2010 FAI 42

DETERMINATION

of

SHERIFF ALAYNE E SWANSON

in

FATAL ACCIDENT INQUIRY

into the circumstances of the death of

MR FRANCIS GOODWIN

In terms of Section 6 of the Fatal Accidents and Sudden Death Inquiry (Scotland) Act 1976

Glasgow 17 September 2010

The Sheriff having resumed consideration determines as follows:

1. Section 6(1)(a)

Mr Francis Goodwin of 352 Kelvindale Road, Glasgow died at 0500 on 27 July 2005 at the Western Infirmary Glasgow as a result of a road traffic accident which occurred at around 0420 on the same date.

2. Section 6(1)(b)

The cause of death was a chest injury sustained as a result of the road traffic accident. The accident was caused by the careless driving of Sean Crangle.

3. Section 6(1)(c), (d) and (e)

There are no circumstances of the death to be set out in respect of these provisions.

Note

Evidence in this fatal accident inquiry was heard on 1 and 2 September 2010 and submissions on behalf of the parties were made following the conclusion of the evidence on the final day. The Crown was represented by Ms Berry, Procurator Fiscal Depute. Mr Pugh, Advocate represented the Scottish Ambulance Service and Mr Sean Crangle, Ms Grant represented the Royal Mail and Mr Kerr represented Mr Goodwin's family. Parties entered into a minute of admissions which expedited matters considerably, and I am much obliged to the agents for their assistance in this regard.

The Determination is what is usually referred to as a formal Determination and contains no recommendations. In order to explain why I have concluded that recommendations were not appropriate in this case I think it will be helpful if I briefly recite the factual background and the events of 27 July 2005 as I found them to be established by the parole evidence and the contents of the Minute of Admissions entered into by the parties.

Background

Mr Francis Goodwin died as a result of a chest injury suffered due to his involvement in a road traffic accident. The accident occurred at the junction of Victoria Park Drive South and Westland Drive in Glasgow at

0420 on 27 July 2005. There were three vehicles involved in the road traffic accident: the Royal Mail van driven by the deceased, an ambulance and a tanker.

The accident

In the course of the Inquiry I heard evidence from the driver of the ambulance Mr Sean Crangle, the tanker driver Mr James Gibson, Sergeant David Wilson the senior investigating officer in respect of the investigation into the accident and Sergeant David Mitchell the officer who prepared the crash investigation report.

From the evidence available to me it was clear that the accident was caused by Mr Crangle's careless driving.

Mr Crangle was answering an emergency response call and was travelling with his colleague down Westland Drive towards the dual carriageway on Victoria Park Drive South with a view to proceeding across the junction. Visibility for a vehicle travelling south on Westland Drive as Mr Crangle was doing is restricted. A driver would be unable to see along Victoria Park Drive South until he was 15 metres away from the junction.

The ambulance had blue lights flashing but no siren was being used. It was still dark. The weather was dry. The traffic light at the junction was red against Mr Crangle. Mr Crangle saw a tanker coming from his right. This was the only vehicle he could see. He believed that vehicle to be slowing and he committed to crossing the junction. As he entered the junction he saw the lights of a van on the far side of the tanker.

Mr Gibson the tanker driver described his approach to the junction. He was aware of the Post Office van on his right. He was also committed to crossing the junction. Visibility for a driver travelling east on Victoria Park Drive as Mr Gibson was doing is also restricted. Visibility opens up about 15 metres from the junction. He explained that there is a point at the junction where he has to commit to going through as given the length and size of his vehicle if he were to brake after a certain point the vehicle would stop in the junction. He was looking in his mirror at the Post Office van as he wanted to make sure that there would be no problem with clipping mirrors once the vehicles were cab to cab going through the junction. He saw something white flash across in front of him and it dawned on him that it was an ambulance. At that point he hit his brakes as hard as he could. He heard a bang and thought that he had hit the ambulance. However the ambulance had struck the Post Office van causing it to hit the kerb of the central reservation. This knocked the vehicle towards the tanker. It hit the tanker on the driver's side and bounced off again. Mr Gibson could see the driver being violently thrown about. The van hit the other side again causing it to come back towards the tanker and collide with the rear of that vehicle. It then came to rest against the kerb.

The crash investigation established that the front of the Post Office van had collided with the rear off-side of the ambulance. Tachographs in the vehicles established that the tanker was approaching the junction at a speed of 45 mph and the Post Office lorry at a speed of 56mph. The Terrafix data recorder in the ambulance recorded that 13 seconds before the collision the ambulance had been doing a speed of 44 mph.

The Highway Code states that a typical stopping distance when travelling at 30 mph is 23 metres. At 40 mph it is 36 metres. That suggests that by the time Mr Crangle had a clear view of the junction he would have been unable to stop.

Mr Crangle was subsequently charged with a contravention of section 3 of the Road Traffic Act 1988 (careless driving) and pled guilty to that charge as amended.

Mr Goodwin was not wearing a seat belt. I heard evidence from Mr Alan Watson the Regional Fleet Compliance Officer with the Royal Mail as to the instructions given to employees of the Royal Mail about the use of seat belts. I was satisfied that the measures taken to remind employees about this safety feature were appropriate.

I heard the evidence of Dr Robert Ainsworth the pathologist who had carried out the post-mortem. He said that it was difficult to say whether the outcome of this accident would have been different if a seat belt had been worn. He said that seat belts are designed to prevent people being thrown forward and so their use might limit the head and chest injuries in a given situation or prevent injury. He said that the speed of the vehicles was relevant to the degree of force with which they impacted and the resultant injuries.

I was also referred to the photographs taken at the time of the accident and at the time when police organised a reconstruction of the accident.

Training

I heard evidence from Mr Crangle about the training he had undergone in September 2004. He attended a 9 week residential course, two weeks of which were devoted to driving. At the end of the driving section he was assessed in driving and theoretical knowledge. Mr Crangle was assessed as satisfactory. Areas for further development were identified.

Mr Crangle appeared to be a knowledgeable and competent driver. He said that he had benefitted from the training; it had changed his driving style entirely. After completing the training course he underwent a probationary year. He explained that an experienced member of staff accompanied him after he qualified from the course. He said that he had made about 500 emergency response calls between November 2004 and July 2005. I was satisfied on the evidence that had he exhibited a total lack of understanding as to how to use warning signs or the approach to red lights this would have been addressed as part of the ongoing process during his probationary year.

Mr Crangle gave a very clear account of the practical and theoretical training provided to him. He did so without reference to the relevant documents, at least initially, and his clear recollection of the elements of the training programme gave the impression that this had been training of a high standard from which Mr Crangle had benefitted and from which he had retained knowledge.

Mr Crangle did not spend any time on practical emergency driving during his driving training. It is not a requirement of the course. Because at that time all emergency driving had to be done in relation to live calls it was

the luck of the draw as to whether there would be sufficient calls available to allow all of the students to gain this experience.

I also heard evidence from Mr Russell Chandler the Training Development Manager for the Scottish Ambulance Service ("SAS") based at the Scottish Ambulance Service College. I heard from Mr Chandler that the position in relation to emergency driving on the training course has changed. Although it is still not currently a requirement, in preparation for new legislation which might come into force next year SAS are now able to put a training ambulance on the road. That training vehicle is allowed the benefit of the exemptions for speed and red lights. Under the proposed new rules anyone claiming an exemption from the speed limit must have completed or be in the course of an approved course for high speed driver training.

By reference to the Drivers Manual I was given details by Mr Chandler of the subjects covered in the course, the paperwork made available to the students, the nature of the assessments carried out and the importance of the system of car control. Mr Crangle also spoke about the importance of that system. The training provided by SAS and undertaken by Mr Crangle is accredited by the Institute of Health and Care Development ("IHCD"). SAS are accredited to deliver the UK Ambulance Awards. Mr Chandler confirmed that a student in his probationary period would be expected to develop through experience the skills he had learned on the course. The divisional driving team would have a role to play in this and colleagues would be expected to report dangerous or inappropriate behaviour by drivers.

I also heard the evidence of Mr Archie Mitchell a Principal Inspector with the Health and Safety Executive ("HSE"). Although it was highly unusual for HSE to investigate a road traffic accident Mr Mitchell had been asked to do so after concerns were raised by Mr Goodwin's family following the conviction of Mr Crangle for careless driving. The concerns raised were in respect of competence of the driver and the training schedules. Mr Mitchell concluded that the training was appropriate, that it met the IHDC standards and that IHDC did not deem it critical for drivers to be given practical emergency driving experience on the training course. The conclusion to his report states that there is no evidence that emergency driving training would have influenced the outcome of this accident. No further action was taken by HSE in this regard.

Red lights

Emergency services drivers are given certain exemptions from the requirements of road traffic law. Regulation 36 of the Traffic Signs Regulations and General Directions 2002 provides that if an emergency services driver would be hindered by a red light the prohibition conveyed by the red light shall not apply and the emergency services driver may proceed beyond the stop line provided that that action is not likely to endanger anyone or to cause the driver of any vehicle to change its speed or course in order to avoid an accident.

Mr Crangle gave evidence that he would approach a red light as if it were a give way sign. He went on to say that that meant that he would proceed with caution and only enter the junction if he was sure that it was clear and it was safe to do so. He was asked if that would involve stopping and he said yes if required. More recent guidance issued by SAS to their staff

in the form of a Standard Operating Procedure states that drivers should stop at a red light before ascertaining that it is safe to enter the junction. Mr Chandler said that this had not changed the practical application. A driver in 2004 would not enter the junction if it was not clear. A driver now would have to stop in any event. His evidence of the position in training in 2004 accorded with what Mr Crangle had to say. I was satisfied that Mr Crangle had understood the training in this respect.

It is clear from the evidence that on 27 July 2005 Mr Crangle did not follow either the guidance in place in 2005, the new guidance or the requirements of Regulation 36. He proceeded into the junction in a situation where because of the restricted visibility and the speed of his approach he had no chance of stopping when he realised that the junction was not safe to cross. I do not find that to be a failing of Mr Crangle's training or the system in place. There was no evidence that an instruction to stop at a red light, if in force in 2005, would have prevented this accident. He made a mistake on that occasion which had tragic consequences. He said in evidence that he knows he should have given way at the junction.

Warning signs

Mr Crangle told the Court that the general rule was that when crew are attending an emergency call warning devices must be used. In addition, if the condition of a patient on board dictates it, then warning devices should be used. During the day warning signs will involve blue lights and sirens. I was told that the practice was not to use audible warning signs at night. Mr Crangle described this as being a courtesy to members of the public in the surrounding area. He and Mr Chandler both gave

examples of situations in which, in adapting to clinical or road conditions, a decision would be taken not to use warning signs.

The crash investigation officer said that he was not sure that the use of the siren would have made any difference to the outcome. He said that the klaxon was not necessary. The important thing was to be going slowly enough to be able to stop.

There was no evidence to suggest that a different training regime or a different instruction about either red lights or warning signs would have prevented this accident.

Alayne E Swanson
Sheriff, Glasgow and Strathkelvin at Glasgow