meet to discuss their respective roles in controlling the parking of unhitched trailers. I am concerned that on the evidence I have heard enforcement of trailer parking may “fall between two stools”.

- 3) That VOSA be invited to send a representative to the liaison meetings regularly held between the police, the Highland Councils Roads Department and Traffic Wardens. Elizabeth Haddow, saw no reason why this should not happen. For its part, the Council welcomed this initiative.

At the very least, any relevant sections of the minutes of these meetings should be circulated to VOSA.

Other Matters

A. It will be obvious from the above that I have made no determination in respect of head (b) or (c) above in relation to Mr Botterill's driving at the material time. This is not an omission.

After reflection, I have determined on the evidence before me that Mr Botterill's ***driving*** at the material time (as opposed to his carrying out this test at this locus at the time with the knowledge he had ⁽³⁾) was not a cause of this accident. I reach this view notwithstanding that Mr Botterill pled guilty to causing death by driving without due care and attention, or driving without reasonable consideration, on the 4th August 2009.

Footnote:

3. See the findings on pages 10 to 11.

I agree with the submissions made by all parties that it is very difficult, if not impossible, to replicate or reconstruct the lighting conditions at the time of the accident – particularly as dawn was just about to break.

However, I accept the evidence given by Mr Alexander to the effect that it would have been difficult for a driver to see the front of this trailer, parked facing oncoming traffic, angled upwards on its landing legs, with no effective front reflective markings in the lighting conditions pertaining at the time.

I also accept the evidence of Mr Botterill himself that he was concentrating on the road ahead: that he was looking forward and being careful; that he was not distracted by the brake test being carried out by Mr Mykoliw; that he did not see any reflector on the trailer headboard – only a dark shape “coming towards”

him: and that the trailer headboard was quite “high up” - at least four and a half feet off the ground – below the level of the beam of the bus lights.

I further accept the professional opinion of Mr Alexander to the effect that the dark blue trailer with its small headboard and flat bed, parked facing the oncoming traffic, on its landing legs would create a significant void between the trailer and the road surface, which would not be illuminated by the bus lights, until the impact was “literally inevitable”. Mr Alexander’s likened the situation confronting Mr Botterill to that confronting drivers in the 1970’s encountering unlit skips parked on public roads.

The fact that the “pooling” effect of the street lighting at the locus, created by the distance between the lamp standards, may have illuminated the front of the trailer more than its rear, in my view, strengthens Mr Alexander’s conclusion.

In deference to the clear and detailed submissions made on this matter, I prefer the evidence of Mr Alexander on this matter to that of the other expert witnesses for, inter alia, the following reasons:

1. Mr Alexander has greater experience than all the other road traffic experts who gave evidence.
2. The Investigating Officer's view that Mr Botterill should have proceeded up Longman Drive after overtaking the Mercedes lorry on the offside of the road, instead of returning to the nearside carriageway, caused me to have considerable doubts about the remainder of his evidence.
3. The focus of investigation after the accident appears to have been wholly concentrated upon Mr Botterill's driving. The parking of a detached, unlit trailer on the wrong side of the

road appears to have been ignored. This approach resulted in a one sided approach to the investigation of the accident with the result that witnesses found that they were justifying their position at Inquiry and ignoring in the process, other more obvious causes of the accident .

I note that at the start of the Inquiry Tulloch Transport were informed that it was not to be prosecuted for its part in this tragic accident. I also note the company's fulsome apology to the deceased's family at the end of the Inquiry.

Finally, on this point, I stress as I did at the outset of the Inquiry, that it is not part of my function to establish or apportion fault or blame for this accident. Rather I am required to establish the causes of Mr Mykoliw's death and any accident resulting therefrom. I have reached the view I have stated solely on the evidence at this Inquiry; it will be for others to determine in

different proceedings the question of fault or blame on the part of the various participants in this accident.

B. Finally, I would like to thank all the witnesses who appeared at this Inquiry. All the witnesses, with the singular exception of Mr Henderson, gave their evidence in a helpful and considerate manner, while doing their best to assist the court.

I particularly wish to thank the Procurator Fiscal Depute, Mr MacDougall, Mr Maillie and Mrs Watt.

C. It is important in such Inquiries to remember the enduring human tragedy which underpins it. This Inquiry was undoubtedly difficult for the family, which faithfully attended each session. Their dignity and restraint were remarkable.

The court extends its sincere sympathy to Mr Mykoliw's relatives.

He died in a tragic accident which was wholly unnecessary and avoidable.

Sheriff I.R. Abercrombie, QC
Sheriff Court, Inverness.

5th August 2010