

SHERIFFDOM OF GLASGOW AND STRATHKELVIN AT GLASGOW

[2015] FAI 28

B557/15

DETERMINATION

BY

SHERIFF JAMES KENNETH MITCHELL, ESQUIRE

**UNDER THE FATAL ACCIDENTS AND SUDDEN DEATHS INQUIRIES
(SCOTLAND) ACT 1976**

into the death of

JAMES LOCHRIE

GLASGOW, November 2015.

The Sheriff, having considered all the evidence adduced, DETERMINES:

- (1) in terms of section 6(1)(a) of the Fatal Accidents and Sudden Deaths Inquiry (Scotland) Act 1976 that:
 - (i) James Lochrie, born 3 December 1949, who resided in Glasgow died, whilst working in the course of his employment with First Glasgow (No 1) Limited, shortly after 8.00 am on 31 March 2012 on the east footway of Cathcart Road, Glasgow approximately 65 metres south of its junction with Aikenhead Road whilst trapped beneath the rear nearside wheels of a Volvo Olympian double deck passenger carrying vehicle registered number R153 EHS, operated by First Glasgow (No 1) Limited. He was pronounced dead there by Robert Pollock, Paramedic, Scottish Ambulance Service at 8.32 am; and
 - (ii) the accident resulting in Mr Lochrie's death occurred shortly after 8.00 am on the east footway of Cathcart Road, Glasgow approximately 45 metres south of its junction with Aikenhead Road, Glasgow.
- (2) in terms of section 6(1)(b) of the Act that:
 - (i) the cause of Mr Lochrie's death was:
 - (i)(a) chest and abdominal injuries
due to

(i)(b) road traffic collision (pedestrian); and

(ii) the cause of the accident resulting in Mr Lochrie's death was the loss of control of passenger carrying vehicle registered number R153 EHS, then in service, by David Logue, who, in the course of his employment with First Glasgow (No 1) Limited, was driving it southwards on Cathcart Road, Glasgow about 20 metres south of its junction with Aikenhead Road. Mr Logue had an episode of vasovagal syncope provoked by dehydration whilst driving the passenger carrying vehicle. He lost consciousness whereby he could no longer control the motion and direction of the passenger carrying vehicle as a result of which it left the south carriageway to its nearside and went on to the east footway and collided with a bus stop shelter of which Mr Lochrie was the sole occupant, thereby striking him and trapping him beneath it and dragging him a short distance.

(3) in terms of section 6(1)(c) of the Act the reasonable precautions whereby the accident resulting in Mr Lochrie's death might have been avoided were that:

1. Mr David Logue should have followed the advice given to him on 17 June 2008 by Dr John Byrne, Consultant Cardiologist, at the Department of Cardiology, Southern General Hospital, Glasgow to maintain a sufficient dietary and fluid intake so as to avoid him becoming dehydrated and having a further episode of vasovagal syncope provoked by dehydration whilst he was driving a motor vehicle or, alternatively, if he was not willing or able to follow Dr Byrne's advice, Mr Logue should not have driven any type of motor vehicle;
2. Because of the importance of the advice to a licence holder, who might drive any vehicle, following upon receipt of Dr Byrne's letter dated 20 June 2008, Mr Logue's general medical practitioner should have seen Mr Logue in early course to discuss and re-iterate Dr Byrne's advice regarding his maintaining sufficient dietary and fluid intake to avoid dehydration. Thereafter, the general medical practitioner should have confirmed this advice to Mr Logue in writing; a copy of this letter being retained in the general medical practitioner's records;
3. Dr John Byrne should have advised the Driver & Vehicle Licensing Agency ("DVLA") in his medical report to them in respect of Mr Logue dated 29 August 2008 (Crown production 6 at pages 167/8) or in an accompanying letter that Mr Logue was a bus driver and that the incident on 6 June 2008 in which Mr Logue lost consciousness occurred unusually whilst he was sitting driving a bus.

4. Prior to 6 June 2008 First Glasgow (No.1) Limited should have instructed (i) the medical officers employed by them to report to the DVLA any matter of which the bus company or the medical officer became aware relating to the possible unfitness to hold a driving licence of any employee who held a passenger carrying vehicle licence; and (ii) all relevant employees that the medical officers employed by the company should receive all information received by First Glasgow (No 1) Limited's personnel department or contained in the personnel records insofar as related to the possible unfitness to hold a driving licence of any employee who held a passenger carrying vehicle licence, including episodes or suspected episodes of loss of consciousness.
- (4) in terms of section 6(1)(d) of the Act it is not established that a defect in any system of work contributed to the accident resulting in Mr Lochrie's death.
- (5) in terms of section 6(1)(e) of the Act that the following facts are relevant to the circumstances of Mr Lochrie's death:
1. The mechanical condition of the Volvo Olympian double deck passenger carrying vehicle R153 EHS ("the bus") did not contribute to the accident on 31 March 2012 resulting in Mr Lochrie's death. The bus had no mechanical defect and post-accident damage found was consistent with the circumstances of the accident.
 2. On the morning of 31 March 2012, at a time when it could not be affirmed that no crime or road traffic offence had been committed by Mr David Logue in respect of Mr Lochrie's death, PC David Murdoch (then of Strathclyde Police), the appointed investigation officer in connection with the accident resulting in Mr Lochrie's death, was instructed not to have any interaction with Mr Logue whereas PC Lorna Breen (then of Strathclyde Police) was instructed to remain with Mr Logue but was not instructed not to have any interaction with him.
 3. Mr David Logue did not report the circumstances of the incident at work on 3 August 2004 in which he suffered loss of consciousness to his general medical practitioner or to the DVLA.

4. Mr David Logue's passenger carrying vehicle licence would have been revoked prior to 31 March 2012 and would not have been in force on that date had the DVLA been aware of the full circumstances in respect of the episodes of loss of consciousness which Mr Logue had on 20 January 1998, 3 August 2004 and 6 June 2008.
5. The reasons that the DVLA was not aware of the full circumstances in respect of Mr Logue's episodes of loss of consciousness were: (i) Mr Logue did not advise the DVLA of the episode of his loss of consciousness on 3 August 2004; (ii) on 17 June 2008 Mr Logue did not provide full and complete information to Dr John Byrne, Consultant Cardiologist, to whom he had been referred for diagnosis and advice upon his future management; (iii) Dr Byrne did not advise the DVLA in his medical report to them dated 29 August 2008 or in an accompanying letter that Mr Logue was a bus driver and that the incident on 6 June 2008 in which he lost consciousness occurred unusually whilst he was sitting driving a bus; and (iv) partly because the questions posed in the forms then in use by the DVLA did not require sufficient relevant information to be given by licence holders and medical practitioners.
6. Prior to 31 December 2008 the forms in use by the DVLA and sent by the DVLA to licence holders to provide information regarding incidents where an episode of loss of consciousness had occurred did not ask open questions requiring licence holders to give sufficient necessary and relevant information to assist the medical advisers at DVLA to reach an informed decision on a licence holder's continued fitness to drive; and in particular did not ask open questions regarding the licence holder's prior medical history; where any prior treatment had been provided; information regarding the identity of the licence holder's general medical practitioner; the circumstances in which the current episode had occurred, including whether the licence holder was standing, sitting or lying at the time of the episode; whether the licence holder was driving at the time of the episode; the licence holder's occupation; and whether there was any other matter which the licence holder considered should be drawn to the attention of the DVLA regarding the licence holder's continuing fitness to drive.
7. Prior to 31 December 2008 the forms in use by the DVLA and sent by the DVLA to medical practitioners to report on the medical condition of licence holders where an episode of loss of consciousness had occurred and whose

continuing fitness to drive was under consideration by the DVLA did not ask open questions requiring the medical practitioner to give sufficient necessary and relevant information to assist the medical advisers at DVLA to reach an informed decision on a licence holder's continuing fitness to drive; and in particular did not ask open questions all as set out and specified in the preceding finding and whether there was any other matter which the medical practitioner considered should be drawn to the attention of the DVLA regarding the licence holder's continuing fitness to drive.

Therefore, in view of findings 3 to 7 (inclusive) the Sheriff respectfully recommends that consideration be given by The Secretary of State for Transport as to whether appropriate legislation is required to:-

- (1) provide that a condition of holding or continuing to hold a licence to drive any class of vehicle is that the licence holder is deemed to consent to the following:-
 - (a) the DVLA, where it considers it necessary to do so in order to determine whether the licence holder is fit to drive, being authorised (i) to require immediate production of any licence holder's general practitioner medical records and any medical records of the licence holder held by any health service in the UK, or suitably certified copies thereof; (ii) to instruct any medical practitioner, including specialist consultants, of its choice to examine the licence holder and report on the fitness to drive of the licence holder; and
 - (b) the licence holder being required to attend and undergo such examination and to honestly and comprehensively answer any questions put by the medical practitioner examiner;
- (2) provide that any such medical practitioner examiner (i) be allowed access to all medical records relating to the licence holder concerned and (ii) may require such further information as s/he considers necessary to determine the licence holder's fitness to drive any class of motor vehicle from any such medical practitioner who has treated the licence holder at any time;
- (3) provide that any such medical practitioner examiner must report to the DVLA in writing, within such period of time as may be specified,

advising the history given by the licence holder, the medical history contained in the medical and hospital records, the findings at examination, the opinion of the examiner as to the licence holder's fitness to drive and the reasons for that opinion.

- (4) provide that in such circumstances as may be considered appropriate the DVLA may revoke on an interim basis any licence holder's licence to drive any category of vehicle pending completion of its inquiries and its decision as to the fitness of the licence holder to continue to hold any such licence;
- (5) provide that a medical adviser employed by the DVLA must give written reasons for the decision on a licence holder's continuing fitness or unfitness to drive any class of motor vehicle;
- (6) amend the terms of section 94 of the Road Traffic Act 1988, as amended, (i) to specify all the relevant disabilities which must be declared forthwith to The Secretary of State for Transport and (ii) determine whether the exemption contained in terms of section 94(2) remains appropriate, particularly having regard to the terms of sub-section 94(2)(b);
- (7) amend the terms of section 94 of the Road Traffic Act 1988, as amended, to make it explicit that the onus of proof of reasonable excuse rests upon the licence holder concerned;
- (8) increase the penalties and alter the mode of prosecution for a contravention of either section 94(1) and (3) or section 94(3A) of the Road Traffic Act 1988, as amended;
- (9) create a discrete indictable offence of driving whilst unfit to do so by reason of the driver not having followed medical advice to maintain fitness to drive;
- (10) require any bus company licensed to operate any bus service or to carry any passenger in any of its vehicles which acquires information that any of its employees holding a passenger carrying vehicle licence may have had an episode of loss of consciousness to report this information (and

any similar previous incident of which it is aware) to the DVLA within 72 hours of acquiring that information, irrespective of whether the licence holder may be under an obligation to report the matter to the DVLA; and

- (11) create an offence, with appropriate penalties, for any such bus company which fails, without reasonable excuse, to so report to the DVLA.

SHERIFF

NOTE:

[1] This Fatal Accident Inquiry was held in terms of section 1(1)(a)(i) of the Fatal Accidents and Sudden Deaths Inquiry (Scotland) Act 1976 into the circumstances of the death of James Lochrie, who died on 31 March 2012 on Cathcart Road, near Aikenhead Road, Glasgow whilst trapped behind the rear nearside wheels of a bus operated by First Glasgow (No 1) Limited, then in service en route to East Kilbride Bus Station.

The application to the court to hold an Inquiry and the subsequent history

[2] On 23 February 2015 the procurator fiscal made application to hold this inquiry. On the same day, a sheriff considered the procurator fiscal's application and appointed this inquiry to be held on 29 June 2015, when it commenced. There were three preliminary hearings. At a preliminary hearing on 1 June 2015, Sheriff Deutsch noted that the procurator fiscal depute anticipated that this inquiry could be completed within the 5 days allocated. Sheriff Deutsch noted that the procurator fiscal depute explained that the focus would be on what the DVLA had done with the information it had received over time in regard to David Logue's medical condition. The witness Dr Gareth Wyn Parry was to speak to the statutory guidelines in place at the material times and was expected to give evidence that there had been compliance with these guidelines. Sheriff Deutsch noted that there was no intention to explore the adequacy of the guidelines.

[3] In the event, this Fatal Accident Inquiry lasted 14 days. It commenced on 29 June 2015 and concluded on 18 August 2015.

Representation

[4] The procurator fiscal was represented by Mr Steven Quither, Procurator Fiscal Depute, Mr Craig Murray, Advocate, appeared for the Lochrie family. Mr Bathgate, Solicitor, Glasgow appeared for the bus driver Mr David Logue. Ms McDonnell, Solicitor, Glasgow appeared for First Glasgow (No 1) Limited. Mr O'Reilly, Solicitor, Glasgow appeared for the Greater Glasgow Health Board. Mr Hugh Olson, Advocate, appeared for the DVLA. There was no other representation at this Inquiry.

A synopsis of the evidence put before this Inquiry

[5] The procurator fiscal led evidence from 24 witnesses, two of whom had to be recalled, namely, David Logue and Professor Gerard McKay. The procurator fiscal also presented affidavit evidence from five other persons. A joint minute of admissions signed on behalf of all parties was lodged at the bar. No evidence was led on behalf of any other party. At the outset the procurator fiscal depute read out affidavits sworn by Teresa Lochrie, Elaine Lochrie and Archibald Lochrie.

Mr James "Jim" Lochrie and the loss suffered by his family as a result of his death

[6] It is clearly established from the affidavits of Mr Lochrie's widow, daughter and brother that Mr James "Jim" Lochrie was a warm hearted and generous man to whom

his family was so very important. He was a kind, loving and respected man, who was looking forward to enjoying his retirement with his wife. He was a very supportive parent and a proud grandfather, who enjoyed spending time playing with his young grandson. He was “a good older brother”. Mr Lochrie’s sudden and unexpected death has left a great emptiness in each of the lives of his family members, which will continue. All the evidence at this Inquiry led from witnesses who worked for his employers, including Mr David Phillips, then General Manager, was that Mr Lochrie was a valued long serving employee, who was well regarded, much respected and popular with his colleagues.

[7] Mr Lochrie’s death has had a profound and continuing effect on his widow, daughter, siblings and family. Their love and respect for him was demonstrated by their dignified attendance throughout this Inquiry. I expressed my condolences to them at the end of the Inquiry, as did the procurator fiscal depute and each of the lawyers appearing for the represented parties. I thanked Mr Lochrie’s family for their patience and the dignity which they showed throughout the proceedings. I now repeat my expression of sympathy and my thanks to each of them.

The other evidence led at this inquiry

[8] The procurator fiscal depute intimated that the first witness would be Mr David Logue. He was the driver of the passenger carrying vehicle registered number R153 EHS at the material time on the morning of 31 March 2012. In answer to the court, the

procurator fiscal depute stated that the Crown was not taking criminal proceedings against Mr Logue arising out of the circumstances of the death of Mr Lochrie. On the basis of that statement by the procurator fiscal depute, it was not appropriate for me to give Mr Logue any warning as regards self-incrimination and none was given. Mr Logue gave evidence and was subsequently re-called to the witness box so that he might have the opportunity to respond to matters which emerged after he had given evidence and about which he had not been asked. This was necessary both in the public interest and in fairness to Mr Logue.

[9] The procurator fiscal depute also led evidence from witnesses John Reilly, Richard Duguid, Jason Perry, Malcolm Dippie, James Findlay, PC Lorna Breen, PC Lynn Caldwell, PC Roger Millar, PC David Murdoch, PC Scott Simpson, Professor Martin Brodie, George Courtney, Dr Kenneth Lyons, Dr Gareth Wyn Parry, Dr John Byrne, Professor Gerard McKay, Dr Alan Rae, Steven Neilson, David Philipps, Stuart Purvis, Dr Julia Cree, Dr Iain Kennedy and Dr Laura Cormack.

Unchallenged evidence as to what occurred on the morning of 31 March 2012

[10] Much of the evidence as to what occurred on the morning of Saturday, 31 March 2012 was not in dispute. Mr Lochrie was working in the course of his employment as a bus driver with First Glasgow (No 1) Limited at the time of his death. He was waiting in a bus shelter on Cathcart Road, Glasgow, not far south of the junction with Aikenhead Road, for the arrival of a No 31 bus operated by his employers between Osborne Street,

Glasgow and East Kilbride Bus Station. Mr Lochrie was to take over the driving of the bus from Mr Logue, who was due to go on a meal break.

[11] On the undisputed evidence led at this Inquiry, there was no passenger on the bus driven by Mr Logue at the time of the accident. Mr Lochrie was alone in the bus shelter. Mr John Reilly, a bus driver employed by First Glasgow (No 1) Limited was waiting to take over the driving of another bus, which was travelling to Glasgow. He was waiting on the other side of Cathcart Road from Mr Lochrie, to whom he waved.

[12] Mr Logue gave unchallenged evidence that he started work that morning when he signed in at Larkfield Depot at 6.17 am. He left Larkfield Depot driving the bus. As he was required to do, Mr Logue drove the bus to East Kilbride Bus Station. During this journey the bus was not in service. At East Kilbride Bus Station the bus commenced service and Mr Logue drove it on the No 31 route, departing at 6.52 am and arriving at Osborne Street, Glasgow at 7.38 am. Mr Logue then had a break until he drove the No 31 bus from Osborne Street, departing at 7.55 am. As noted, Mr Logue was due to go on a meal break at 8.01 am and to that end was to stop the bus at the bus shelter where Mr Lochrie was to take it over. Mr Logue would then go to the nearby Larkfield Depot for his meal break.

Crash investigation report

[13] Crown productions 3 and 4 comprise a crash investigation report prepared by PC Scott Simpson and PC Mark Caldwell. PC Scott Simpson gave unchallenged evidence at this Inquiry, which was plainly credible and reliable. He and his colleague

are to be commended for the care and attention which they paid to their task. The report has been of great assistance to me in reaching my determination. The crash investigation report has established that shortly after 8.00 am, whilst Mr Logue was driving the bus southwards along Cathcart Road about 20 metres south of its junction with Aikenhead Road, he lost control of its motion and direction.

[14] The crash investigation report has established that about 20 metres south of the junction with Aikenhead Road, the bus left the southbound carriageway and went partly onto the east footway. The bus continued travelling south partly, then wholly, on the east footway. The front nearside of the bus collided with a bin located on the east footway. The bus continued southwards on the east footway colliding with the bus shelter where Mr Lochrie was waiting. The bus shelter was destroyed. The bus struck Mr Lochrie, who passed under it. Mr Lochrie became trapped beneath the bus and was dragged a short distance before the bus came to a halt.

The people who came to help

[15] A number of people saw or heard what had happened and, in the best traditions of Glasgow people, came to offer such assistance as each could give. When it became known that someone was trapped under the rear of the bus, Mr Stuart Purvis, a gardener (who had stopped to offer assistance because he was a first aider,) and PC Lorna Breen attended and both tried to elicit any sign of life from Mr Lochrie. But none was found. Heavy rescue equipment was necessary to release Mr Lochrie from under the bus. This equipment was summoned promptly and arrived quickly. The bus had

come to rest on the east pavement but by means of four hydraulic bags it was possible to lift the body of the bus whilst all of its wheels remained on the pavement. The result was that by 8.25 am Mr Lochrie was removed from under the bus by fire fighters and paramedics and into the care of the paramedics. Mr Lochrie did not respond to an ECG applied by paramedics. Mr Robert Pollock, a paramedic, pronounced Mr Lochrie's life extinct at 8.32 am.

Post-mortem examination results

[16] The undisputed evidence led at this Inquiry has established that Mr Lochrie suffered a traumatic death shortly after 8.00 am on Saturday, 31 March 2012. Mr Lochrie suffered severe extensive injuries as a result of being struck by the advancing bus. On 4 April 2012 at post-mortem examination the forensic pathologists found the primary cause of his death to be chest and abdominal injuries due to a road traffic collision. It should be recorded that Mr Lochrie had no alcohol in his blood and that he had no underlying natural disease which could have played any part in his death or the circumstances surrounding it. I do hope that it has provided some measure of comfort to Mr Lochrie's widow, daughter, sisters, brother and family to know that, given the traumatic circumstances of this collision, Mr Lochrie did not endure lengthy suffering for both pathologists concluded from their examination that he would have died very quickly.

VOSA examination of the bus

[17] I found Mr George Courtney, an experienced VOSA vehicle examiner, to be an excellent witness. He gave evidence in an open, measured and straightforward manner. His evidence was not challenged in any respect. He subsequently examined the Volvo Olympian double deck passenger carrying vehicle registered number R153 EHS (“the bus”) on 4 April 2012. He produced a comprehensive and careful report, to which he spoke during evidence. I have no hesitation in accepting his unchallenged findings and opinion. It is established that the bus had no defects and that the damage to it was consistent with the circumstances of the accident. The mechanical condition of the bus did not contribute to the collision.

Undisputed police evidence

[18] Sergeant Dawn Miller was the senior investigating officer in respect of this inquiry. She did not give evidence in court but deposed in an affidavit, which was of assistance in that it established that there was no CCTV evidence of this collision. It also established that no radio transmission was received that day from Mr Logue and that he had not called the depot at any time that day using his mobile phone.

Mr Logue’s account of the morning of 31 March 2012

[19] Mr Logue’s position in evidence was that on 31 March 2012 he “would have been up” at 5 am and arrived at the Larkfield depot 20 minutes before his shift started. He stated that he had a small cup of tea. He stated that there was nothing unusual in the

start up to his shift and that there was nothing out of the ordinary during the driving of the bus to East Kilbride bus station. He stated that there was nothing unusual on the journey back from East Kilbride when he had passengers on board.

[20] Mr Logue stated that there was nothing unusual on the journey from Osborne Street, Glasgow until he was coming over a hill approaching a set of traffic lights “about 100 yards from the bus stop”. Mr Logue stated that he remembered the traffic lights were showing green in his favour but once he drove over “the hill”, he could “remember nothing, not a thing”. Mr Logue stated that the next thing he remembered was someone banging. Mr Logue stated that he was aware that he was slumped at the wheel and in the driver’s seat of the bus. He recalled Mr James Reilly (witness) helping to get the bus doors open. Mr Logue described his legs “giving way”. Mr Logue stated that there was “nothing I could have done to avoid this accident apart from not turning up for work”.

[21] In answer to counsel for the family, Mr Logue stated that there was nothing unusual in his health on the morning of the accident. He stated that he “woke up with what he thought was a nightmare”. He accepted that after discussion with the doctors it could have been a palpitation. He stated that he had last eaten the night before he went to work. He stated that if he had felt unwell he would not have gone to work. He asserted that there was nothing to give him any indication that he was unfit for work on 31 March 2012.

[22] In answer to the procurator fiscal depute, Mr Logue stated that he was told that dehydration was the cause of his loss of consciousness. He stated that he did “not drink a lot when driving a bus” because there was nowhere to go to the toilet. In answer to

counsel for the DVLA, Mr Logue accepted that “I could have been dehydrated. I can’t medically say I was”. He further stated “My mouth was bone dry at the time of the accident”. He went on to state that his mouth had never been that dry and to assert that he had taken his normal amount to drink that morning.

The evidence of those who saw Mr Logue at the scene of the accident on 31 March 2012

[23] Mr Reilly described the bus ploughing straight through the bus shelter. Once the bus had stopped Mr Reilly ran towards it. Along with a cyclist (Mr Stuart Purvis), he helped Mr Logue from the bus and to sit him on a nearby grass verge. He described Mr Logue as being “very shocked and shaken”. The cyclist said to call the emergency services but Mr Logue said “no”. Richard Duguid, a joiner, who was working nearby came to assist. He went up to the bus and saw the driver slumped over the wheel and tried to get his attention. Mr Duguid said the driver looked “dazed”. He said that others arrived and when removed from the bus Mr Logue was “very shaken” and “not steady on his feet”. Mr Duguid did not remember anything the bus driver may have said. Jason Perry was working on a nearby building site and came to assist. He said that the bus driver “seemed pretty dazed”. I have no doubt that the witnesses John Reilly, Richard Duguid, Jason Perry and Malcolm Dippie did their very best to recollect honestly and accurately what they had seen or heard and I accept the evidence of each of them as being credible and reliable.

The evidence of Mr Stuart Purvis

[24] At the end of the first day of the Inquiry, after Mr Logue and other witnesses had completed their evidence, an affidavit from Mr Stuart Purvis was read to the court by the procurator fiscal depute. The affidavit deponed that Mr Purvis was employed by Glasgow City Council. He was cycling to work and saw the accident. Mr Purvis was a trained first aider at his place of work. He approached the passenger door of the bus. There was another bus driver there and a construction worker. Mr Purvis and the construction worker (Mr Duguid) entered the bus. Mr Purvis deponed in his affidavit that "We could see that the driver was dazed, confused and very concerned. As he got off the bus he said something along the lines of 'What the fuck have I done'".

[25] Mr Purvis deponed in his affidavit that "It almost looked like (Mr Logue) was sleepwalking, eyes open but completely dazed. I don't think he could compute what had just happened". Mr Purvis deponed that Mr Logue went to the grass verge but had to be ushered away from the bus to near to the shrubs where he bent over almost like he was going to be sick. Mr Purvis specifically deponed: "The bus driver said he was okay and didn't need an ambulance". Mr Purvis deponed: "I briefly went back to my bike to move it and put it against the tree and then went back to the driver. I told him I was a first aider and asked him about medication and food. He said he was taking water tablets. I asked him if he had taken his medication and he said he had. I then asked him if he had anything to eat and he said no. He then said after that that his head was really hurting".

[26] In view of certain other evidence heard at the inquiry as to what might have caused Mr Logue to lose consciousness on 31 March 2012, it was agreed that Mr Purvis should be called as a witness. On 10 August 2015 Mr Purvis gave evidence and explained that when he got to the bus, the other bus driver went in and opened the driver's door and assisted the driver out very slowly. The bus driver seemed to be dazed. Mr Purvis stated in evidence "I can't remember if he (Mr Logue) said anything." The bus driver was not feeling well. He had to be supported walking but he was on his own feet. As Mr Logue was not steady on his feet, Mr Purvis advised that the safest thing was to put him on the ground. In evidence Mr Purvis confirmed that he had asked the bus driver if he was on any medication. Mr Purvis stated that the bus driver said "no". He recollected that the bus driver had shaken his head. Mr Purvis said he asked the bus driver if he had had anything to eat and that the bus driver replied "no".

[27] Mr Purvis confirmed that he had asked the other bus driver to phone an ambulance but he had refused because he had first to contact his employer. Mr Purvis then said to the bus driver (Mr Logue) "Are you sure you're not on any medication?" Mr Purvis stated that Mr Logue replied "Just my water tablets". Mr Purvis explained that he recollected this because his father used to take water tablets to bring down his weight. Mr Purvis recollected that he then again asked the other bus driver to phone for an ambulance but he refused. At that Mr Logue stated "Oh my head is killing me, I feel sick" and, on hearing this, the other bus driver decided to phone an ambulance. Another member of the public appeared and explained that it was necessary to phone an

ambulance because there was a “guy under the bus”. At that Mr Logue stated either “Oh fuck, what have I done?” or “Oh no, what have I done?”

[28] Mr Purvis was shown his earlier affidavit, which he stated was not quite accurate in parts. His evidence was that he was “clear” that Mr Logue said “Just my water tablets.” Mr Purvis very properly clarified that Mr Logue had not actually indicated that he had taken water tablets that day although Mr Purvis had assumed that from what Mr Logue had said. Mr Purvis explained that it made a connection with him at that time because his father had had to take water tablets.

[29] Mr James Findlay, paramedic, spoke to Mr Logue outside an ambulance at the scene of the accident. He felt that Mr Logue was stable enough to travel to the Victoria Infirmary without monitoring. He drove him there. Mr Logue was accompanied by PC Lorna Breen. Mr Findlay was unable to remember exactly what Mr Logue may have said but Mr Findlay’s recollection was that Mr Logue did not remember anything about the accident. He was referred to Crown production 8 at pages 335/6 where it was noted that Mr Logue’s skin colour was normal and his skin texture was “dry”. It was noted: “no recollection of accident. Unsure if any LOC (loss of consciousness) after the event”.

[30] Mr Findlay explained that Mr Logue was asked whether he had had anything to eat in the last 5 hours. The reply Mr Logue gave indicated that it had been more than 5 hours since he had last eaten. Mr Findlay was clear that he would have been asked when he last “ate” as opposed to “drank”. Mr Findlay considered that it was difficult to assess if Mr Logue was dehydrated when he saw him.

[31] Mr Logue was seen at the Accident & Emergency Department of the Victoria Infirmary by Dr C. Buchanan (non-witness). The history noted by Dr Buchanan is recorded in Crown production 8 at pages 326/7. The joint minute only records that "Southern General Hospital Medical Records relating to DAVID LOGUE form Crown Production 8". It does not admit the truth and accuracy of the noted history which was: "... Recalls coming over hill, unsure what happened "out like a light"...PMH: HTN reports dizzy spells". PC Breen spoke to being present when Dr Buchanan spoke to Mr Logue. PC Breen stated that Mr Logue had said that he did not know how the accident happened and that he thought that he had blacked out. To that extent her evidence provides support for the accuracy of the note made by Dr Buchanan.

[32] Dr Buchanan recorded:

"Imp(ression) RTA ? fell asleep at wheel. No clear post ictal phase.
D/W Mr Ritchie, no clear cause LOC
GP to refer syncope clinic if deemed appropriate."

Medical evidence as regards Mr Logue's condition on 31 March 2012

[33] On 4 April 2012 Dr Julia Cree, then a salaried general medical practitioner employed at the medical practice carried on by Dr Iain Kennedy, saw Mr Logue at the practice at 3 Ashton Road, Glasgow. She stated that she remembered the consultation. She made an urgent referral of Mr Logue to the Department of General Medicine at Stobhill Hospital.

[34] On 19 April 2012 Professor Gerard A. McKay, Consultant Physician, saw Mr Logue at his medical clinic. Professor McKay's notes of that consultation are found in

Crown production 9 at pages 382/3. On that day, a member of staff recorded in the medical notes Mr Logue's height, weight and BMI. Professor McKay said that Mr Logue was "overweight" and with a BMI of 32 was "technically obese". Professor McKay did not recall having seen Dr Buchanan's notes and test results: Crown production 8 at pages 324/7.

[35] Professor McKay was asked in detail about the history given to him by Mr Logue. He had recorded "syncope-no warning". Professor McKay did not recall Mr Logue telling him about any other episodes apart from 1998 and 2008. He did not recall Mr Logue talking about previous "dizzy spells". Professor McKay decided that Mr Logue should be referred to a cardiologist and did so by letter dictated 20 April 2012 and typed on 25 April 2012: see Crown production 9 at page 355. The reason for referral to a consultant cardiologist was for advice as to Mr Logue's management: see Professor McKay's letter dated 25 April 2012: Crown production 9 at page 347. Professor McKay also reported in detail to Dr Kennedy by letter of the same date: see Crown production 9 at page 354.

[36] On 19 June 2012 Dr Alan Rae, Consultant Cardiologist, saw Mr Logue. Dr Rae had not seen Professor McKay's notes (pages 382/3) when he saw Mr Logue. He had seen the letter Professor McKay wrote following upon the consultation on 19 April 2012 and the results of the two inquiries instructed by Professor McKay. Dr Rae's notes of that consultation are found in Crown production 9 at page 381 in the nursing notes. The only previous incidents mentioned by Mr Logue were in 1998 and 2008. Dr Rae was not aware that the accident on 30 March 2012 was the third vasovagal episode suffered by

Mr Logue whilst he was at the wheel of a bus. Dr Rae's views following upon his consideration of Mr Logue's case are set out in his letter to Professor McKay dictated on 19 June 2012 and typed on 21 June 2012: Crown production 9 at page 346. It should be noted that in the second paragraph, the first sentence should read: "Clinical examination was unremarkable...." In the last paragraph of that letter Dr Rae stated:

"The circumstances and description of events do certainly suggest a vasovagal event. In each of the three episodes there was preceding dehydration which could well be a provocative factor".

Mr Logue's evidence regarding previous incidents of loss of consciousness

[37] At the outset of his evidence, in answer to the procurator fiscal depute, Mr Logue stated that he was no longer a bus driver. Mr Logue had been a bus driver for 23½ years until 2012. Mr Logue stated "I was no longer fit to do the job". He stated that on 31 March 2012: "I fainted while I was driving a bus". It was accepted by Mr Logue that the accident which resulted in Mr Lochrie's death was the third accident in which he had been involved having lost consciousness whilst driving a bus.

[38] The number and the circumstances of previous incidents where Mr Logue may have lost consciousness were in dispute at this Inquiry. It is necessary to consider the evidence before this Inquiry relating to each one of them.

The first previous bus accident on 20 January 1998

[39] On Tuesday 20 January 1998 Mr Logue was involved in a road traffic accident in Maryhill Road, Glasgow, at the junction with Queen Margaret Drive. He was working

in the course of his employment with Strathclyde Buses Limited. He was taken to the Accident & Emergency Department at the Western Infirmary, Glasgow. He was interviewed there by Inspector K L Benjamin (non-witness) of the bus company. According to the note taken by Inspector Benjamin (Crown production 18 at pages 669/70) Mr Logue stated:

“I was turning bus in Maryhill Road going right into Queen Margaret Drive. I had my full lock on and waiting for westbound traffic to stop when I became unwell. As I turned right I lost consciousness and as far as I know the bus hit two vehicles that were about to drive north out of Queen Margaret Drive.”

[40] When questioned by counsel for the Lochrie family, Mr Logue accepted that this was what he had said to Inspector Benjamin and also that he had made no mention of dizziness. Mr Logue was referred to Level 8 Medicine, where he was seen the same day by Dr Alan Denison, a Senior House Officer (non-witness). Crown production 28 comprises the notes taken by Dr Denison, who recorded:

“Was driving bus today (had felt light headed earlier).
Sitting at traffic lights
Next memory is coming to following crashing bus into other cars/vans
No warning
Nauseous afterwards
Felt disorientated afterwards. No dysphasia
Duration? approximately 10 seconds/20 seconds
Urinary incontinence
No tongue biting”.

Another incident two years before?

[41] At the end of his note Dr Denison recorded “Identical episode 2 years ago while on jury duty”. Dr Denison advised Mr Logue not to drive and referred him to the

Epilepsy Clinic at the same hospital. In the referral Dr Denison specifically mentioned the duration of loss of consciousness being approximately 30 seconds; urinary incontinence; stressful job; and apparently similar episode 2 years ago.

[42] Mr Logue was seen at the Epilepsy Clinic. When shown a letter dated 5 February 1998 from Dr Elaine Wilson, Assistant Director, Epilepsy Unit (non-witness) to his then GP Dr Burman (non-witness), (Crown production 5, page 140) Mr Logue accepted the description of the accident given by Dr Wilson was correct. It was in the following terms:

“Then when sitting at the traffic lights waiting to pull off he started to feel dizzy and nauseated then he lost consciousness. The bus continued to move forward and he crashed into two vans and a wall”

He stated that he did not remember the third sentence which stated:

“Before going to work on the day of the accident he had had several dizzy attacks all of which had passed off and had lasted seconds perhaps up to one minute at the most.”

[43] In evidence, Mr Logue accepted that when sitting at the traffic lights waiting to pull off he started to feel dizzy and nauseated then he lost consciousness. None of the passengers actually witnessed what was happening to him during this time. When he came to he was confused and he had a headache and he vomited several times and it took him around 2 days before he felt entirely back to normal.

An earlier incident three years before?

[44] Dr Wilson’s letter also records that “His wife said that three years ago he had an attack which was attributed to an inner ear infection. He apparently felt dizzy for a few

seconds and nauseated and then seemed to go into a dream-like state for a minute or two after which he made a full recovery within a few minutes but did vomit afterwards. During that attack he had no urinary incontinence or tongue biting and he was given a course of Serc to take.” Dr Wilson’s letter further records that Mr Logue had told her that he had seen Dr Burman regarding this latest attack and “he felt it might be related to the stress of his job and also a throat infection”.

[45] In evidence, Mr Logue stated that he had no recollection of an earlier incident some 3 years previously in or around 1995, which had apparently been mentioned by his wife to Dr Wilson. When Mr Logue was shown Crown production 17 at page 655 and, in particular, the entry in these GP records dated 14 June 1996 which recorded dizziness, he stated that he did not remember the dizziness. The GP record records that on that occasion he had been prescribed Serc. When shown medical certificates certifying him unfit for work (Crown production No 18 at pages 688 and 700) because of viral labyrinthitis, Mr Logue stated that he did not recall being off work.

[46] At all events, as indicated in Dr Wilson’s letter, Mr Logue underwent a CT and an EEG and he was reviewed by Professor Brodie at the Epilepsy Clinic. Professor Brodie wrote to Dr Burman on 19 March 1998 (Crown production 17 at page 613). The letter was in the following terms:

“I am pleased to report Mr Logue has been fine since we saw him last. His CT and EEG were entirely normal. I note that prior to his loss of consciousness, he had a throat infection and that his piles were bleeding! Accordingly, I have little doubt that this was a vasovagal episode consequent upon an unusual sequence of events. I have reassured him accordingly and discharged him to your care.”

[47] Professor Martin J Brodie is Professor of Medicine & Clinical Pharmacology at the University of Glasgow. He is also the Director of the Epilepsy Unit. He explained in evidence that in 1995 a system was set up and has since been in place to diagnose whether referred patients suffer from epilepsy. Patients can be referred to rule out that they are suffering from epilepsy so that they are not prescribed unnecessary medication. Professor Brodie emphasised that his role was to diagnose or exclude epilepsy. He was clear that his role did not go further than that in this specialist clinic to which Mr Logue was referred. Professor Brodie described the difference between epileptic seizures and other sorts of attacks including syncope. Professor Brodie pointed out that, in her letter dated 5 February 1998, Dr Wilson was not certain of her diagnosis. That was why she arranged for further investigations including a surface EEG and a CT brain scan. She also arranged for Mr Logue to be reviewed by Professor Brodie.

[48] Professor Brodie was emphatic that he had reached the correct diagnosis in respect of Mr Logue, which was that he had not had a seizure in the road traffic accident on 20 January 1998. Professor Brodie, who saw Mr Logue once some 17 years ago, pointed out that the time which had since elapsed without seizure proved his diagnosis to be correct. Professor Brodie stated that he had had little doubt that Mr Logue suffered a vasovagal episode consequent on an unusual sequence of events. He stated that he had “reassured Mr Logue accordingly” and discharged him to his general medical practitioner’s care. Professor Brodie did not attach any significance to the previous episodes of altered consciousness noted by Dr Wilson (see page 615). He also stated that everyone who has an episode of collapse should tell the DVLA about it and

added that a person should not be driving a bus if he was fainting. Professor Brodie confirmed that Mr Logue was told to inform the DVLA of the episode. Mr Logue was told not to drive. In the event, the DVLA did not seek any information directly from Professor Brodie: they sought a report from Dr Burman: Crown production 16, page 609.

Mr Logue's evidence regarding previous episodes, when recalled

[49] When recalled, Mr Logue was shown Dr Wilson's letter to Dr Burman. He was unable to say anything about an inner ear infection in 1995. He stated that he was not even sure if his wife was with him when he attended at the seizure clinic at the Western Infirmary. He recalled being sent to Professor Brodie but stated that he was "struggling to remember the consultation". So far as Dr Denison's note regarding an identical incident whilst on jury duty was concerned, Mr Logue accepted that he had served on a jury. He explained that the jury had deliberated and returned a verdict but that he was in the minority. This had played on his mind. He explained that he went home, felt terrible and sat down with a cup of tea. He was then was sick over the family dog. Once he had been sick, he felt fine. He maintained that he did not lose consciousness on this occasion.

An incident at work on 3 August 2004

[50] The procurator fiscal depute asked Mr Logue about an incident on 3 August 2004 at Larkfield Depot. Mr Logue said that he was leaning against a loose railing outside the snooker hall in the bus depot. Someone came out of the snooker hall and he (Mr Logue)

fell backwards striking his head against a wall. He said he felt dazed and sick as a result. Mr Logue was referred to Crown production 18 (First Bus health and safety incident report form HS60) at page 755 where it is recorded that: "Feeling unwell for 30 minutes prior to incident. Leaning on barrier then moved away from barrier then next thing remembers waking up on his back looking up." The form, which is signed by Mr Logue, records that he was taken to the Victoria Infirmary. Mr Logue stated that he did not remember going to hospital. He stated that he did not remember feeling unwell for 30 minutes prior to the incident. He stated that he was "pretty sure" it was an accident and not a faint. He maintained that he had a tendency to sign documents without reading them.

[51] When referred to an employee's report at page 717, Mr Logue emphasised that he was positive that he had not fainted. In this report a fellow employee, Stephen O'Reilly (non-witness), had stated "On Tuesday, 3rd August I had just finished my shift and came into the garage and I was talking to Davie Logue then all of a sudden he felt faint and collapsed banging his head off the concrete." Mr Logue did not accept this account of events. He suggested that Mr O'Reilly "may have been badgered" into making the statement. Mr Logue asserted that Mr O'Reilly had leant against the fence. Mr Logue could not remember if he had been knocked out for a few seconds. He accepted that he did not tell the DVLA about the incident because he did not think it was necessary to do so.

[52] Mr Logue was taken to the Victoria Infirmary with a minor head injury at work. He attended but did not wait to be seen: Crown production 17, page 602. He did not

report loss of consciousness. He was seen by a medical officer at his employers on 9 August 2004 (Crown production 5, page 84). He advised “KO when fell against wall at work on 1/8/04. Vomited x 2 on way to hospital (Victoria)”. There is no record of loss of consciousness. He was deemed fit to work. Mr Logue accepted that he had been given a formal oral warning regarding his attendance levels at work on 3 June 2004, when he was advised that an immediate and sustained improvement must be made in respect of attendance levels and that his performance would be monitored over the next few months.

[53] Mr Logue did not offer any explanation why Mr O'Reilly would invent a false accident report in respect of him. He accepted that Mr O'Reilly had been present during the incident. He offered no reason for Mr O'Reilly being badgered into making such an invented report. Steven Neilson, the employer's Service Provision and Reliability Officer had over 13 years' service with them, having started off as a bus driver. He could not understand why an employee would be pressured into giving a false account of an incident at work and pointed out that for an employee to do so would be disciplinable.

The second previous bus accident on 6 June 2008

[54] On 6 June 2008 Mr Logue had another episode of loss of consciousness whilst engaged in the course of his employment driving a bus. Mr Logue stated that he drove a bus into the back area of the garage. There was a trainee doing a reversing manoeuvre with a bus. Mr Logue stated that he reversed up and stopped his bus to let the trainee

finish his manoeuvre. Mr Logue stated that he felt dizzy and that was the last thing he remembered. He stated that he was still in the driver's seat when he awoke. He had crashed into another bus. He was taken to the Accident & Emergency Department at the Victoria Infirmary, Glasgow. The discharge letter to the general practitioner is contained in the GP records (Crown Production 17) at page 595. This records "LOC at wheel of bus" and that Mr Logue was "well" and "fit for home". It also recorded that he would be followed up in the Syncope Clinic.

[55] The records of the Victoria Infirmary Accident & Emergency Department are contained within Crown Production 8 at pages 317/320. The doctor (Browne) who took these notes was not led as a witness at this Inquiry. The notes record that on 6 June 2008 at 10.30 a history was taken from Mr Logue. The note states:

"Syncope whilst driving bus.
Not eaten since 9 am yesterday morning (on a "diet"!). Had diarrhoea last night – 3 large volume watery movements. No sickness/vomiting.
Woke today 0530 hours for work – bus driver. Had usual cup of tea then into the bus. Was driving in the garage, without warning passed out at the wheel resulting in him hitting another parked bus. Denies chest pain, tightness or palpitations preceding, no prodromal features. ?duration LOC. When he came round felt discomfort lower chest/epigastria and nauseated. Orientated. No chest pain/palpitations. No tongue biting or urinary incontinence. Small vomit in back of ambulance on way to Vic Inf, A&E.
No previous medical HX.
Nil allergies, nil meds.
Smoker 40cpd.
Occasional alcohol only."

[56] On 17 June 2008 Mr Logue was seen by Dr John Byrne, Consultant Cardiologist, at the Syncope Clinic. The history recorded by Dr Byrne is found at pages 315/316A. Dr Byrne remembered seeing Mr Logue. Following upon this consultation, Dr Byrne

reported to the responsible referring consultant and to others, including Mr Logue's GP.

This letter comprises Crown production No 8, pages 313/314, which echoes the terms of his notes. Dr Byrne wrote:

"He (Mr Logue) attended the Victoria Infirmary A&E on the 6th June 2008. He had been feeling a bit off colour for several days. This coincided with a period where he was restricting his dietary intake in order to try and lose weight. The day before the syncopal episode he had mild diarrhoea, and as a result only had a sandwich during the entire day. On the following day (Friday 6th June 2008) he went into work having only had a cup of coffee to drink. He recalls that he felt slightly dizzy before he got into the bus, and this got abruptly worse as he was driving it through the depot. It seems he blacked out and collided with another vehicle. He came round quickly afterwards and there was no evidence of incontinence or tongue biting. He then began to feel dizzy again and had to sit down. He was picked up by ambulance but felt nauseous and vomited. He was given intravenous fluids and felt immediately better. He has been well in the 10/11 days since then.

Mr Logue now reports that he had investigations at the Western Infirmary and Gartnavel 11-12 years ago following some kind of blackout. It sounds as though this focused on neurological investigation including EEG. He says that his driving licence was suspended at the time. There has been no recurrence since then, and there is no other family history of note. He is on no medication."

[57] In this letter, dictated shortly after his consultation with Mr Logue, Dr Byrne advised that he thought "it is very likely that this chap's recent syncopal attack was almost certainly vasovagal, perhaps triggered by inadequate dietary and fluid intake. I have advised him accordingly for future reference." Dr Byrne confirmed that he had told Mr Logue that dehydration was a possible trigger for the vasovagal attack and that he would have advised him to maintain a good fluid level and to be particularly conscious of the need to do so if he were unwell.

[58] On 29 August 2008 in response to a request from DVLA, Dr Byrne completed a *pro forma* DVLA medical report in respect of Mr Logue advising that the episode of 6

June 2008 had been attributed to a simple faint. There was no obvious space on the DVLA form to include further information regarding the circumstances of the accident. Dr Byrne did not send an accompanying letter advising the DVLA that Mr Logue was driving a bus at the time of the episode when he returned the report.

[59] Dr Byrne was asked whether two faints at the wheel indicated a driver who would put others at risk. He replied: "Absolutely". Dr Byrne noted that the history given to him was different to that recorded by Dr Browne. During examination Dr Byrne was taken through Mr Logue's recorded previous medical history. Dr Byrne, who had unsuccessfully sought Mr Logue's medical records, was not aware of previous dizziness or apparent similar episodes. He said that this information would have altered the view which he formed in 2008 because this information increased the risk of recurrence.

Mr Logue's evidence regarding the incident of 6 June 2008, when recalled

[60] On 29 June 2015, Mr Logue was asked by the procurator fiscal depute about the incident on 6 June 2008. Under reference to the 1998 incident and another alleged incident in 2004, Mr Logue was asked if he was concerned about whether this was going to keep happening. He replied: "Yes. I was". He was examined about the information which he had given to the DVLA. Under reference to Crown production 6 at pages 159/160, he accepted that he had advised the DVLA: "6/6/08. Had been unwell for a week and was suffering from diarrhoea when I fainted". Mr Logue was asked about going to hospital and stated that he could not remember the name of the doctor he saw.

He accepted that the DVLA by letter dated 20 October 2008 (Crown production 5, page 51) advised him that he was allowed to retain his licences. In answer to the procurator fiscal depute, he stated that the diagnosis was “high blood pressure” and that he went on medication as a result. He stated: “I had thought that my driving days were over. I don’t recall what the doctor said”.

[61] During examination by counsel for the family, Mr Logue stated that he had not been having dizzy turns before he got into the bus. He stated that: “(he) had been in the bus for a couple of hours”. He stated that: “I think he’s (Dr Byrne) misinterpreted me”. He emphasised that he was “quite certain” that he was not dizzy before he got into the bus. He also stated that: “If I had felt dizzy before I came to work, I wouldn’t have come to work”. After lunch, Mr Logue again asserted that this was a misunderstanding and that he had not been dizzy when he got into the bus. When asked by counsel whether Dr Byrne had told him that his dietary and fluid intake had contributed to the episode, Mr Logue replied: “I believe so”. Counsel then said that he was “returning” to the accident of 6 June 2008. Mr Logue stated that he “was sitting at traffic lights and felt dizzy. I was sitting at traffic lights and I passed out”. Mr Logue confirmed that he had had nothing to eat in the 24 hours to the accident. He said that he did not know if he was dehydrated. He also said that he did not know whether he had told his then general practitioner Dr Burman (non-witness) whether he was having dizzy turns in 2008.

[62] When examined by the solicitor for the bus company, Mr Logue was referred to Crown production 18 at pages 1004/5. Mr Logue confirmed that this was a record of a

Preliminary Investigation regarding the accident on 6 June 2008 which took place on 6 June 2008 at 12.30 hours, some 3.5 hours after the accident. The account given by Mr Logue in that transcript accords with his account that he had been driving for some 2.5 hours before he returned to the bus depot. This account is not consistent with Mr Logue being dizzy before the accident.

Evidence relating to First Glasgow (No.1) Limited

[63] On 20 January 1998 when the first previous bus accident occurred Mr Logue was employed by Strathclyde Buses Limited. The notes taken by Inspector Benjamin relating to this incident are contained within the First Glasgow (No.1) Limited personnel file relating to Mr Logue (Crown production 18 at pages 669/70).

[64] Mr David Phillips, who was General Manager at the time of Mr Lochrie's death, spoke to the contractual responsibility of employee bus drivers such as Mr Logue to report for work when fit and capable. He stated that it was a responsibility of an employee bus driver to inform the bus company of anything which might affect his ability to drive. Mr Phillips confirmed that Mr Logue had not been in radio contact on the morning of 31 March 2012. Mr Phillips was not aware of any problem regarding lack of toilet facilities. He explained that a driver could request a toilet stop. He stated that there was no difficulty about it but it was necessary to let passengers and prospective passengers know of the delay. Mr Steven Neilson, Service Provision & Reliability Officer, gave evidence to the same effect regarding toilet breaks.

[65] Dr Kenneth Lyons is a retired general practitioner with some 35 years of experience. For some years he has been the company doctor of First Glasgow (No 1) Limited. In 1984 he became company doctor to Strathclyde Passenger Transport Executive and has since served with their successor bus companies. In answer to the procurator fiscal depute, Dr Lyons stated that his duties as company doctor included dealing with PCV licence renewals, health surveillance, fitness to drive and sick list management. It became clear that the extent of the health surveillance was in respect of hearing tests. Dr Lyons stated that he considered that he would need written permission from an employee licence holder before he could contact the DVLA in regard to that employee. Dr Lyons stated that First Glasgow (No 1) Limited did not carry out any routine medical examination of their bus drivers. Dr Lyons stated that he did not have access to any employee's general medical practitioner's records. Dr Lyons stated that he did not have access to the bus company's personnel file on any employee.

[66] Dr Lyons did see and examine employees and advise management on an employee's fitness to return to work. But, as he explained during cross examination, he relied upon the employee's general medical practitioner and the DVLA to investigate the matter of fitness to drive. Dr Lyons stated that if the DVLA assessed a licence holder as suitable to hold a licence that was "good enough for me". He stated that in his experience as a general medical practitioner, he knew that the DVLA would write to a licence holder's general medical practitioner and specialist.

[67] Dr Lyons first met Mr Logue in 1998 following upon the first bus incident. He was involved in advising management as regards Mr Logue's fitness to return to work.

He advised upon the basis of the medical reports which he received from the general medical practitioner and the decision of the DVLA. Dr Lyons did not see Mr Logue in connection with the incident at work on 3 August 2004. He thought that a Dr Coyle saw Mr Logue at that time.

[68] On 10 June 2008, following the second bus incident on 6 June 2008, Dr Lyons saw Mr Logue. His notes of that consultation form Crown production 5 at pages 73/4. Dr Lyons has recorded that Mr Logue told him that he had become “very dizzy (had diarrhoea)”. Dr Lyons also recorded that: “(I was told that this happened before)”. He explained that Mr Logue had told him this at the consultation.

[69] On 3 July 2008 Dr Lyons met with Mr Logue. Dr Lyons’ note of this consultation comprises page 69 of the same production, which records: “Went to specialist and dehydration was the diagnosis”. Dr Lyons took appropriate steps to confirm the position with Dr Burman. Later, once the DVLA had reached its decision that Mr Logue could continue to drive, a colleague of Dr Lyons so advised the bus company’s management. Dr Lyons saw Mr Logue on 30 October 2008 before the DVLA decision was available but did not see him again until after the accident resulting in Mr Lochrie’s death.

The DVLA and its involvement prior to the accident on 31 March 2012

[70] Dr Gareth Wyn Parry has been the Senior Medical Adviser to the DVLA since about April 2014. He was formerly a surgeon and had not previously worked for the DVLA. Dr Wyn Parry explained the statutory system in place in the United Kingdom,

which places on the Secretary of State for Transport acting through medical advisers at the Drivers Medical Group, DVLA, the responsibility to ensure that all licence holders are fit to drive.

[71] In the United Kingdom, as in many parts of the world, a self-notification system operates whereby it is the responsibility of the individual licence holder to report to the DVLA any notifiable disability. Reference was made to section 94(1) of the Road Traffic Act 1988, as amended, which states: "If at any time during the period for which his licence remains in force, a licence holder becomes aware-(a) that he is suffering from a relevant or prospective disability which he has not previously disclosed to the Secretary of State, or (b) that a relevant or prospective disability from which he has at any time suffered (and which has been previously so disclosed) has become more acute since the licence was granted, the licence holder must forthwith notify the Secretary of State in writing of the nature and extent of his disability". In terms of section 94(3) a person who fails without reasonable excuse to notify the Secretary of State as required by subsection (1) above is guilty of an offence. Section 94(3A) states: "A person who holds a licence authorising him to drive a motor vehicle of any class and who drives a motor vehicle of that class on a road is guilty of an offence if at any earlier time while the licence was in force he was required by subsection (1) above to notify the Secretary of State but has failed without reasonable excuse to do so".

[72] During examination by counsel for the Lochrie family, Dr Wyn Parry stated that he was unaware of any prosecution ever having been brought in the United Kingdom for giving false information to the DVLA. There was no evidence before this Inquiry as

to whether there have been prosecutions for breach of either section 94(1) and (3) or section 94(1) and (3A) i.e. failure to notify. At the conclusion of closing speeches, the procurator fiscal depute helpfully provided information that in the period from 2002 to mid-2015 there had been 1412 prosecutions under section 94 and, in particular, 20 prosecutions for contraventions of section 94(3)(A).

[73] Section 92 of the Road Traffic Act 1988, as amended, refers to prescribed, relevant and prospective disabilities. A prescribed disability is one that is a legal bar to the holding of a licence to drive. A relevant disability is any medical condition that is likely to render a driver a source of danger while driving. A prospective disability is any medical condition which because of its progressive or intermittent nature may develop into a prescribed or relevant disability in the course of time.

[74] Dr Wyn Parry stated that he would not expect every member of the public to know what conditions to report to the DVLA. His evidence was that he would not expect members of the public to know if they were suffering from a relevant disability unless they were told by a doctor. However, during his evidence, he also made it clear that the DVLA had a telephone helpline and a website to assist licence holders on this matter.

At a glance Guide to the current Medical Standards of Fitness to Drive

[75] The Drivers Medical Group, DVLA issue for medical practitioners an “At a glance Guide to the current Medical Standards of Fitness to Drive”. This publication summarises the National Medical Guidelines of Fitness to Drive. The information in the

booklet is intended to assist doctors in advising their patients whether or not they should inform DVLA of their medical condition and what is the likely outcome of medical enquiries. The booklet emphasises in bold type: “In the interests of road safety, those who suffer from a medical condition likely to cause a sudden disabling event at the wheel or who are unable to safely control their vehicle from any other cause should not drive”. The DVLA website contains this summary of the national medical guidelines of fitness to drive.

National Medical Guidelines of Fitness to Drive

[76] The Secretary of State for Transport has Honorary Medical Advisory Panels, which consist of doctors eminent in the respective fields of Cardiology, Neurology, Diabetes, Vision, Alcohol/Substance Abuse and Psychiatry together with lay members. Over many years these panels have advised successive Secretaries of State for Transport, who have published National Medical Guidelines of Fitness to Drive. The Panels meet twice yearly when the standards are reviewed and, if appropriate, updated.

The DVLA process in respect of deciding upon a licence holder's fitness to drive

[77] Dr Wyn Parry has responsibility for 21 other doctors employed by the DVLA and around 200 non-medical staff. The medical advisers require to review the information submitted to the DVLA, and make decisions as to the fitness to drive of individual licence holders by applying the National Medical Guidelines. This is essentially the

system which has been in place for some years although since Dr Wyn Parry's arrival the operation of the system has been reviewed.

[78] Dr Wyn Parry explained that once a notification regarding fitness to drive was received at the DVLA a form FEP1 would be sent to the licence holder for completion. The form was designed to elicit "Yes/No" information which would be followed up at the DVLA. Once the completed form was received the DVLA would assess the form and make appropriate medical inquiry. There was discussion of the DVLA forms and the lack of space for other than "tick box" replies. Dr Wyn Parry explained that the DVLA has never sought information from employers of licence holders regarding fitness to drive nor disclosed information to employers. As his evidence progressed, it became clear that in some cases in the past the information upon which medical advisers at DVLA have reached decisions as to a licence holder's continuing fitness to drive has been somewhat limited.

The DVLA records in respect of Mr Logue

[79] Dr Wyn Parry had examined the DVLA's records relating to Mr Logue. He was able to confirm that on 30 April 1998 Mr Logue first informed the DVLA by telephone of a medical condition of blackout. Under reference to Crown production 6 at various pages between 119 and 135, Dr Wyn Parry advised that the records confirmed that correspondence from Mr Logue's general medical practitioner Dr Burman indicated that the results of investigations relating to this blackout had been normal. After completion of inquiries Mr Logue was allowed to retain his car licence and his vocational licence

was issued for one year. The reasoning for these decisions was based upon the then current (1995) medical standards as set out in the DVLA publication "At a glance Guide to the current Medical Standards of Fitness to Drive". Mr Logue applied to renew his vocational licence in May 1999. Once inquiries were completed his vocational licence was reissued.

[80] Dr Wyn Parry confirmed that the next contact the DVLA had from Mr Logue was when he telephoned on 20 June 2008 to advise he had fainted at work "believed due to dehydration". DVLA began a medical inquiry. A F2C questionnaire was completed by Dr Byrne stating the opinion that Mr Logue had suffered a simple faint. There was no inquiry made of Mr Logue's general medical practitioner. Mr Logue was allowed to retain his car and vocational licences after consideration by caseworkers in the DVLA applying the then current (2008) "At a glance Guide to the current Medical Standards of Fitness to Drive".

[81] Counsel for the Lochrie family went through the actual information given to the DVLA in 1998 and 2008 by Mr Logue and various doctors in some detail. Under reference to Crown productions 6 at page 119 and 17 at page 663, it was confirmed that the DVLA were not informed by Mr Logue that he had suffered "dizzy turns" in 1998. Mr Logue did not report "dizzy turns" to the DVLA prior to the accident which resulted in Mr Lochrie's death. Dr Wyn Parry accepted that at no part of the F1 form sent to Mr Logue in 1998 was he required to provide information as to where the episode had occurred. The form did not require Mr Logue to state whether the episode had occurred whilst he was driving.

[82] Counsel also put to Dr Wyn Parry detailed questions regarding information about Mr Logue which was not known to the DVLA in respect of particular incidents. Where he could assist, on the basis of the additional information to which counsel drew attention, Dr Wyn Parry was prepared to express views on the application of the medical guidelines in force at particular times and the decisions which he considered would have been reached in respect of Mr Logue's fitness to drive.

The evidence from general medical practitioners

[83] Dr Julia Cree commenced employment with Dr Iain Kennedy in November 2011 and, at that time, Mr Logue became one of her patients, although Dr Kennedy remained as his NHS referred general practitioner. She first saw Mr Logue on 4 November 2011. Dr Cree stated that she had seen Mr Logue's medical records but pointed out that as she had only 10 minutes allocated for his appointment, she had not time to go through "every single thing". Her record of this consultation is contained in Crown production 17 at page 535. At this time Mr Logue was in receiving prescribed medication, namely, Simvastatin and Ramipril. As noted at paragraph [33] above, Dr Julia Cree saw Mr Logue at one of Dr Kennedy's practices on 4 April 2012. Dr Cree stated that Mr Logue did not mention previous dehydration to her. She also stated that he had not told her about suffering dizzy spells on 4 April 2012. Dr Cree stated that she was clear that Mr Logue had not told her about dizzy spells but did tell that he had had a blackout 4 years previously. She did not remember him being overweight. She later wrote to the DVLA on Mr Logue's behalf: Crown production 15 at page 493. She accepted that she would

not have written to the DVLA in these terms had she seen Dr Rae's letter dated 21 June 2012: Crown production 15 at page 491.

[84] Dr Laura Cormack has been a general medical practitioner since 2009. She was employed as a long term locum on a part-time basis by Dr Kennedy, who, she explained, used locums regularly whilst he was not at the practice. She also explained that it was not usual for her to see a patient more than once. Her evidence centred mainly on the prescription of Ramipril to Mr Logue. She explained that syncope was not a contra-indicator to the prescription of Ramipril. She was unable to think of any patient in her experience who had suffered syncope as a result of taking Ramipril. She also confirmed that she had not given any advice to Mr Logue regarding avoiding dehydration.

[85] Dr Iain Kennedy is a 53 year old general medical practitioner, who carries on practice at 43 Hyndland Street, Glasgow and at Springburn Health Centre. Dr Kennedy took over Dr Burman's practice when he retired on 31 July 2008. Mr Logue had been a patient of Dr Burman and once he retired Dr Kennedy saw Mr Logue "on and off over the years". The procurator fiscal depute took Dr Kennedy through Dr Burman's medical records. Dr Kennedy was of some assistance in trying to interpret Dr Burman's handwriting. There was no note in the records of Dr Burman having discussed Dr Byrne's letter with Mr Logue. Dr Kennedy first saw Mr Logue on 8 August 2008. He had no recollection of the discussion which then took place but the consultation was directed to the matter of Mr Logue being off work. Dr Kennedy lost no opportunity to inform the court of matters which he considered "you should be aware". He gave unsolicited positive character references to Dr Cree, Dr Cormack, Dr Burman and

Mr Logue. Dr Kennedy did accept that hydration is “probably something that, as gps, we should be giving more advice on”. He also raised the question as to whether patients actually read the information leaflet which comes with all prescribed drugs.

An outline of the closing submissions of the procurator fiscal, the family of Mr Lochrie and other represented parties

[86] The procurator fiscal depute submitted that formal findings should be made in terms of section 6(1)(a) and (b) of the 1976 Act. In his proposed finding in terms of section 6(1)(b) the procurator fiscal depute suggested that it was appropriate to determine that Mr Logue lost consciousness whilst driving the bus. The lawyers for all of the parties represented were content to accept that it had been established that Mr Logue had lost consciousness whilst driving the bus. But they were not at one as to what, if any, cause of his loss of consciousness had been established on the evidence.

[87] The procurator fiscal depute submitted that there should be no finding in terms of either section 6(1)(c) or (d). He submitted that there were other facts which were relevant to the circumstances of Mr Lochrie’s death in terms of section 6(1)(e). Counsel for the Lochrie family sought findings in terms of each paragraph of section 6(1)(a) to (e), inclusive. The solicitor for Mr Logue submitted that findings should only be made in terms of section 6(1)(a) and (b). He submitted that on the basis of the acceptable evidence led no other finding should be made. Ms McDonnell for First Glasgow (No 1) Limited made the same invitation, as did Mr O’Reilly for Greater Glasgow Health Board. Mr Olsen, Advocate for DVLA, stated that he was not inviting the court to make

any finding beyond section 6(1)(a) and (b) but he did comment on the procurator fiscal's submission in respect of section 6(1)(e).

The closing submission of the procurator fiscal

[88] The procurator fiscal depute submitted that no finding should be made by the court in terms of section 6(1)(c) of the 1976 Act, which relates to the reasonable precautions, if any, whereby the death or the accident resulting in Mr Lochrie's death might have been avoided. He submitted that, on the acceptable evidence, there was no reasonable precaution which could have been taken to avoid Mr Logue having a syncope on 31 March 2012. He submitted that it was not clear on the evidence what had been the cause of the syncope and so it was difficult to identify reasonable precautions to prevent it happening. He submitted that there were three factors to be considered: dehydration; Ramipril; unknown factors; and any combination of them.

[89] The procurator fiscal pointed to the evidence of James Findlay, who did not see anything in Mr Logue's demeanour to say that he was dehydrated, although he accepted that dehydration was a difficult matter to assess. Dr Cree spoke to Mr Logue's blood results from the morning of 31 March 2012 (Crown production 8 at page 325) and stated that there was nothing there to show dehydration. Professor McKay stated that there was not any way of checking for dehydration.

[90] So far as the first previous bus accident on 20 January 1998 was concerned, the procurator fiscal depute submitted that the evidence of Professor Brodie should be accepted. He further submitted that Professor Brodie's opinion that Mr Logue had had a

vasovagal episode consequent upon an unusual sequence of events, as set out in his letter to Dr Burman dated 19 March 1998, was the most likely explanation and should be held established.

[91] So far as the second previous bus accident on 6 June 2008 was concerned, the procurator fiscal depute submitted that Dr Byrne's diagnosis was "not emphatic": he was "almost certain" that Mr Logue had suffered a vasovagal episode "perhaps triggered by" dehydration. The procurator fiscal depute accepted that Mr Logue had never been told that the vasovagal episode on that date was blood pressure related. He submitted that Mr Logue was a credible witness who had become confused and unreliable in his recollection on this matter. The procurator fiscal depute accepted that Mr Logue should have followed Dr Byrne's advice.

[92] The procurator fiscal submitted that Dr Byrne's evidence was "authoritative and reasonable" and it was not being suggested that Dr Byrne should have further referred Mr Logue. It was accepted that Dr Byrne's purpose was to try and get to the bottom of the vasovagal episode and not to do "an overall health review". He pointed out that Dr Byrne had not felt that Mr Logue was hiding anything from him.

[93] So far as the accident on 31 March 2012 was concerned, the procurator fiscal referred to the evidence of Professor McKay and to his letters in Crown production 9 at pages 382, 354 and 351 where his diagnosis was tentative.

[94] The procurator fiscal submitted that that on the evidence led it could not be affirmed what caused Mr Logue to faint in 1998, 2008 or 2012. He submitted that the evidence of Dr Rae echoed that of Dr Byrne and that vasovagal episodes were very

difficult to predict and were too unpredictable to prevent Mr Logue fainting. Dr Byrne stated that some people had a tendency to faint. It was recognised that Mr Logue had been sitting down when he fainted in 1998, 2008 and 2012 but there was nothing in the evidence to show what the cause of each episode was, far less that there was any reasonable precaution whereby this could be avoided on 31 March 2012. Dr Cormack and Professor McKay were agreed that Ramipril was less likely than other hypotensive drugs to cause fainting and was unlikely, by itself, to be the cause of a faint.

[95] The procurator fiscal depute further submitted that there were no reasonable precautions which could have been taken to prevent Mr Logue from having driven on 31 March 2012. So far as the 2008 incident was concerned, the procurator fiscal stated that Dr Byrne had concluded that this was a simple faint. He accepted that had Dr Byrne known about other episodes he would not have assessed Mr Logue as having suffered a simple faint when he reported to the DVLA. Under reference to Crown production No 24 at page 1163, Dr Byrne was applying the Guidelines issued in February 2008. He had assessed Mr Logue as falling within box 1 but accepted that he might now have reassessed him as falling within box 3 with the result that Mr Logue would have had to go off the road for about one year. Under current Guidelines, as contained in Crown production No 30, Mr Logue would have fallen within the new box 6. However, even if Mr Logue had gone off the road for one year, there was no evidence to support the conclusion that he would still have been off the road at the time of the accident on 31 March 2012.

[96] The procurator fiscal submitted that the evidence of Mr Logue should be accepted. He stated that Mr Logue was “forthright” and “did his best to assist this inquiry”. The procurator fiscal depute did not attack but rather supported Mr Logue’s credibility. He submitted that during his evidence Mr Logue displayed clear compassion and remorse: he was in tears as he did so. He regarded Mr Logue as a reliable witness, whose evidence should be accepted. He pointed out that no medical witness who had dealt with Mr Logue had considered that he was hiding anything from them. Mr Logue had reported the 1998 and the 2008 accident to the DVLA. He had attended when required to do so for medical examination. He had awaited the DVLA decision and after both the 1998 and the 2008 incidents, he had been allowed to continue driving. There were no reasonable precautions which would have prevented Mr Logue from driving the bus on 31 March 2012.

[97] The procurator fiscal depute submitted that in terms of section 6(1)(d) there was no defect in any system of working which contributed to Mr Lochrie’s death or the accident which resulted in his death. He submitted that First Glasgow (No 1) Limited, their predecessors and Dr Lyons were content to be guided by the DVLA, who had the statutory responsibility for determining Mr Logue’s continued fitness to drive. Dr Lyons’ function was to make assessments and prepare a report for management. In 1998 before recommending that Mr Logue return to work, Dr Lyons had checked with Professor Brodie. Again, in 2008 the incident had been reported to the DVLA: Mr Logue was only allowed to return to driving once the DVLA had decided that he could continue to hold a licence to drive. The procurator fiscal depute submitted that the

employers had an adequate system for assessing fitness of their drivers to drive buses and that no defect in their system had been identified which had contributed to the accident resulting in Mr Lochrie's death. The procurator fiscal depute also submitted that there was simply no evidence to justify any finding that there had been any defect in the system of working operated by the DVLA which contributed to Mr Lochrie's death or the accident which resulted in his death.

[98] The procurator fiscal depute submitted that in terms of section 6(1)(e) of the 1976 Act, there were facts which were relevant to the circumstances of Mr Lochrie's death. He submitted that the DVLA forms to which reference had been made during the inquiry could be improved. He referred to Crown production 6 at page 188. He suggested that it should be routine for the licence holder's occupation to be stated on the form. He also suggested that there be a question asking whether the incident arose in the course of the licence holder's occupation. He suggested a further question "Did this happen whilst driving?" He also suggested that there should be a question enquiring whether the incident occurred whilst standing or seated. The procurator fiscal depute suggested, under reference to Crown production 6 at page 192, that the form could reflect the new box 6 at page 17 of the Guide to the current Medical Standards of Fitness to Drive (November 2014) but he accepted that Dr Wyn Parry had not been asked about this. The procurator fiscal depute submitted that the medical forms could also be improved and he suggested that full details should have to be given as the forms, for example Crown production 6 at page 167/8, were "very stark and basic".

[99] The procurator fiscal depute under reference to the National Medical Guidelines of Fitness to Drive submitted that it would be appropriate for the DVLA to consult with the General Medical Council and medical bodies with a view to clarifying whether the present system for notifying prescribed relevant and prospective disabilities and information gathering for medical advisers could be improved.

[100] The procurator fiscal depute advised that the penalty for a breach of section 94 of the Road Traffic Act 1988, as amended, was a fine of an amount up to Level 4 and 3-6 penalty points with discretionary disqualification. He submitted that it was not for the Crown Office & Procurator Fiscal Service to make any submission in relation to the level of appropriate penalty, that being a matter for Parliament. He also stated that he was making no submission in respect of the way Mr Logue was dealt with by the police on 31 March 2012. He expressed his condolences to the Lochrie family and stated that throughout the family and their legal advisers had conducted themselves with courtesy, dignity and respect. He also thanked the lawyers for the represented parties for their cooperation and their conduct at this inquiry.

The closing submission of counsel for the Lochrie family

[101] I am indebted to Mr Murray for preparing a most comprehensive and detailed written submission, which extended to 30 typewritten pages. Rather than add to the length of this determination by repeating it in full, I have appended a copy of it to the determination. At the outset, counsel helpfully provided a synopsis of the position he advanced and what he sought in the determination. As he read it to the court, counsel

took the opportunity to clarify some points. I now set out the synopsis of the position and the determination sought:

Synopsis

David Logue has a medical condition of recurrent syncope episodes (blackouts). Prior to the fatal accident on 31 March 2012, he had two of these episodes whilst driving a bus in the employment of First Bus. Evidence was led of another fainting episode at work in 2004.

Once is happenstance, twice might be coincidence, three times is a pattern.

By 2008 at the latest, it ought to have been apparent to Mr Logue and anyone with access to his medical or occupational health records that this was a recurrent problem. The episodes in 1998 and 2008 were particularly significant because he was at the wheel of a PCV. It is more difficult to faint when sitting or driving.

First Bus say that the DVLA were responsible for certifying him fit to drive a PCV, but they employed Mr Logue and put the keys to a bus in his hand. Their medical officer, Dr Lyons, said that it was for Mr Logue's GP to provide information to the DVLA. He abdicated any responsibility for the safety of employees or the public. First Bus failed to bring the 2004 incident to the attention of any medical practitioner or the DVLA. The DVLA decisions were based on information provided to them, which was materially deficient. It is not possible to be too critical of the DVLA decisions because their records are hopelessly incomplete. Mr Logue's GPs, Dr Burman and Dr Kennedy, did not correspond at all with the DVLA. Dr Kennedy said that it was primarily the responsibility of First Bus and their medical officer to provide information to the DVLA; and for First Bus to make decisions about Mr Logue's fitness to drive.

The months after the episode on 6 June 2008 were effectively the last best opportunity for First Bus, Dr Lyons, the GPs or the DVLA to examine Mr Logue's case and make a decision which would have prevented him from driving on 31 March 2012. Each of them failed in their responsibilities in different ways and each contributed to Mr Logue driving a bus on 31 March 2012. Primary responsibility for the death rests with Mr Logue.

2 *Determination*

The court is invited to make the following determinations, under s. 6(1) of the Fatal Accidents and Sudden Deaths Inquiries (Scotland) Act 1976:

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

James Lochrie died on 31 March 2012 at around 0801 hours at Cathcart Road, near Aitkenhead Road in Glasgow.

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

James Lochrie died when he was struck by a southbound white coloured Volvo Olympian double deck PCV bus, registration R153 EHS ('the bus'). The bus was travelling route number 31 East Kilbride Bus Station. The bus was driven by David Logue, an employee of First Glasgow (No. 1) Limited, 197 Victoria Road, Glasgow, G42 7AD. Mr Logue began route 31 at around 0627 hours. At around 0800 hours, he approached the junction of Cathcart Road and Aitkenhead Road. At the lights, he lost consciousness. The bus continued along Cathcart Road. At a point around 20 metres from the lights, the bus mounted the offside kerb. The bus struck a bus stop around 50 metres from the junction. James Lochrie was waiting in the bus stop as the relief driver on the route 31. The bus struck the bus stop and James Lochrie. It continued along the pavement, coming to rest approximately 70.5 metres from the junction. James Lochrie was trapped under the bus. He was completely unresponsive to witnesses moments after the accident. It is likely that he died, or at least was rendered completely unconscious, instantly.

Moments before the collision, David Logue lost consciousness as a result of a syncope vasovagal attack. He had experienced two previous syncope vasovagal attacks with loss of consciousness whilst driving at work, on

20 January 1998 and 6 June 2008. Both previous attacks resulted in collisions. He also lost consciousness as a result of syncope attacks in 1996 and 2004. On the latter occasion, he fainted at work and required medical treatment for a minor head injury.

There were no defects in the bus which caused or contributed to the accident.

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

- (i) David Logue could have, on any number of occasions, informed his GP, his treating physicians, his employer and/or the DVLA, of episodes of dizziness and loss of consciousness. As his evidence is unreliable and incredible, it cannot be known how many episodes were not reported. There is evidence of a failure to report 2 or 3 episodes in 1995 and 1996 and one episode in 2004. Had Mr Logue been candid about his (known) medical history, he would not have held a PCV licence on 31 March 2012.
- (ii) Mr Logue could have relinquished his PCV licence prior to 31 March 2012.
- (iii) Professor Brodie could have made a referral to cardiology in March 1998. On his own evidence, had there been more than one syncopal episode, he would have made that referral. He was aware of two previous episodes.
- (iv) Professor Brodie could have properly documented a previous syncopal episode in his correspondence. He failed to record the “identical episode” on jury duty 2 years previously. That failure resulted in the creation of an inaccurate medical history.
- (v) First Bus could have provided their medical officer with a copy of the accident report dated 3 August 2004. Had a detailed referral been made, or had the GP been given the accident report, Mr Logue’s false report of the accident might have been investigated. First Bus did not let its left hand know what its right hand was doing.

- (vi) First Bus had no routine assessment of an employee driver's fitness to drive. Had the First Bus medical officer routinely examined Mr Logue, the medical condition of recurrent syncope episodes might have been identified.
 - (vii) The First Bus medical officer did not carry out a critical review of the occupational health records in assessing Mr Logue's fitness to drive. A pattern of syncopal episodes could have been identified earlier.
 - (viii) The First Bus medical officer could have corresponded with the DVLA regarding Mr Logue's fitness to drive (in 1998, 2004 and/or 2008).
Dr Lyons said only the DVLA could take a driver off the road, but he had no idea what information had been submitted to the DVLA or the basis of their decisions.
 - (ix) First Bus could have spoken to Mr Logue or instituted disciplinary action in respect of his reporting for driving duties on 20 January 1998 and 6 June 2008 after experiencing dizzy spells. Mr Logue was apparently in breach of their Driver's Handbook rule on reporting for work.
 - (x) Mr Logue's GP (both Dr Burman and Dr Kennedy) could have corresponded with the DVLA. Dr Kennedy in particular ought to have been alert to Mr Logue's tendency to mislead others about his medical history. Had Dr Kennedy recognised that, on his own evidence, he would have reported it to the DVLA.
 - (xi) The notification to the DVLA by Mr Logue and/or by Dr Byrne could have stated that the episode on 6 June 2008 occurred at the wheel of a PCV and resulted in a crash. That information, material to the DVLA decision, was omitted.
- (d) *The defects, in any, in any system of working with contributed to the death or any accident resulting in the death*

- (i) The failure of First Bus to send the accident report of 3 August 2004 to their medical officer resulted in him recording an inaccurate medical history. An accurate medical history would have resulted in the DVLA reaching a different decision following the episode of 6 June 2008.
 - (ii) If Mr Logue's evidence that he did not drink much because of a perceived lack of toilet facilities whilst driving is accepted, there is either a lack of toilet facilities for drivers, or Mr Logue did not know what toilet facilities were available for drivers.
 - (iii) The failure of First Bus to correspond with the DVLA concerning the fitness of their employees to hold a PCV licence. First Bus appear to proceed on the assumption that it is the responsibility of the employee and their GP to provide information to the DVLA. First Bus ought to recognise that they share responsibility for the fitness of their employee PCV drivers, in particular because they may have information not known to the GP.
 - (iv) The DVLA do not give information about driver licencing to employers. Had such a system of notifying the employer of a PCV licence holder of medical unfitness to drive or their entitlement to drive a PCV, First Bus may have become more involved in monitoring their employee's fitness to drive.
 - (v) The failure of Mr Logue's GP to correspond with the DVLA. Dr Kennedy said that primary responsibility lay with First Bus and their medical officer. He said that he shared some of that responsibility, but could not identify any act by the GP practice discharging that responsibility.
- (e) *Any other facts which are relevant to the circumstances of the death*
- (i) First Bus failed to monitor their employee's entitlement to drive. Mr Logue did not hold a PCV licence between 20 June 1999 and 7 July 1999. That was following expiry of a 1-year licence, which was subject to

review on medical grounds. First Bus appear to have had no system in place to check the fitness of Mr Logue on expiry of that period or confirm that he was entitled to drive thereafter.

- (ii) Dr Burman wrote a letter to DVLA on 25 May 1999, advising them that Mr Logue was “absolutely free from symptoms including black-outs” and “there is no concern about his state of health and he is physically and mentally fit”. Dr Burman had not examined Mr Logue in 11 months. He was in no position to make those statements in relation to Mr Logue’s fitness to drive. Those statements resulted in the grant of a new licence to Mr Logue, commencing 7 July 1999.
- (iii) Mr Logue was prescribed Ramipril from 5 November 2010 to the date of the accident. It was known that a side effect of Ramipril is syncope. In the opinion of Professor McKay, the ingestion of Ramipril may have contributed to the syncope episode on 31 March 2012.
- (iv) An opportunity was missed by the investigating police officers to take a contemporaneous statement from Mr Logue. A statement taken shortly after the accident might have shed light on his apparent statement to Dr Buchanan in A&E that he had experienced “dizzy spells”.
- (v) The absence of a robust system of identifying and prosecuting those who give false information to the DVLA. There has never been a prosecution for giving the DVLA false information. Drivers, such as Mr Logue, are able to give misleading accounts to the DVLA with impunity.
- (vi) The DVLA forms sent to both licence holders and licence holders’ doctors failed to raise pertinent matters and were inadequate to obtain sufficient information surrounding the incident, previous episodes and relevant previous history on the licence holder to give medical advisers full and accurate information relating to matters relevant to a determination of continued fitness to drive; and the forms sent to doctors, including specialists, were not designed to enable the specialist to respond fully to

all relevant matters which might bear on the licence holder's fitness to drive.

[102] Counsel submitted that although Mr Logue's account of events on 31 March 2012 was not challenged, his evidence in relation to his medical history was largely incredible and unreliable. Counsel then made a detailed analysis of the evidence led at this inquiry in support of his submission that the evidence given by Mr Logue in relation to his medical history should be rejected which, because of its importance to counsel's various submissions, I set out in full:

"1995-6

In cross-examination, Mr Logue denied having dizzy spells at any time other than the episodes in 1998 and 2008. He said that he could not remember any episode in 1996 (which his wife reported) of going into a dream-like state [p. 140]. He said that the episode he consulted his GP about on 14 June 1996 was different from any episode reported by his wife [p. 655]. In cross-examination, Mr Logue said that he could not remember anything about episodes of dizziness prior to the episode on 20 January 1998. He accepted that he had been given an oral warning about his absence from work on 1 July 1996 [p. 795].

Mr Logue's evidence was inconsistent with his apparent report that he had "an identical episode" while on a jury in around 1996. It is simply not credible that a person who has a faint on jury duty would forget it. Taking part in a jury is a memorable experience for anyone. It is inconceivable that anyone would forget they had fainted. When the report of fainting on jury duty was put to Mr Logue when recalled, he minimised its significance. His description did not sound like an "identical episode".

From an early stage in the reporting of dizziness, Mr Logue had a motive to conceal the extent of any medical problems. He had been warned about absence from work.

1998

On 20 January 1998, he crashed a bus after he felt light-headed and became dizzy. He lost consciousness. His employers, possibly Strathclyde Buses, knew of the accident and Mr Logue informed his GP. In cross-examination, Mr Logue did not recall having several dizzy spells earlier that day [GP letter, p. 103]. When speaking to his employer's investigator, Mr Logue made no mention of the

previous dizziness [p. 669]. When Mr Logue saw Dr Lyons, he downplayed the dizziness, saying that it was “just prior” to the accident [p. 91]. In cross, he said he couldn’t remember, no-one was injured.

Mr Logue was not consistent or candid in reporting his symptoms of dizziness prior to the accident on 20 January 1998. It is likely that his account to his GP was the truthful and accurate one. When he spoke to either representative of his employer, he either omitted reference to the several dizzy spells or substantially downplayed it. That indicates a consistent intent to mislead his employer about the nature of symptoms of dizziness in the context of crashing a bus.

In March or April 1998, Mr Logue informed Dr Lyons that he had the “all clear” from Professor Brodie to return to driving [p. 98]. That was false. He also did not tell Dr Lyons about any dizziness in 1995 or 1996. He did not tell the DVLA about previous episodes of dizziness.

The first notification to DVLA was by Mr Logue, telephoning on 20 April 1998 (DVLA acknowledged in a letter, dated 30 April 1998 [p. 122]). It is not clear why Mr Logue delayed 3 months before contacting DVLA. He was either unaware that he had to report the incident to DVLA or did not want to. Either possibility is concerning from a public safety perspective. After medical enquiries, Mr Logue was permitted to drive under a new PCV licence on 11 June 1998 [p. 93].

Mr Logue could not say what led to the granting of the new licence. He thought that it might have been after a medical with the company doctor. He described the cause of the episode on 20 January as cardio-vascular.

In response to questions from the bench, Mr Logue said that he did not drive from the date of the episode until the 1-year licence was granted on 1 July 1998. He was clearly concerned about losing his job and told the DVLA so [Crown Production 29, p. 8].

2004

Mr Logue was asked about the incident on 3 August 2004 in the bus depot. He said in chief that there was a railing outside the snooker hall which was loose. He knocked it back and forth. Someone came out of the hall and he fell back and cracked his head on the wall. He felt dazed and sick as a result. When he was asked further questions about the report of the accident in chief, he said that he didn’t remember. He said that the form was not in his handwriting [p. 755]. The signature was his, but he probably did not read it before signing. He said he was pretty sure it was an accident rather than a faint. When the report of Stephen O’Reilly was put to him in chief, he denied that he had fainted [p. 717].

In cross-examination, Mr Logue could offer no explanation for why Mr O'Reilly would make up a false accident report. He accepted Mr O'Reilly was there at the time of the incident. He ventured that pressure might have been put on Mr O'Reilly (that he was "badgered" into writing it).

Mr Logue's denial of a loss of consciousness on 3 August 2004 is not credible. His position is contradicted by two contemporaneous records, one of which he signed.

Mr Logue did not report a loss of consciousness when seen at Victoria Infirmary later than day [p. 602]. Mr Logue was later seen by Dr Lyons [p. 756]. Mr Logue did not inform the DVLA of the incident on 3 August 2004 because he didn't think it was necessary.

Mr Logue had received a formal oral warning about his attendance level at work some 2 months previously [p. 752].

Mr Logue's cover-up of the fainting episode on 2 August 2004 began as soon as he was taken to hospital. He concealed the faint from Dr Lyons and was certified by Dr Lyons as fit to work on 9 August 2004. The motive for Mr Logue to conceal the faint was his concern about being off work due to illness and the formal oral warning he had received recently.

Mr Logue subsequently told Dr Byrne that he had not experienced any fainting or blackout between 1998 and 2008 [p. 313]. Dr Byrne's assessment was made on that basis.

In cross-examination, Mr Logue posed the rhetorical question: "If they thought that I had a blackout would they have allowed me to drive 2 days later?" The answer of course lies in what he told Dr Lyons about the episode. Dr Lyons proceeded on the false account by Mr Logue.

2008

Mr Logue had another loss of consciousness at the wheel of a bus on 6 June 2008. He explained in chief that he had driven into the back of the garage. A trainee was reversing and he stopped, waiting to park his bus. He felt dizzy and lost consciousness. When he regained consciousness, he had crashed into another bus.

When Mr Logue was cross-examined about his statements that he felt dizzy going into work [p. 315] and before he got on the bus [p. 313], he said they had been misinterpreted. In response to a query from the bench, Mr Logue said that he was not dizzy when he got onto the bus. Mr Logue could not remember telling his GP about dizzy spells [p. 663].

That attempt to explain away the contemporaneous notes is not credible. On p. 315, there is a careful long-hand note [by Dr Byrne] of “coming into work feeling slightly dizzy, increase on bus”. Mr Logue’s evidence that he would not have come into work if he had felt dizzy was self-serving and rang false. The GP records note “dizzy spells” contemporaneously (albeit Dr Burman is not available to speak to them). That note is likely to be accurate because it was an important symptom in the context of loss of consciousness at the wheel of a bus. Mr Logue informed the DVLA on 20 June 2008 [p. 205]. He thought he could not drive for around 6 months and accepted the suggestion that might have been until October 2008. When he was asked whether anyone had suggested his driving days were over, he said that he thought that himself. He couldn’t remember what the doctor had said. On the DVLA form, Mr Logue made no reference to the episode in 2004 [p. 160]. It is unlikely that Mr Logue told DVLA that he had lost consciousness at the wheel of a bus and crashed it on 6 June 2008. That information is not recorded anywhere in the DVLA papers and on the evidence of Dr Parry, it would have resulted in revocation of Mr Logue’s PCV licence.

2012

On 31 March 2012, Mr Logue started work at 6.17 am and drove a route from Larkfield to East Kilbride, returning to Glasgow City Centre. He was due to have a meal break at 8.01 am. At the time of signing on, he had a cup of Klix tea, later described in cross as a small cup of tea. He had nothing to eat since the previous day. Mr Logue said that he did not feel different that morning. On Cathcart Road, at the junction with Butterbiggin Road, Mr Logue lost consciousness.

Mr Logue said in chief that he did not have a lot to drink while driving a bus because there was nowhere to go to the toilet. In cross, he confirmed this position and said there were no public toilets which he knew of on the route. Mr Logue accepted in cross that he had told Dr Buchanan at Victoria Infirmary A&E that he had dizzy spells. Since the accident on 31 March 2012, this is a unique admission by Mr Logue that he had a history of dizzy spells. There was no reference to a history of dizzy spells given to Dr Cree (see computer notes [p. 535] and her referral, [p. 500]).

Mr Logue said he could not remember telling Dr Mackay about palpitations the night before. He did not tell Dr Mackay about the episode in 2004.

Mr Logue appealed the decision to remove his car and PCV licence, although he appears only to have sought return of his car licence. They were both restored to him.

Mr Logue continued to drive. He is an IT engineer, who drove a van very occasionally at work. His licence was removed by DVLA on 4 August 2015. He has appealed against that decision. In the circumstances Mr Logue’s evidence on 14 August 2015 shows, at best, a totally cavalier attitude to public safety. His

grotesque question of why it was relevant to the enquiry is a clear demonstration of his impudent failure to take any responsibility for the accident on 31 March 2012. It clearly shows the reason why it is necessary for employers and the DVLA to take a more robust approach to medical conditions affecting fitness to drive.”

[103] Counsel submitted that the unchallenged evidence of John Reilly, Richard Duguid, Jason Perry, Malcolm Dippie, James Findlay, PC Lorna Breen and PC Lynn Caldwell should be accepted. Counsel submitted that Mr Stuart Purvis was clear and decisive as to what he had been told by Mr Logue just after the accident on 31 March 2012. Counsel invited acceptance of Mr Purvis’ evidence as being both credible and reliable. It was submitted that Mr Purvis’s evidence pointed to Mr Logue having failed to adhere to the advice given to him by Dr Byrne in 2008 regarding dehydration. Mr Logue had failed to ask himself whether he should continue to drive. He carried on driving as if he was properly dehydrated when he was not. Counsel pointed out that Mr Logue had denied episodes of dizziness. It was submitted that he did this because he did not want to lose his licence. Dr Caroline Buchanan (non-witness) had recorded that Mr Logue had had dizzy spells.

[104] Counsel pointed out that no statement had been taken from Mr Logue at any time after the accident by the police. He was not interviewed under caution. Sergeant Dawn Miller was the senior investigating officer. In her affidavit she made no mention of her instruction not to have contact with Mr Logue, which was given to the investigating officer PC David Murdoch. The reasons for her instruction to PC Murdoch are not known. PC Murdoch said in evidence that he took the decision not to interview Mr Logue but had been instructed to have no contact with him. Counsel described this

as a failure which was a “missed opportunity” to ascertain why Mr Logue had fainted. It could not be said that he was not fit to be interviewed by the police for he had been released from hospital within a short time.

[105] Counsel made criticism of Professor Brodie, which was responded to by Mr O'Reilly. Counsel made it clear that he did not challenge Professor Brodie's expertise or his evidence regarding Mr Logue not suffering from epilepsy or the working diagnosis of previous syncopal episodes or the proposition that “fainters faint”. Counsel's submission was that it was clear that an opportunity to question Mr Logue about his history of fainting was missed and that what was covered was poorly documented. It was submitted that Professor Brodie's certainty about Mr Logue reporting to DVLA was not matched by his general attitude towards syncopal attacks. It was submitted that as Professor Brodie could exclude epilepsy, his view was that the episode in 20 January 1998 was consequent on an “unusual sequence of events”. Counsel submitted that it did not stand up to logical scrutiny since it appeared that Professor Brodie was aware of two or three other similar episodes within the two preceding years from Dr Wilson's letter. Counsel pointed out that Professor Brodie had stated that he did not refer to cardiology because he was dealing with one episode of collapse. Counsel pointed out that Professor Brodie also said that had there been more than one episode the referral would have been made. It was submitted that Professor Brodie was completely preoccupied with the issue of epilepsy. Professor Brodie had said that if he knew the nature of the problem he would refer the patient otherwise the patient would be sent back to the GP. He pointed to Professor Brodie's evidence which was “If I referred every patient with

syncope there would be too many referrals...He did not have an epileptic seizure. It is not my responsibility. It is for the GP and him. I think it was done through the bus company."

[106] Counsel pointed out that Dr Lyons answered the procurator fiscal depute's question in relation to his duties by stating these included PCV licence renewals, health surveillance, fitness to drive and sickness management. Counsel pointed out that when further examined Dr Lyons accepted that there was little in the way of health surveillance. It was also clear that once a driver employee was referred to the DVLA, Dr Lyons took no active part in deciding whether that employee was fit to drive for First Glasgow (No 1) Limited. Counsel submitted that Dr Lyons took a curious view of his responsibilities in that he would not contact the DVLA in relation to a bus driver. Dr Lyons did not appear to accept that he could or should inform the DVLA of anything concerning a bus driver's medical circumstances. Counsel submitted that on 31 March 1998, Mr Logue told Dr Lyons that Professor Brodie had given him the "all clear". Dr Lyons stated that he was not happy to go on "verbal information" from Mr Logue and subsequently received the emphatic answer that Professor Brodie "certainly did not" give Mr Logue the "all clear". Dr Lyons did not appear to have challenged Mr Logue about his inaccurate statement or consider that Mr Logue's truthfulness might be in doubt.

[107] Counsel did not challenge the credibility or reliability of Dr Lyons but he made criticism of him and submitted:

“Dr Lyons’ report of 10 June 2008 contains inaccuracies [p. 72]. Mr Logue lost consciousness on 6 June 2008, not as he states in the report “became weak and drowsy”. Mr Logue also lost consciousness during the episode in 1998, but is reported here as an “episode of impaired consciousness”. There is no mention of crashing the bus on a public road in 1998. The loss of consciousness and crash are clearly recorded in Dr Lyons’ own records [p. 91, 98, 102, and 103]. Dr Lyons accepted the report was inaccurate and sought to explain that his statement of “impaired consciousness” probably meant loss of consciousness. Dr Lyons’ report of 10 June 2008 was sloppy and inaccurate. Had a manager at First Bus been considering Mr Logue’s fitness to resume duties, this report would have given a misleading impression of the seriousness of the incidents.

Dr Lyons made clear in cross that his role was to pass on the diagnosis to First Bus. He could not make referrals and did not contact the DVLA himself (except on one occasion to help Mr Logue get his licence back (2008)). He relied on the employee’s GP and DVLA to investigate fitness to drive. Only the DVLA could take Mr Logue off the road. Dr Lyons did not even know what information DVLA were proceeding upon.

Dr Lyons said that First Bus do not carry out any routine medical examinations of their drivers. The ‘health surveillance’ he referred to was hearing tests.

Dr Lyons’ statement that he assessed drivers for their safety is wholly meaningless. He could not conduct any enquiries or investigations, his only apparent source of information was the driver himself, and he did not even know the basis upon which the DVLA made their decisions. Dr Lyons and First Bus took no practical responsibility for assessing driver safety.

Dr Lyons was referred to the DVLA guidance current in June 2008 (p. 1160). He accepted that Mr Logue would have fitted Box 3, indicating a high risk of recurrence. That conclusion ought to have been obvious to Dr Lyons on the information available to him at that time. It is not expressed in any of the reports he prepared”.

[108] So far as the evidence of Dr Byrne was concerned, counsel did not suggest that Dr Byrne was other than a credible and reliable witness but he did criticise the terms of his medical report to the DVLA. Counsel particularly invited the court to accept as credible and reliable Dr Byrne’s evidence regarding the advice about maintaining proper hydration which he stated he had given to Mr Logue. Counsel submitted that:

“Dr Byrne spoke to his examination of Mr Logue on 9 June 2008 [p. 315]. Mr Logue had explained that he felt dizzy when he came into work on 6 June 2008 and it got worse. Dr Byrne said that if a driver felt any sort of incapacity, he should not be driving. In cross, Dr Byrne said he had no concerns about Mr Logue’s reliability when he completed the DVLA form. When shown the entry stating Mr Logue had no previous medical history, Dr Byrne stated that Mr Logue had not been accurate.

Dr Byrne completed the DVLA form, noting that this episode was a simple faint [p. 167]. He went on to say that after a third episode of collapse, he would assume the patient had a tendency to faint. It was unusual for a faint to take place whilst sitting down and particularly when driving (due to the movement of feet on the pedals). He would want to know the detailed circumstances. If the cause was not identified, he would be concerned.

Dr Byrne was asked whether two faints at the wheel indicated a driver who would put others at risk. He replied “absolutely”.

Dr Byrne was taken through Mr Logue’s previous medical history in cross-examination. He was not aware of entries relating to dizziness and similar or identical episodes. He said they would have altered his view in 2008 and increased the risk of recurrence. The number of events increased, so did the risk of recurrence. He would have had some concern.

Dr Byrne’s report to DVLA appears to have been the basis of the decision [by the DVLA] to allow Mr Logue to retain his licence. The report omitted the key information that the loss of consciousness was while sitting at the wheel of a bus, causing a crash. That was known to Dr Byrne and ought to have been included in his report.”

[109] Counsel then turned to the evidence given by Professor McKay and Dr Rae. He made no challenge in respect of any of their evidence. He pointed out that neither of them was informed by Mr Logue of the episode in 2004. Dr Rae was clear that Mr Logue did not tell him that he suffered from dizzy spells because had he done so Dr Rae would have recorded this information. Dr Rae did not know and was not told that the episodes in 1998 and 2008 occurred at the wheel of a bus which Mr Logue was driving. Dr Rae did not know that that 31 March 2012 was the third occasion when Mr Logue had had

an episode when he was sitting at the wheel driving a bus. Dr Rae had stressed the importance of knowing a patient's full medical history. It was important to know to know whether the episodes were a repetitive condition. Dr Rae considered that, in the light of the information put to him regarding other episodes, Mr Logue was more prone to recurrent episodes. Had he been asked in 2008, he would have considered it would have been surprising if Mr Logue did not have another episode.

[110] Counsel submitted that on the basis of the evidence of Dr Byrne, Dr Rae and Dr Wyn Parry the inescapable conclusion was that had full information been available to a consultant cardiologist advising in respect of the 2008 incident, Mr Logue would not have been driving a bus thereafter with the result that the accident which resulted in Mr Lochrie's death would have been avoided.

[111] Counsel's submissions on the principal issues were as follows:

(1) *Syncopal episodes*

Episode 1

Mr Logue was examined at Professor Brodie's Seizure Clinic on 20 January 1998. His wife reported that 3 years previously he had an attack in which he "felt dizzy for a few seconds and nauseated and then seemed to go into a dream-like state for a minute or two". That attack probably took place in 1995 or 1996. Mr Logue said he could not remember it, but there is no reason to doubt the accuracy of the report by his wife, or the record of it taken by Dr Wilson. Dr Rae said it sounded like a syncope episode. It is significant that Mr Logue's wife reported the attack, rather than Mr Logue himself.

On 14 June 1996, Mr Logue was examined by his GP, Dr Burman. He reported dizziness and appears to have been observed to have spontaneous nystagmus. Precisely what was or was not observed by Dr Burman is not known. He gave a tentative diagnosis of viral labyrinthitis. Spontaneous nystagmus is usually indicative/diagnostic of an inner ear problem. That might tend to suggest this was not syncope-related, but the diagnosis was tentative.

Episode 2

When examined by Dr Hunter on 20 January 1998, Mr Logue described an “identical” syncopal episode 2 years previously. The note which preceded that is detailed and clearly identifies a syncopal episode. There can be no doubt that in or around 1996, Mr Logue experienced a syncopal episode on jury duty in around 1996. That was episode number 2. Mr Logue accepted this was not the same as episode number 1.

Episode 3

Mr Logue lost consciousness at the wheel of a bus on 20 January 1998. He was admitted to A&E by ambulance at 6.03 pm. The Western Infirmary medical records are not available, nor is any note or report from the Ambulance Service. Mr Logue was examined by Dr Denison in A&E, where the tentative diagnosis was of a “fit” [p. 618]. Dr Hunter in Level 8 Medicine noted a detailed account of the incident [Production 28]. That was episode number 3. Mr Logue told Dr Hunter that he had felt light-headed earlier in the day. On 20 January 1998, Mr Logue told Dr Wilson in the Seizure Clinic that he had several dizzy attacks prior to going to work [p. 251]. On 10 March 1998, Mr Logue later told Dr Lyons that he felt dizzy just prior to the blackout [p. 91; p. 102].

Episode 4

On 3 August 2004, Mr Logue lost consciousness at work when he was speaking to a colleague, Stephen O'Reilly [p. 717; 755]. He did not tell the doctor at Victoria Infirmary that he had fainted, or that he had been feeling unwell for 30 minutes prior to the accident [p. 755]. That was episode number 4. Mr Logue subsequently gave a false account to Dr Lyons.

Episode 5

On 6 June 2008, Mr Logue again lost consciousness at the wheel of a bus and crashed [p. 595]. That was episode number 5. On 16 June 2008, Mr Logue described a dizzy turn or turns to his GP [p. 663]. On 17 June 2008, Mr Logue was examined by Dr Byrne in the Syncope Clinic. He told Dr Byrne that on 6 June 2008, he came into work feeling dizzy and that dizziness increased when he was on the bus [p. 315].

Episode 6

On 31 March 2012, Mr Logue had a third syncopal episode at the wheel of a bus, causing a collision and the death of James Lochrie. That is episode number 6. He reported dizzy spells to Dr Buchanan in A&E [p. 326]. It is not known whether Mr Logue was referring to dizzy spells prior to the accident on 31 March 2012, general and intermittent dizzy spells or only the episodes 1 to 6 referred to above.

In 1998 and 2008, Mr Logue experienced dizzy spells on his way into work. In 1998, he had experienced two documented episodes (one loss of consciousness and one impaired consciousness), yet he reported for work. On 6 June 2008, Mr Logue had experienced four documented syncopal episodes, including one causing a collision, yet he reported for work despite the dizzy spells.

By 6 June 2008 at the very latest, it ought to have been apparent to Mr Logue that dizzy spells could precede a syncopal episode and that it was not safe for him to drive. It ought to have been apparent to him by that time at the very latest, that he had a tendency to syncopal episodes.

(2) *The medication taken by David Logue at the time of the accident*

Mr Logue was taking Ramipril (5mg tablets, one per day) on 31 March 2012. A known side-effect of Ramipril is syncope. That was known to Dr Cormack when Ramipril was first prescribed on 5 November 2010 (2.5 mg dose), and when it was increased. The prescription was a contributing factor to the syncopal episode on 31 March 2012.

(3) *The counterfactual in 2008:*

(a) What advice doctors would have given David Logue

All of the doctors who gave evidence would have given different advice to Mr Logue had they known the extent of his history of syncopal episodes.

(b) What decision would have been made by the DVLA

The unchallenged evidence of Dr Parry is that the DVLA would have reached a different decision in 2008 had they known the extent of Mr Logue's history of syncopal episodes.

(4) *The role of First Bus in monitoring the health of their drivers*

First Bus elected not to bring a witness to their decision-making process (if any) in 1998 and 2008. Nor did they lead any evidence as to why the reports of the 2004 incident were not sent to Dr Lyons. Evidence on either of those matters would have been of assistance to the Inquiry. Where

appropriate, I invite the court to draw an adverse (as opposed to a neutral or favourable) inference.

Mr Logue was seen by Dr Lyons on 10 March 1998. He was unfit to drive [p. 102]. On 31 March 1998, he was seen again by Dr Lyons and said that he had been “given the all clear to go back to work”. That was misleading. Dr Lyons’ approach demonstrates a lack of rigour.

Dr Lyons wrote to Professor Brodie before advising First Bus of Mr Logue’s fitness to drive. However, it was clear from his evidence that Dr Lyons made no decision about Mr Logue’s fitness to drive; he considered that to be the role of the DVLA. Dr Lyons and by extension, First Bus abdicated responsibility for driver safety.

When Dr Lyons reported to First Bus, he noted Mr Logue’s description of feeling dizzy just before the blackout. He omitted information contained in Dr Wilson’s letter that Mr Logue had several dizzy attacks before going into work. It appears that no advice or disciplinary action was taken against Mr Logue for reporting to work after experiencing several dizzy spells. An opportunity to reinforce Mr Logue’s responsibility to report illness, or even discipline him for (an apparent) breach of the Driver’s Handbook was missed.

Dr Lyons stated in his report to First Bus that he referred the case to DVLA in response to Professor Brodie’s letter of 3 April 1998. However, the DVLA records [Crown Production 29] show that it was Mr Logue who contacted them on 30 April 1998. There is no correspondence between First Bus (including Dr Lyons) and DVLA in relation to the incident on

20 January 1998. First Bus and Dr Lyons did not know what information was considered by DVLA prior to granting a 1-year licence.

First Bus failed to provide a copy of the accident report of 3 August 2004 to Dr Lyons when they referred Mr Logue to him. There is no copy of the referral to Dr Lyons. The omission of the accident report allowed Mr Logue to give a false report to Dr Lyons of the incident.

Dr Lyons considered Mr Logue fit to return to work on 9 August 2004. There is no record of how or when he conveyed that to First Bus. Had Dr Lyons given a written report detailing Mr Logue's account of the incident on 9 August 2004, it might have given First Bus an opportunity to see the discrepancy in accounts.

Mr Logue was seen by Dr Lyons on 10 June 2008 [p. 73]. Dr Lyons took blood pressure and conducted the Romberg's test (for balance and dizziness). Dr Lyons requested a medical report from Dr Burman [p. 67].

In each of Dr Lyons' reports to First Bus (10 June, 3 July and 20 July 2008), he states that Mr Logue became weak and drowsy while driving a bus. There is no reference to Mr Logue feeling dizzy before going to work. That might explain why there is no apparent record of any advice or disciplinary action against Mr Logue for reporting to work with dizziness (and with a known history of dizziness and fainting).

There is no correspondence between First Bus (including Dr Lyons) and DVLA in relation to the incident on 6 June 2008. First Bus and Dr Lyons did not know what information was considered by DVLA prior to their decision that Mr Logue could retain his licence. An opportunity was

missed by First Bus and Dr Lyons to inform DVLA of the material information that the syncopal episode on 6 June 2008 occurred at the wheel of a bus and resulted in a crash.

Dr Lyons took very few proactive steps to investigate Mr Logue's health or fitness to drive. There was no correspondence with DVLA. Dr Lyons completely abdicated any responsibility for the safety of the public and employees. His approach to reporting was sloppy and inaccurate.

Evidence was led from David Phillips of the First Bus Driver Handbook [First Production 1, para 4.9.3]. No evidence has been led that anyone spoke to Mr Logue about his responsibility to only report for work when fit, or sought to emphasise that after the episodes in 1998, 2004 and 2008.

(5) *The role of the GP in advising Mr Logue*

Dr Burman's letter to DVLA on 25 May 1999 [p. 604] was not based on any examination of Mr Logue. His conclusions and advice to DVLA are completely unsupportable.

Dr Kennedy clearly adopted the role of advocate for Mr Logue. He candidly said that he had a degree of responsibility for assessing and reporting Mr Logue's safety as a driver, but could not point to a single instance in which he discharged that responsibility.

It appears Mr Logue was not advised that hypotensive drugs could increase the likelihood of syncope episodes. However, given Mr Logue's cavalier attitude, it is doubtful whether advice would have made any difference to his conduct.

(6) *The decision making process of the DVLA*

The decision-making process of the DVLA is largely opaque, due to missing records and a failure to record the basis upon which decisions were made. It is not even possible to say how the DVLA Guidelines were applied to the decisions made in 1998 or 2008.

(7) *The evolution of the DVLA Guidelines*

Since March 1996, the DVLA Guidelines have dealt ever more specifically with syncopal episodes. In March 1996, if a syncopal attack was neither sudden nor disabling, they need not have been notified [p. 1061]. However, that applies where the attack is physiologically provoked and the result of postural hypotension. The evidence indicates that postural hypotension does not occur when sitting. The 1996 Guidelines do not deal specifically with the range of syncopal episodes referred to in later Guidelines. Retrospectively, they fall far short of adequate.

By February 2008, the DVLA Guidelines on loss of consciousness clearly states: “A full history is imperative to include pre-morbid history, prodromal symptoms, period of time unconscious, degree of amnesia and confusion on recovery”. This appears to have been done very little by any of the medical practitioners. It underlines the importance of full and detailed reporting of previous episodes (compare the reports of Dr Lyons, for instance, or Dr Byrne’s omission of loss of consciousness at the wheel of a bus).

The February 2008 Guidelines have a far more detailed set of definitions. It appears that there was a tendency to report Mr Logue’s 2008 episode (and indeed the 1998) episode as a “simple faint” (box 1). However, that

overlooks the exclusion of “unlikely to occur whilst sitting” and the requirement to consider (if recurrent) the 3 P’s. A proper construction of the February 2008 guidelines leads to the conclusion that box 3 was applicable to Mr Logue in June 2008.

In October 2008 [p. 170], it appears that because 3 months had passed from the date of the accident to the DVLA decision, Mr Logue was allowed to retain his PCV licence (box 3, Group 2 entitlement).

Under the current Guidelines, box 6 has been introduced. If there are two or more episodes of loss of consciousness without reliable prodromal symptoms within the last 10 years, the PCV licence is revoked (until such time as the risk has reduced to less than 2% per year).

It is submitted that the current Guidelines contain suitable and sufficient measures for dealing with Mr Logue’s case. By necessary implication, and applying retrospection, all previous Guidelines are inadequate. Had the Guidelines in 2008 have been in the form they are now (and the 2004 episode known to DVLA), his PCV licence would have been revoked. Even if the 2004 episode was not known to DVLA, they could have exercised discretion to revoke Mr Logue’s licence.

The Guidelines demonstrate that medical advice to the DVLA has evolved over time. Syncopal episodes do not appear to have been given much prominence in early guidance. The risk to the public from recurrent syncopal episodes has only been properly recognised in the current Guidelines.

(8) *Offences:*

Section 92 of the Road Traffic Act 1988 provides:

“92. — Requirements as to physical fitness of drivers.

- (1) An application for the grant of a licence must include a declaration by the applicant, in such form as the Secretary of State may require, stating whether he is suffering or has at any time (or, if a period is prescribed for the purposes of this subsection, has during that period) suffered from any relevant disability or any prospective disability.

...

- (10) A person who holds a licence authorising him to drive a motor vehicle of any class and who drives a motor vehicle of that class on a road is guilty of an offence if the declaration included in accordance with subsection (1) above in the application on which the licence was granted was one which he knew to be false.”

A “relevant disability” is defined in regulation 71 of the Motor Vehicles

(Driving Licences) Regulations 1999/ 2864 as including *inter alia*:

“71.— Disabilities prescribed in respect of Group 1 and 2 licences

- (1) The following disabilities are prescribed for the purposes of section 92(2) of the Traffic Act as relevant disabilities in relation to an applicant for, or a person who holds, a Group 1 or Group 2 licence —

...

- (c) liability to sudden attacks of disabling giddiness or fainting which are caused by any disorder or defect of the heart as a result of which the applicant for the licence or, as the case may be, the holder of the licence has a device implanted in his body, being a device which, by operating on the heart so as to regulate its action, is designed to correct the disorder or defect;
- (d) liability to sudden attacks of disabling giddiness or fainting, other than attacks falling within paragraph (1)(c)...”

Section 94 of the 1988 Act provides:

“94.— Provision of information, etc. relating to disabilities.

- (1) If at any time during the period for which his licence remains in force, a licence holder becomes aware —

- (a) that he is suffering from a relevant or prospective disability which he has not previously disclosed to the Secretary of State, or
 - (b) that a relevant or prospective disability from which he has at any time suffered (and which has been previously so disclosed) has become more acute since the licence was granted,
- the licence holder must forthwith notify the Secretary of State in writing of the nature and extent of his disability.

...

- (3) A person who fails without reasonable excuse to notify the Secretary of State as required by subsection (1) above is guilty of an offence.
- (3A) A person who holds a licence authorising him to drive a motor vehicle of any class and who drives a motor vehicle of that class on a road is guilty of an offence if at any earlier time while the licence was in force he was required by subsection (1) above to notify the Secretary of State but has failed without reasonable excuse to do so."

Under Schedule 1 to the Road Traffic Offenders' Act 1988:

A contravention of s. 92(10) is triable only summarily, with a penalty of a fine at Level 4 on the standard scale [£2,500], discretionary disqualification and obligatory endorsement of the holder's licence with 3 to 6 penalty points.

A contravention of s. 94(3) is triable only summarily, with a penalty of Level 3 on the standard scale [£1,000]. There is no power to disqualify the driver or endorse the holder's licence.

A contravention of s. 94(3A) is triable only summarily, with a penalty of a fine at Level 3 on the standard scale, discretionary disqualification and obligatory endorsement of the holder's licence with 3 to 6 penalty points.

It is objectively unlikely that a person facing the loss of livelihood because of a medical condition affecting their fitness to drive would be deterred by a fine of up to £1,000, with no possibility of imprisonment and

discretionary disqualification. There is a factual analogy between driving whilst medically unfit to do so and driving whilst unfit through drink or drugs. In the latter situation, disqualification is obligatory (ss. 4(1) and 5(1)(a) of 1988 Act; Road Traffic Offenders Act 1988, Schedule 1).

Preventing medically unfit persons from driving by enactment of the provisions of s. 94(3) and (3A) is but a pious aspiration if there are never any prosecutions for contravention. The current system of self-reporting is inadequate if it is not backed by sufficiently robust enforcement and penalties for those, like Mr Logue, who serially mislead doctors and the DVLA.

Concluding remarks

It is submitted that it is proved David Logue experienced syncopal episodes in 1996, 1998, 2004 and 2008.

This was an accident waiting to happen. It may not have taken place on 31 March 2012. James Lochrie may not have lost his life. But at some point – be it the third, fourth, fifth loss of consciousness by David Logue at the wheel of a PCV – his medical condition was ultimately going to result in injury or death.

Mr Logue was not fit to hold a PCV licence after the accident on 6 June 2008. By that time, at the very latest, Mr Logue, his GP, Dr Lyons, First Bus and the DVLA ought to have taken him off the road. Each of them contributed to a failure to recognise the danger Mr Logue posed to himself, his colleagues and to members of the public. Mr Logue, however, bears primary responsibility for the death of Mr Lochrie.

The closing submission of the solicitor for Mr David Logue

[112] Mr Bathgate, solicitor, took no issue with the procurator fiscal depute's suggested findings in respect of section 6(1)(a) and (b) of the 1976 Act. He submitted that, on the evidence led at this inquiry, no further findings under any of the other paragraphs were appropriate. Under reference to the submissions advanced by counsel for the Lochrie family, Mr Logue's solicitor asserted that the incidents of alleged loss of consciousness in 1995, 1996 and 2004 had not been proved on the basis of the evidence led at this inquiry.

[113] In 1998 Dr Elaine Wilson saw Mr Logue. Her letter was to be found in Crown production 6 at p 140/1. Dr Wilson had not been called to give evidence at this inquiry nor had Mrs Lochrie. Mr Logue had given his evidence but it was submitted that findings in fact should not be made on the basis of Dr Wilson's letter. The same approach required to be taken in relation to the allegations regarding jury service. Mr Logue had given his account of events and there was no quality evidence to contradict his account.

[114] So far as the incident in 2004 was concerned, Mr Logue stated that he did not faint. There was no oral evidence from any witness that he did faint. No witness had been led by the procurator fiscal or the family to speak to this event. Mr O'Reilly had not given evidence nor had Mr McIntyre. It was submitted that evidence of statements should not be accepted without scrutiny and the evidential value of such evidence was limited so far as its quality was concerned. It was submitted that findings in fact should not be made to the effect that Mr Logue lost consciousness in either 1995, 1996 or 2004.

[115] Mr Logue's solicitor stated that he had to accept that Dr Byrne gave Mr Logue advice in 2008 regarding keeping his fluid intake up. So far as the incident in 2008 was concerned, Mr Logue's solicitor accepted that had the full facts of the 1998 and 2008 incidents been known the then current DVLA Guidelines required that Mr Logue's licence would have been revoked. His syncope had occurred whilst he was sitting and at the wheel. Accordingly, it was accepted that had the DVLA known of the full circumstances his driving licence would have fallen to be revoked for one year. However, Mr Logue could have re-applied and his licence might have been restored to him. It was accepted that there was a question as to whether Mr Logue would still have been employed by First Glasgow (No 1) Limited after 2008 but on the evidence led before this inquiry the answer to that question was not established.

[116] It was submitted that on 31 March 2012 Mr Logue had only taken Ramipril and Simvastatin. The medical evidence from his general practitioner's practice was that only these medications had been prescribed for him. The evidence of Mr Purvis had been quite clear, "Just my water tablets". However, it was submitted that it was appropriate to prefer the evidence of Mr Logue which was consistent with the evidence given by his general practitioner. On Mr Logue's evidence he had had a cup of tea. It was accepted that there was evidence of poor oral intake on the day of the accident, which may have been contributory to but not causative of the vasovagal syncope which he suffered that day which led to the death of Mr Lochrie: the cause of the vasovagal syncope suffered by Mr Logue on that morning was, on the evidence led at this inquiry, unexplained. The

evidence demonstrated a number of possible contributory factors but none was established, on the balance of probabilities, as a causative factor.

[117] It was submitted that Mr Logue had always reported matters to the DVLA. All information supplied by him was correct and not false in any way. He had lost consciousness in both the 1998 and 2008 incidents whilst at the wheel. He reported both incidents and subjected himself to medical enquiry. He had complied with all legal obligations incumbent upon him.

Submissions for First Glasgow (No 1) Limited

[118] Ms McDonnell for the bus company made a short, sharp submission. She accepted the Crown position in relation to section 6(1)(a) and (b). So far as paragraph (c) was concerned, there were no reasonable precautions which could have been taken by the bus company to avoid either Mr Lochrie's death or the accident which resulted in his death. So far as paragraph (d) was concerned, there was no evidence of any defect in any system operated by the bus company which contributed either to Mr Lochrie's death or the accident on 31 March 2012.

[119] Ms McDonnell pointed out that the Secretary of State for Transport through the DVLA has a statutory responsibility for ensuring that all drivers are fit to drive. The question of fitness to drive was a medical decision and the DVLA had the statutory duty and was best placed to discharge that duty. That was why the law required that the DVLA determined through its medical advisers, the fitness to drive of any particular licence holder. She submitted that the bus company were not best placed to second

guess decisions on fitness to drive made by DVLA. The bus company's doctor did not have access to records and it was not reasonable to expect the bus company to carry out that exercise: the law was that they were entitled to and obliged to defer to the decision of the DVLA on matters of fitness to drive. Whilst Ms McDonnell stated that she did not go so far as to say that the DVLA were infallible, she did submit that it was not reasonably practicable to ask the bus company to oversee the DVLA decision or to "regulate the regulator".

[120] Ms McDonnell submitted that the bus company clearly had responsibility when it is given information as with the 1998 and 2008 incidents to ensure fitness is considered by the bus company. The system was that management referred to the medical adviser who deferred to the decision of DVLA. It was not reasonable for the bus company to go beyond the decision of the DVLA unless they became aware of another incident. Ms McDonnell pointed out that Dr Wyn Parry stated that the DVLA do not seek information from employers or provide information to employers. The statutory system was a self-notification system and First Glasgow (No 1) Limited followed that system. If a bus driver became unfit then the matter was referred to the medical officer and that employee was not able to drive again until the regulator had deemed him fit. It was submitted that it was not reasonable for the bus company to second guess or question the decision of the DVLA. Any decision taken by the bus company would be arbitrary and subject to challenge by the employee concerned. It was sufficient and lawful for First Glasgow (No 1) Limited to defer to the decisions of the regulator unless there was additional information. The DVLA were involved in the 1998, 2008 and 2012 incidents.

At the time of the 1998 incident Mr Logue was not employed by First Glasgow (No 1) Limited.

[121] As far as the 2004 incident which occurred within the premises, the bus company had an incident report form signed by Mr Logue. They also had a report from Mr O'Reilly. The bus company assumes that employees are truthful and accurate. Ms McDonnell submitted that there was no causal link between the 2004 incident to Mr Lochrie's death in 2012.

[122] Ms McDonnell submitted there was no evidence of a "benchmark" system which the bus company could be expected to have had in place. Mr Logue made no mention of dizzy turns to the bus inspector in 1998. In 2008 Mr Logue was sent to Dr Lyons for assessment. Ms McDonnell accepted that it would have been reasonably practicable for the bus company to tell the DVLA what it knew regarding Mr Logue but she emphasised that there had been no defect in any system of work operated by them.

Closing submission for Greater Glasgow Health Board

[123] Mr O'Reilly emphasised at the start of his submission that he did not act for the general medical practitioners who had given evidence. So far as the alleged syncopal episode in 1995 was concerned, Mr O'Reilly pointed out that this had not been reported until 1998 to Dr Wilson. The inquiry had not heard from Mrs Logue who had not been cited and Mr Logue could not remember what had been said to Dr Wilson. On the evidence, it appeared the prescription of Serc by Dr Berman had resolved the issue. At

all events, it was clear from Dr Wyn Parry's evidence that the DVLA were not concerned with an episode of viral labyrinthitis not involving loss of consciousness.

[124] So far as the syncope in 1996 was concerned, again this was not reported until 1998. Neither Dr Alan Denison nor Dr Hunter was cited to give evidence at this inquiry. Reference was made to Dr Byrne's evidence to the effect that an emergency department was a busy place where it was important to maintain turnover and that notes taken in Accident & Emergency were not necessarily contemporaneous. Mr O'Reilly submitted it was unclear if there had been loss of consciousness in any incident in 1996. At all events, any loss of consciousness in 1996 caused Professor Brodie no concern.

[124] Mr O'Reilly submitted that the first definite loss of consciousness episode was on 20 January 1998 when Mr Logue was driving a bus. He was taken to hospital and Dr Denison advised Mr Logue against driving. He was then seen in the epilepsy unit by Dr Wilson and referred for EEG and CT tests. These were normal. He was referred to Professor Brodie, who had little doubt that Mr Logue had suffered a vasovagal episode. Professor Brodie did not think that Mr Logue needed to be referred to cardiology. Mr O'Reilly pointed out that Professor Brodie discharged Mr Logue to the care of his general medical practitioner Dr Burman and had written to him by letter dated 19 March 1998. Mr O'Reilly emphasised the role which Professor Brodie had which was to diagnose epilepsy or to exclude epilepsy. Professor Brodie was not concerned by the 1996 incident. As understood by me, the submission was that Professor Brodie could not properly be criticised. It was submitted that Professor Brodie had done all that was

required of him and that there were no reasonable precautions which could have been taken which would have avoided Mr Lochrie's death in 2012.

[125] On 3 September 2004 Mr Logue was taken to hospital after an incident at work the same day. He did not want to be seen at hospital and nothing could have been done by employees of Greater Glasgow Health Board in that situation.

[126] On 17 June 2008 Dr Byrne saw Mr Logue and took a medical history from him. On the information given to him, Dr Byrne was entitled to fill in the medical report to the DVLA as he did (Crown production 6 at page 167) and he could not be faulted on that account. Dr Byrne made it clear that he sought the earlier hospital records but these were not provided to him. The system within the health board had since improved and records are now scanned and can be accessed by all clinicians in the health board area. It was emphasised that this was of benefit in a therapeutic context for patients.

[127] Mr O'Reilly made it clear that he did not act for Dr Kennedy, Mr Logue's general practitioner or any general medical practitioner employed in his practices. Mr Logue had been prescribed Ramipril on 18 July 2008 and Mr Logue took this prescription, which had been titrated to 5mg daily with milk. Dr Cormack could not recall a single patient suffering loss of consciousness with Ramipril. Mr O'Reilly also pointed to the evidence given by Professor McKay to the effect that it was unlikely 14 months after starting Ramipril that a patient taking it would suffer loss of consciousness. As I understood him, his submission for the assistance of the court was that the prescription of Ramipril to Mr Logue had not in any way contributed to the loss of consciousness on 31 March 2012 which had resulted in Mr Lochrie's death.

Closing submission for DVLA

[128] Mr Olson, Advocate, invited acceptance of Dr Wyn Parry as a credible and reliable witness whose unchallenged evidence should be accepted. He submitted that Mr David Logue was not a wholly credible and reliable witness and he supported the submissions made in that regard by counsel for the Lochrie family, particularly in respect of Mr Logue's account of the 2004 incident. Mr Olson submitted that, at Crown production 6 at page 160, Mr Logue had not given the DVLA accurate information. Counsel pointed out that Dr Wyn Parry's evidence had been that the forms sought basic information and after that the DVLA sought further information from either a GP or a consultant. He submitted that all doctors were aware that the medical guidelines in use since 2008 required a full medical history to be taken and that a full history was essential in order to reach the correct diagnosis.

[129] Mr Olson suggested that the forms should ask open questions. He submitted that employers should be required to give information to the DVLA and that if they were required to do so but failed to comply there may be ramifications in respect of the bus operator's licence.

[130] Counsel submitted that the penalties for the breach of the various road traffic provisions referred to by counsel for the family were not commensurate and might usefully be reviewed. However, he submitted that the "at a glance booklet" and the National Medical Guidelines of Fitness to Drive were in step with medical knowledge and changes would result because medical knowledge changes. He submitted that the

National Medical Guidelines of Fitness to Drive did keep up with medical changes and the change in box 6 which was introduced in October 2012 reflected that the medical view of syncope had changed as a result of medical knowledge and cases which had come to the attention of the medical advisory panels.

The public statements of Mr Lochrie's family expressed by counsel

[131] At the conclusion of his submissions, Counsel for Mr Lochrie's family stated that he had been instructed by them to state publicly "that they have no criticism of the Crown for the decision at the outset of this inquiry not to prosecute Mr David Logue in respect of matters before this Inquiry". Counsel further stated that: "The family gratefully acknowledge that this Inquiry had allowed them to hear detailed evidence of all the circumstances surrounding Mr Lochrie's death". Counsel stated that he was also instructed to state publicly that "(the family) consider enforcement of sections 92(10), 94(3) and 94(3A) of the Road Traffic Act 1988, as amended, by the DVLA and prosecuting authorities to be woefully inadequate". Counsel added that the family expressed some concern regarding the length of time which had elapsed before the holding of this Inquiry.

The procurator fiscal's response regarding the delay in holding this Inquiry

[132] The procurator fiscal depute responded to the family's concern regarding the delay in holding this inquiry. He stated that Mr Lochrie's death had been the subject of two reports to Crown Office in connection with the matter of possible criminal

proceedings and this inquiry. The first report was made on 23 January 2014. The second report was made on 14 October 2014 and he indicated that consideration had been given to hearing this Inquiry along with another Inquiry into the deaths of two young women, Mhairi Samantha Convy and Laura Catherine Linda Stewart. The procurator fiscal depute gave no further information or explanation for the delay.

Determination: the requirements of law

[133] This determination must proceed upon the basis of the acceptable evidence led at this Inquiry, including the evidence agreed in the joint minute of agreement. The determination is limited to the matters set out in section 6(1) of the Fatal Accidents and Sudden Deaths Inquiry (Scotland) Act 1976, which requires a determination setting out the following circumstances of the death so far as they have been established to the sheriff's satisfaction:

- (a) where and when the death and any accident resulting in the death took place;
- (b) the cause or causes of such death and any accident resulting in the death;
- (c) the reasonable precautions, if any, whereby the death and any accident resulting in the death might have been avoided;
- (d) the defects, if any, in any system of work which contributed to the death or any accident resulting in the death;
- (e) any other facts which are relevant to the circumstances of the death.

[134] At this Inquiry, the normal civil standard of proof, which is the balance of probabilities, applies to the determination. Corroboration is not required and hearsay

evidence is admissible. There is no power in section 6 of the 1976 Act to make a finding as to fault or to apportion blame between any persons who might have contributed to the accident: *Black v Scott Lithgow Ltd* 1990 SC 322 at 327 per Lord President Hope. But I respectfully agree with and follow what Sheriff A C Normand stated in his Determination, dated 14 November 2014, in the Fatal Accident Inquiry into the deaths of Mhairi Samantha Convy and Laura Catherine Linda Stewart at 1.8: “However that is not to say that evidence tending to demonstrate fault may not properly be led before the Inquiry. Nor does it mean that the sheriff is precluded from making findings which may infer fault where it is proper to do so. This is important when having regard to future safety and the prevention of a recurrence of the accident or the death”.

The assessment of the evidence led

[135] It is my responsibility to assess and judge the evidence which has been led at this Inquiry and the facts which have been established by acceptable credible and reliable evidence. There are two tests to be applied to the evidence of each witness, namely credibility and reliability. I am required to decide upon the credibility, reliability or otherwise of the individual witnesses. A witness can be accepted as being credible and reliable in whole, in part or not at all. Accordingly, a witness may be doing his or her best to tell the truth but may be unreliable in the sense of being inaccurate or mistaken. Evidence can be unreliable for a variety of reasons, including the witness’s memory being affected or lost by lapse of time. It must be stressed that where evidence is rejected as being either false or unreliable, that rejected evidence does not prove the

opposite or something different from what the witness actually stated. Evidence which is rejected, as being either false or unreliable, proves nothing at all and falls to be discarded and ignored.

The consequences of the delay in holding this Inquiry

[136] It is very much less than satisfactory for this Inquiry to have been held so long after Mr Lochrie's death. I share the concerns expressed by Mr Lochrie's family in this regard. Mr Lochrie's family had to wait almost three years before the procurator fiscal applied to hold this Inquiry. The delay cannot have been easy for them to bear, which is a matter of genuine concern to me. In a Fatal Accident Inquiry, it is important to hear all the relevant evidence within as short a time as possible so that it can be assessed and the sheriff can fully discharge the statutory duties incumbent in terms of section 6 of the 1976 Act. As in other types of litigation, both criminal and civil, genuine difficulties of recollection on the part of witnesses can and do arise where witnesses are asked to recollect events which occurred a long time before, particularly where events have happened quickly or in a background of excitement or distress. This can happen where persons have witnessed an incident and are asked to recollect what occurred some years later. But genuine difficulties of recollection can also be found where witnesses whose jobs involve them seeing large numbers of people on a daily basis, such as doctors, are asked about meetings or consultations which took place many years before. Difficulties in lack of recollection do not make the task of the witness or the court any easier.

Reliability or otherwise of recollection is a critical factor which requires to be taken into

account in the assessment of a witness's evidence. It was clear that the recollection on matters of importance of some witnesses who gave evidence at this Inquiry had been affected by the lapse of time. The loss of reliable evidence by reason of the delay in holding this Inquiry is matter of real concern for it has frustrated the finding of facts relevant to the required statutory determination.

The unchallenged evidence

[137] I have had no difficulty in accepting all of the unchallenged evidence led at this Inquiry as being credible and reliable evidence. I accepted the terms of the most helpful Crash Investigation Report, (Crown productions 3 and 4), and the unchallenged evidence of PC Scott Simpson as credible and reliable. I accepted the unchallenged evidence of Mr George Courtney and the terms of his careful report. I accepted the unchallenged affidavit evidence of Sergeant Dawn Miller. I also accepted the unchallenged evidence of PC Lorna Breen, PC Roger Millar, PC David Murdoch, John Reilly, Richard Duguid, Jason Perry and Malcolm Dippie.

The evidence of Mr David Logue

[138] Counsel for the Lochrie family did not challenge the account given by Mr David Logue of events on 31 March 2012 but he did challenge other parts of Mr Logue's evidence. Counsel for the Lochrie family invited rejection of parts of Mr Logue's other evidence as being false. This was supported by counsel for the DVLA. The procurator fiscal depute and Mr Logue's solicitor invited acceptance of his evidence as being

credible and reliable. I have considered their competing submissions. In answer to a number of questions, Mr Logue maintained that he could not remember what had happened or what had been said. Given the lapse of time since some of the events about which he was questioned – 1998, 2004, 2008 and 2012 – it was hardly surprising that his recollection might have dimmed. During the course of his evidence over two separate days, Mr Logue was questioned about entries in medical records, which apparently recorded what he or some member of his family had said on a particular occasion.

[139] I found the task of assessing Mr Logue's credibility and reliability to be extraordinarily difficult, not least because of the lapse of time since some of the events or matters examined and the considerable lapse of time since Mr Lochrie's death. Mr Logue's evidence conflicted with that given by Stuart Purvis. Reference to records or letters of non-witnesses, namely, Dr Browne, Dr Buchanan, Dr Burman, Dr Denison and Dr Wilson did not make my task any easier in the absence of admission that these various records or letters were true and accurate. Mrs Logue was not led as a witness and so her position in respect of anything which she may have said to Dr Wilson in 1998 is not known. Mr Logue's evidence in court conflicted with that given by Mr Steven O'Reilly in his affidavit. The court did not hear from Mr O'Reilly. There is also the matter of what Mr Logue did or did not say to the various medical witnesses including Dr Byrne, Professor McKay, Dr Rae, Dr Lyons and his general medical practitioners.

[140] It was necessary for me to judge whether Mr Logue was a credible and reliable witness in his evidence before this Inquiry and also whether he was credible and reliable in what he told the various doctors when they saw him in connection with various

incidents. It was necessary to assess his presentation as a witness, the content of his evidence and to compare his account of events with the other of other witnesses. I had in mind that, as with many people, Mr Logue might have been a poor historian and found difficulty in recalling the detail of events.

[141] Mr Logue presented in the witness-box in what appeared to me to be an open and straightforward way. He answered the questions which were put to him by the procurator fiscal depute and then by each of the other represented parties. In the witness-box Mr Logue was, at all times, respectful. It appeared that he had been badly affected by the circumstances of the accident on 31 March 2012 and the death of Mr Lochrie, whom he both knew and respected.

[142] Mr Logue denied having dizzy spells at any time other than the episodes in 1998 and 2008. Looking at the evidence in respect of the first bus incident in 1998, under reference to the letter from Dr Wilson, Mr Logue said that he could not remember any episode in 1996 (which his wife is said to have reported) of going into a “dream-like” state. He said that the episode he consulted his GP about on 14 June 1996 was different from any episode reported by his wife. He stated that he had been unwell after completing jury service. He gave the explanation recorded above at paragraph [49] as to why he had become unwell.

[143] I was surprised that Mr Logue had no recollection of the incident apparently mentioned by his wife to Dr Wilson. I was surprised that when he was shown the entry in his GP records dated 14 June 1996, which recorded dizziness, Mr Logue stated that he did not remember the dizziness. I was also surprised that he did not recall being off

work even when his memory was jogged by being shown certificates certifying him unfit for work.

[144] However, in my judgment, the powerful submission advanced by Mr Bathgate was sound and bearing in mind the absence of evidence from Dr Denison, Dr Wilson and Mrs Logue, I concluded that it would be unsafe to proceed upon any disputed unproved entry or letter in the medical records (which are not admitted as being a true and accurate records). So far as the alleged incident on jury service is concerned, there was simply no other evidence in relation to this matter apart from that given by Mr Logue, which, if rejected, does not prove the opposite or something different from what he said as being fact. In my judgment, on the evidence led at this Inquiry, it was not proved that the “jury incident” was a previous fainting incident. Mrs Logue was not called to give evidence and she was the authoress of the information apparently given to Dr Wilson. Mr Logue accepted that he had been off work with viral labyrinthitis. In my judgment, on the evidence presented at this Inquiry, it was not proved that that incident was a previous fainting episode. On the evidence led at this Inquiry, no fainting episode prior to 20 January 1998 has been established.

[145] Counsel for the Lochrie family contended that in April 1998 Mr Logue told Dr Lyons that he had the “all clear” from Professor Brodie. Counsel contended that this was false but I did not accept that submission. Plainly, Professor Brodie did not use those terms in his letter dated 19 March 1998 but I did not consider it was unreasonable for Mr Logue to take from it that he was getting the all clear to return to driving once the DVLA confirmed the position. However, I accepted that it was unexplained why Mr

Logue delayed until 20 April 1998 before contacting the DVLA. It was clearly established that Mr Logue was concerned about losing his job and telephoned the DVLA to tell them so (Crown production 29, page 8).

[146] Mr Logue did not report the incident on 3 August 2004 to the DVLA. His account during examination by the procurator fiscal depute was that when someone came out of the snooker hall, he had fallen back and cracked his head on a wall. Mr Logue stated he did not remember feeling unwell for 30 minutes prior to the incident or going to hospital. He stated that he was “pretty sure” it was an accident and not a faint. He explained that he had a tendency to sign documents without reading them. He was shown Crown production 18 at page 755, where he signed a document stating “Feeling unwell for 30 minutes prior to incident. Leaning on barrier then moved away from barrier then next thing remembers waking up on his back looking up”. Mr Logue was shown a statement from Stephen O’Reilly (non-witness) but he did not accept this account of events. He made suggestions that Mr O’Reilly “may have been badgered” into making the statement. Mr Logue offered no explanation as to why Mr O’Reilly would invent a false accident report in respect of him. He accepted Mr O’Reilly had been there. Mr Logue was taken to Victoria Infirmary with a minor head injury at work but did not wait to be seen.

[147] I regarded this chapter of Mr Logue’s evidence as unsatisfactory. His account does not fit with the unchallenged evidence of Stephen Neilson, who I considered to be an honest, straightforward and reliable witness. I am not prepared to accept as credible Mr Logue’s account of events on 3 August 2004 given in the witness-box. I am prepared

to accept as credible and reliable the contemporaneous account which Mr Logue signed on that date, namely, the employer's health and safety incident report form HS60 (Crown production 18 at page 755), which records that he had lost consciousness. This report is consistent with the hearsay report of fellow employee Stephen O'Reilly, who said that he was talking to Mr Logue "then all of a sudden he felt faint and collapsed banging his head off the concrete".

[148] Mr Logue accepted that he had been given a formal oral warning regarding his attendance levels at work on 3 June 2004 advising that an immediate and sustained improvement must be made in respect of attendance levels and that his performance would be monitored over the next few months.

[149] I accepted the submission made by counsel for the Lochrie family that the proved facts and circumstances surrounding the incident on 3 August 2004 supported the inference and led to the conclusion that Mr Logue, who had received a formal oral warning about his attendance level at work some 2 months previously, tried to cover up the fainting episode. He did not report a loss of consciousness when seen at the Victoria Infirmary. He did not wait for treatment. He did not tell Dr Lyons about the faint and was certified as fit to work on 9 August 2004. Mr Logue did not tell his general medical practitioner about this incident nor did he report to the DVLA that he had suffered an episode of loss of consciousness at work. The evidence of Mr Logue to the contrary effect was rejected by me as being false. In my judgment, it was not credibly given by him nor was it consistent with the actions of a person who had sustained injury in the way he maintained.

[150] On 6 June 2008 Mr Logue had another episode of loss of consciousness whilst engaged in the course of his employment driving a bus. As counsel for the Lochrie family correctly pointed out, this was a most significant incident because it is the last proved incident of loss of consciousness on the part of Mr Logue prior to the accident which resulted in Mr Lochrie's death on 31 March 2012. The incident on 6 June 2008 was also a significant one for Mr Logue. He accepted that he was concerned whether "this" (i.e. the episodes of loss of consciousness) was going to keep happening. When asked by the procurator fiscal depute, Mr Logue replied "I had thought my driving days were over".

[151] Mr Logue also told the procurator fiscal depute that the diagnosis as to why he had fainted was "high blood pressure". In my judgment, that answer was not credible. Mr Logue had never been told of any such diagnosis. He knew full well what the actual diagnosis was because he had telephoned the DVLA on 20 June 2008 to advise that he had fainted at work "believed due to dehydration". He told Dr Lyons on 3 July 2008 that dehydration was the diagnosis. Dr Lyons' note was "went to specialist and dehydration was the diagnosis". I accept that note as being a true and accurate record of what Mr Logue then said.

[152] So far as the circumstances of the accident on 6 June 2008 are concerned, the contemporaneous account given by Mr Logue in Crown production 18 at pages 1004/5 coincides with the account recorded by Dr Browne (non-witness) at 10.30am on 6 June 2008. The note taken by Dr Byrne does not entirely coincide with these contemporaneous reports. Counsel for the Lochrie family referred Mr Logue to a note in

the GP medical reports, Crown production 17 at page 663. However, Dr Burman was not called as a witness in this case and whilst his successor Dr Iain Kennedy did his best to try and interpret Dr Burman's handwriting, I was not prepared to hold that Dr Burman recorded "dizzy turns". It appeared to me that it was equally possible that he recorded "dizzy turn" and I was not prepared to accept this note as being a true and accurate note of what Mr Logue conveyed to Dr Burman on that occasion.

[153] In my judgment, Dr John Byrne was a credible and reliable witness. He had sufficient qualification and experience to be regarded as expert in the field of cardiology. I accepted that, for whatever reason, Dr Byrne did not have an accurate account of how long Mr Logue had been in the bus prior to the incident. Nevertheless, I was satisfied that Dr Byrne accurately recorded "He recalls he felt slightly dizzy before he got into the bus and this got abruptly worse as he was driving it through the depot". That was a matter of significance to Dr Byrne and is what Mr Logue told him. I preferred the evidence of Dr Byrne together with his contemporaneous note to the contrary evidence given in court by Mr Logue. Mr Logue told Dr Byrne that he had not experienced any fainting or blackout between 1998 and 2008, which was false. Mr Logue did not tell Dr Byrne about the incident in 2004. In my judgment, this was a deliberate omission by Mr Logue, which was consistent with the position he had previously adopted in relation to the 2004 incident. In my judgment, the proper inference to draw from Mr Logue's proved lack of candour on this occasion was that he was motivated to keep his job as a bus driver. Mr Logue's concern that he would lose his PCV licence was expressed in his answer to the procurator fiscal depute: "I thought that my driving days were over".

[154] Dr Byrne made the assessment he made on the information provided by Mr Logue. It has been established that Dr Byrne was wrong in his view that Mr Logue was not hiding anything from him. However, his view was formed upon the slender basis of a single meeting with Mr Logue. No doubt, it was salutary for Dr Byrne to have to accept in the light of matters put to him during his examination that Mr Logue had not given him the full picture and that had he done so, he would have reached a different view as to what he would have reported to the DVLA.

[155] Counsel for the Lochrie family submitted that the evidence of Stuart Purvis should be accepted as credible and reliable. I have already rehearsed the evidence of Mr Purvis between paragraphs [24] and [28]. I regarded Mr Purvis as a conspicuously honest witness who gave clear and forthright evidence in a very careful and considered way. Mr Purvis' evidence was plainly affected by the lapse of time between the accident on 31 March 2012 and the holding of this Inquiry. He stated that his earlier affidavit was not quite accurate in parts. I am satisfied by his explanation that this situation does not reflect adversely upon him. Mr Purvis made it clear that Mr Logue had not actually said that he (Mr Logue) had taken water tablets that day. What Mr Logue had said to him about water tablets resonated with him because his father had taken water tablets to lose weight. When recalled, Mr Logue stated that he did not remember telling anyone that he was taking water tablets. He asserted "I don't even know what water tablets do". Later on he said "I don't know where they've got water tablets from".

[156] I preferred the account given by Mr Purvis to that given by Mr Logue because I regarded it as being the credible account which was reliably given by a most impressive

witness. The words stated by Mr Logue resonated with Mr Purvis. This does not establish that Mr Logue had taken water tablets prior to the accident on 31 March 2012, but Mr Logue's failure to disclose anything about water tablets to any of the medical practitioners who saw him subsequent to the accident and his position in evidence as set out in the last paragraph did raise serious concerns about his credibility and reliability not just as a witness but in respect of what he told the various medical practitioners, including specialists, whom he has seen over the years.

[157] For all of the foregoing reasons I did not accept the invitations of the procurator fiscal depute or Mr Logue's solicitor to accept as credible and reliable the evidence of Mr Logue. In my judgment, his evidence in respect of the incidents on 3 August 2004, 6 June 2008 and 31 March 2012 was not wholly credible and reliable when considered along with and compared to other acceptable evidence. It is only where Mr Logue's evidence fits with other acceptable evidence that I was prepared to accept and proceed upon his account.

[158] I regarded Professor Brodie as an impressive witness. At the conclusion of his evidence I noted an initial impression "really on top of his work". That is my considered opinion. I regarded him as an entirely credible and reliable witness who gave evidence in a clear and forthright way. For the reasons which he gave, Professor Brodie's role in the clinic to which Mr Logue was referred in 1989 was to determine whether he suffered from epilepsy. The Health Board were entitled to set up a specialist referral clinic of the type then operated at the Western Infirmary. For the reasons given by Professor Brodie, such a clinic was plainly necessary. The object of the clinic was to

ensure that patients who suffered from epilepsy received treatment for epilepsy and those who were diagnosed as not suffering from epilepsy did not receive treatment for epilepsy.

[159] Mr Logue was seen by the Assistant Director, Dr Wilson, who wished further enquiries to be made before reaching a diagnosis. She referred Mr Logue to Professor Brodie who, having considered all the information before him including the CT brain scan, EEG and such information as there was regarding previous incidents, concluded that Mr Logue did not suffer from epilepsy. He was a very experienced consultant physician and advised that he had little doubt that Mr Logue suffered a vasovagal episode consequent on an unusual sequence of events. He reassured Mr Logue and discharged him to the care of his general medical practitioner, then Dr Burman. Mr Logue was warned by Professor Brodie not to drive and was told that he had to tell the DVLA about the episode. I have considered the submissions advanced by counsel for the Lochrie family. In my judgment, no legitimate criticism can properly be made in respect of Professor Brodie. In my judgment, Professor Brodie discharged his responsibility in relation to Mr Logue and reached the correct conclusion which, as he pointed out, has been confirmed by the lapse of time during which Mr Logue has not been found to suffer from epilepsy. He discharged Mr Logue to the care of his general medical practitioner.

[160] Professor Gerard McKay's evidence was largely unchallenged. He was an impressive witness. His evidence was credible and reliable. He had sufficient

qualifications and experience to give expert evidence and I found his evidence of fact and opinion to be most helpful.

[161] Dr Alan Rae, consultant cardiologist, was a most impressive witness. He was a well-qualified and very experienced medical witness who gave evidence in a careful, considered and measured manner. He had sufficient qualifications and experience to be regarded as an expert. I found his evidence as to fact and opinion to be most helpful and of considerable assistance to this Inquiry. Dr Rae made it clear that vasovagal syncope was frequently a recurrent repetitive condition, which could be unpredictable. Each individual can have his own provocative indicators. When he saw Mr Logue after Mr Lochrie's death, Dr Rae had only limited information with which to work. Dr Rae accepted that the account given to him by Mr Logue was different from that recorded by Dr Buchanan when she saw him at the Victoria Infirmary on 31 March 2012. Dr Rae was not aware that this was the third episode of loss of consciousness suffered by Mr Logue whilst driving a bus. As Dr Rae recorded in his letter to Professor McKay dated 21 June 2012 "In each of three episodes (1998, 2008 and 2012) there was preceding dehydration, which could well be a provocative factor".

[162] Dr Gareth Wyn Parry, the senior medical adviser to the DVLA, gave evidence clearly and did his very best to assist this Inquiry. He was clearly a well qualified and experienced former surgeon, who demonstrated a realistic and practical approach to the problems faced by the DVLA, not least because of the increase in casework. As he has only been in post since about April 2014, it will be appreciated most of the matters about which he was asked related to a period prior to his commencing work with the DVLA.

His evidence was largely unchallenged and was given in a most credible and reliable way. His explanation of the statutory system in place in the United Kingdom was very clear and helpful. His acceptable evidence and the helpful submission made by counsel for the DVLA have caused me to reflect at length on the inter-relationship between the statutory system and Mr Lochrie's death.

[163] The evidence of Dr Iain Kennedy was fairly criticised by counsel for the Lochrie family. I regret to say that Dr Kennedy seemed to have difficulty in appreciating his role as a witness and that he had not been called so that this Inquiry could hear about the matters which he thought it should be told. On some occasions, he seemed to have difficulty in answering straightforward questions and went off at a tangent. On other occasions he appeared to give inconsistent answers. He gave unsought positive testimonials for Mr Logue, Dr Burman, Dr Cree and Dr Cormack. Having given prolonged consideration to his evidence I was not prepared to impugn his credibility. I concluded that he was simply unduly defensive of himself and over-protective of the doctors who had worked for him and, particularly, his patient Mr Logue. At times, for understandable reasons, I considered that his recollection of meetings with Mr Logue may have been unreliable. But I accepted him as a credible and generally reliable witness, although on the evidence available to me, which was considerably greater than available to him, I did not share his entirely positive view of Mr Logue. I considered that each of Dr Cree and Dr Cormack gave credible and reliable evidence upon which I could proceed, although I considered that Dr Cree was wrong in her recollection that Mr

Logue was normal weight when she saw him on 4 April 2012. I preferred the contrary evidence of Professor McKay.

Determination in terms of section 6(1)(a) and (b) of the 1976 Act

[164] My determination in terms of section 6(1)(a) proceeds upon the basis of the acceptable unchallenged evidence led as to what occurred that morning, the most helpful crash investigation report prepared by PC Scott Simpson and PC Mark Caldwell and the most helpful VOSA examination carried out by Mr George Courtney. My determination in terms of section 6(1)(b)(i) proceeds upon the basis of the post-mortem report. My determination in terms of section 6(1)(b)(ii) proceeds upon the unchallenged eye witness evidence, the crash investigation report, the evidence led in respect of the previous episodes of vasovagal syncope which Mr Logue had had, the evidence led in respect of the inquiries made following Mr Logue's general medical practitioner's referral of him after 31 March 2012 and by his own evidence insofar as I found it acceptable.

[165] There was no acceptable evidence of other episodes of loss of consciousness by Mr Logue, apart from the incidents in 1998, 2004, 2008 and 2012. Mr Logue's state of hydration in 2004 was not established.

[166] In 2008 Mr Logue was on a diet and restricting his intake. In 2012 Mr Logue was technically obese and said to Mr Purvis that he was taking water tablets. I did not hold that Mr Logue took water tablets on 31 March 2012 but he accepted during his evidence that he was restricting his fluid intake on that date. He maintained this was because of

the lack of toilet facilities available to him whilst he was working as a bus driver. I accepted that Mr Logue was restricting his fluid intake but I did not accept his explanation, which was contradicted by the acceptable evidence of Stephen Neilson.

[167] He was also taking Ramipril, which had been prescribed by his general medical practice. I accepted the evidence of Professor McKay and Dr Cormack established that Ramipril was less likely than other hypotensive drugs to cause fainting and was unlikely by itself to cause a faint, especially in a person who had been taking it for a period of months. Accordingly, it was established that Ramipril did not contribute in any way to the episode of vasovagal syncope which Mr Logue had on 31 March 2012.

[168] In my judgment, it was proved by acceptable evidence that in each of the episodes on 20 January 1998, 6 June 2008 and 31 March 2012 Mr Logue had an episode of vasovagal syncope provoked by dehydration whilst driving a bus in the course of his employment. As Dr Rae noted, on each occasion there was dehydration. Dr Rae considered that dehydration could well be a provocative factor. So far as the 1998 episode was concerned, this opinion was consistent with the acceptable opinion evidence of Professor Brodie. I accepted the submission advanced by counsel for the Lochrie family that it was proved that David Logue experienced an episode of vasovagal syncope on 6 June 1998. After the second episode on 6 June 2008 Mr Logue received clear advice from Dr Byrne concerning the episode being provoked by dehydration and the need for him to maintain a proper dietary and fluid intake to avoid similar episodes being provoked by dehydration. Mr Logue accepted that he had been given this advice. He understood this advice. He told both Dr Lyons and the DVLA about the

dehydration. The advice should have been important to Mr Logue because after this second episode on 6 June 2008 Mr Logue thought his driving days were over because his licence would be revoked.

[169] Dr Byrne agreed with counsel that two faints at the wheel of a vehicle indicated a driver who would put others at risk. He stated that fainting whilst sitting was a “red flag” symptom: a significant finding. Where two episodes occurred under similar circumstances there would be significant concern. I accepted his unchallenged opinion evidence on these matters.

[170] On 31 March 2012 Mr Logue had taken no food and only a small cup of tea. In answer to counsel for the DVLA he accepted that: “I could have been dehydrated. I can’t medically say I was”. In my judgment, this account of what he had taken was redolent of Mr Logue’s restriction of diet prior to the circumstances of the incident on 6 June 2008. In my judgment, on the acceptable evidence before this Inquiry it was established that it is more likely than not that dehydration was the provocative factor resulting in Mr Logue having an episode of vasovagal syncope. The evidence disclosed no other possible competing provocative factor. In my judgment, these individual episodes of vasovagal syncope are sufficiently connected in time, place, character and circumstance to enable me to infer that the provoking feature for each episode was dehydration.

[171] For the avoidance of doubt, it is not my conclusion that Mr Logue deliberately drove knowing that he was going to have another vasovagal event. However, he had restricted his fluid and dietary intake on 31 March 2012. He went to work and drove a

PCV in the course of his employment. Mr Logue knew that he had fainted twice before at the wheel of a bus when dehydrated. After the incident on 6 June 2008, Mr Logue thought that his driving days were over. Mr Logue knew that he had been advised by Dr Byrne that he must maintain an appropriate fluid and dietary intake. In my judgment, on the morning of 31 March 2012 Mr Logue drove the bus without having maintained a proper dietary and fluid intake and courted the risk that dehydration might provoke another episode of vasovagal syncope whilst he was driving, as it had on 6 June 2008.

[172] For all of the reasons set out above I did not accept the submission of the procurator fiscal depute that it could not be affirmed what caused Mr Logue to lose consciousness in 1998, 2008 or 2012. I have rejected his submission and that of Mr Logue's solicitor that there was nothing in the evidence to show what was the cause of each episode.

Determination in terms of section 6(1)(c) of the 1976 Act

[173] My determination in terms of section 6(1)(c) covers a number of matters. Section 6(1)(c) of the 1976 Act involves an exercise of retrospective consideration of matters with the benefit of hindsight on the basis of the acceptable evidence before the Inquiry. A finding under sub-paragraph (c) requires not a probability but a "real and lively possibility" that the accident resulting in the death might have been avoided by the reasonable precaution.

[174] I had little difficulty in reaching a determination that a reasonable precaution whereby the accident resulting in Mr Lochrie's death might have been avoided was for Mr Logue to have followed the advice given to him on 17 June 2008 by Dr John Byrne to maintain a sufficient dietary and fluid intake to avoid becoming dehydrated and having a further vasovagal episode provoked by dehydration whilst he was driving a motor vehicle. Alternatively, if Mr Logue was not prepared to follow Dr Byrne's advice (as I have found established), it was a reasonable precaution whereby the accident resulting in Mr Lochrie's death might have been avoided for Mr Logue simply not have driven any type of motor vehicle, whether a car or a bus.

[175] Dr Iain Kennedy, Mr Logue's general practitioner from August 2008, could not confirm from his inspection of the records whether Mr Logue had ever been seen by a doctor at the practice following upon receipt of Dr Byrne's letter dated 20 June 2008 to discuss Dr Byrne's opinion and advice in regard to the accident on 6 June 2008. Dr Byrne gave unchallenged evidence that patients do not always follow the advice they are given and this evidence probably reflects universal experience in the medical profession. Dr Kennedy raised the question as to whether patients actually read the information leaflet which comes with all prescribed medication.

[176] In my judgment, taking full account of these circumstances, it would have been a reasonable precaution which might have avoided the accident resulting in Mr Lochrie's death for Mr Logue's general medical practitioner to have seen Mr Logue to discuss and reiterate Dr Byrne's advice regarding maintaining sufficient dietary and fluid intake to avoid provoking another episode of vasovagal syncope in order to underline its vital

importance, particularly if Mr Logue wished to continue to drive and to be employed as a bus driver. I consider it a lively possibility that had Mr Logue received this further advice then he might have followed it because Dr Kennedy was at pains whilst giving evidence to stress that, in his view, Mr Logue was a reasonable man who wanted to make sure that everything was done in an appropriate way. Alternatively, he may have had to come to terms some years earlier than he did that he could not continue to work as a bus driver if, for whatever reason or reasons, he wished to continue to restrict his dietary and fluid intake. He might have looked for and found suitable alternative employment, as he did after the accident on 31 March 2012 which resulted in Mr Lochrie's death.

[177] The purpose of the final sentence is two-fold. Firstly, it is to give the patient the advice in writing. In universal experience, it is sometimes takes the stark terms of a letter to bring matters home to a person. Moreover, it means that the patient has been advised orally by the consultant and the general practitioner and has a written copy of the specialist's advice. Second, for evidential reasons, the letter can be used to support proof of knowledge of the advice on the part of the patient.

[178] It is evident from the terms of Dr Byrne's letter dated 20 June 2008 that on the information available to him he considered that the likelihood of recurrence of loss of consciousness was very low. Dr Byrne did not have the benefit of seeing the medical records from 1998, although he did attempt to recover them. He did not know about the 2004 episode and he did not know the full details of the 2008 episode. However, he knew that Mr Logue had had a vasovagal episode whilst driving a bus and in a seated

position. On Dr Byrne's own evidence, fainting whilst sitting was a red flag symptom. In my judgment, the submission advanced by counsel for the Lochrie family was sound and must be sustained. I am satisfied that, in these circumstances, it would have been a reasonable precaution whereby the accident resulting in Mr Lochrie's death might have been avoided for Dr Byrne to have advised the DVLA either on the DVLA medical report form which he completed on 29 August 2008 or in an accompanying letter that Mr Logue was a bus driver and that the incident on 6 June 2008 in which he fainted occurred unusually whilst he was sitting driving a bus. Dr Wyn Parry's acceptable opinion evidence established that on a proper application of the then current guidelines that had Dr Byrne done so it would have led the DVLA to revoke Mr Logue's licence. It is a lively possibility that Mr Logue might not have been driving on 31 March 2012 when the accident in which Mr Lochrie lost his life occurred.

[179] Although the DVLA do not seek information from employers of a licence holder or provide information to them, I understood the solicitor for First Glasgow (No 1) Limited to accept that it would have been reasonably practicable for them to tell the DVLA what it knew regarding an employee licence holder's fitness to drive. I consider that that acceptance was properly and appropriately made. No bus company could possibly wish to endanger any member of the public, whether passenger or not, or any fellow employee by a bus driver who was not fit to hold a licence driving a bus in the course of his employment. The acceptable evidence revealed that there were disciplinary rules which could be invoked by the bus company in respect of a driver who failed to inform the bus company of anything which could affect his ability to drive.

In that situation, the onus is placed on the individual bus driver. The acceptable evidence at this inquiry reveals Mr Logue lost consciousness on 3 August 2004 in an incident at work. The bus company's personnel department had a record of this incident but it was not shared with the bus company's medical staff. Dr Lyons stated that he would not often contact the DVLA and that he would need the licence holder's permission to do so.

[180] In my judgment, it was a reasonable precaution whereby the accident resulting in the death of Mr Lochrie might have been avoided for First Glasgow (No 1) Limited to have instructed the medical officers employed by them to report to the DVLA any matter of which the bus company or the medical officer became aware relating to the possible unfitness to hold a driving licence of any employee who held a passenger carrying vehicle licence. In the circumstances here this would have required to have been implemented prior to 6 June 2008. Moreover, another reasonable precaution whereby the accident which resulted in the death of Mr Lochrie might have been avoided was for the bus company to have instructed that the medical officers employed by them should receive all information received by the personnel department or contained in the personnel records insofar as related to episodes or suspected episodes of loss of consciousness by any employee who held a passenger carrying vehicle licence.

[181] So far as counsel for the Lochrie family's submissions as to the reasonable precautions which should be found on the basis of the acceptable evidence are concerned, I concluded that I could not sustain the first one he sought on the basis that compliance with a statutory obligation is obligatory: it cannot be a reasonable precaution

to advise the DVLA if the licence holder is statutorily obliged to do so. Moreover, to make a finding in terms of section 6(1)(c) requires a real and lively possibility that the accident resulting in Mr Lochrie's death might have been avoided had the precaution been taken. I was unable to conclude that Mr Logue would have taken any of the desiderated steps. I have gone as far as I considered that the acceptable evidence permitted in making my first finding in terms of section 6(1)(c).

[182] I have set out my positive conclusions in respect of Professor Brodie above. I am satisfied that the third and fourth ones sought are not justified on the acceptable evidence led. Professor Brodie had good reason not to refer Mr Logue to cardiology; he fully discharged his duties in relation to Mr Logue; and he referred Mr Logue back to the care of his general medical practitioner.

[183] So far as the findings sought in respect of "First Bus" are concerned, Ms McDonnell correctly pointed out that there was no evidence before this Inquiry of a bench mark system of work which a bus company could be expected to have in place. On the basis of the acceptable evidence led, I was not satisfied that any of the findings sought in respect of First Glasgow (No 1) Limited were justified beyond the finding which I have made.

[184] So far as the finding sought in respect of Mr Logue's general medical practitioner is concerned, I concluded that this was not justified by the acceptable evidence. Dr Kennedy gave Mr Logue a positive character reference and he did not consider that Mr Logue had a tendency to mislead others about his medical history. In any event, the obligations of a medical practitioner to draw to the attention of the DVLA that his

patient has a tendency to mislead others about his medical history is both sensitive and has wide ranging implications. This issue was not focussed in evidence or submission at this Inquiry. I was not prepared to express a view without much fuller evidence, including expert medical evidence about any position the General Medical Council may have taken regarding such a situation.

[185] So far as the final finding sought is concerned, I sustained the submission and made a finding so as Dr Byrne was concerned. Mr Logue filled in the DVLA form sent to him. He was not asked any supplementary question by the DVLA. The DVLA forms then in use are considered later.

Determination in terms of section 6(1)(d) of the 1976 Act

[186] Counsel for the Lochrie family sought five separate findings. So far as the first finding sought is concerned, it was not established to my satisfaction on the acceptable evidence led that this was a failure on the part of the bus company. It was accepted that the personnel department did not share information with the medical officers but the reason or reasons for this are unclear. I was not satisfied that this was a systemic failure in work practice. I have, of course, made a finding in terms of section 6(1)(c) of the 1976 Act in respect of this matter. So far as the second finding sought is concerned, this was erected upon acceptance of Mr Logue's evidence regarding lack of toilet facilities, which I did not accept. So far as the third finding sought is concerned, there was no statutory obligation upon the bus company to correspond with the DVLA. The unchallenged evidence was that the DVLA did not correspond with employers, either to seek or to

give information. In my judgment, the fact that the bus company did not correspond with the DVLA was not properly categorised as a defect in a system of working. I have made a finding in terms of section 6(1)(c) in respect of this matter.

[187] So far as the fourth finding sought is concerned, I concluded that this was not properly categorised as a defect in a system of working. The reasons why the DVLA do not give information about licence holders to the licence holder's employers were not explored in any depth at this Inquiry. I was not satisfied that any "defect" had been established. Finally, so far as the fifth finding sought, I reached the same conclusions: the lack of correspondence is not a system of working issue; the reasons why there was no correspondence between the general practitioner and the DVLA were not explored in any depth and I was not satisfied that any "defect" had been established.

[188] In my judgment, on the acceptable evidence led before at this Inquiry, it is not established that a defect in any system of work contributed to the accident resulting in Mr Lochrie's death on 31 March 2012.

Determination in terms of section 6(1)(e) of the 1976 Act

[189] The procurator fiscal depute and counsel for the Lochrie family sought findings in terms of section 6(1)(e). Counsel for the DVLA made certain submissions and observations, which I found to be of great assistance. I considered all the competing submissions advanced and was satisfied that the facts I have found reflected many of the submissions advanced and were relevant of the circumstances of Mr Lochrie's death.

The first finding is made upon the unchallenged evidence of Mr Courtney and his report, to which reference has already been made.

[190] So far as the second finding is concerned, it is clear from the terms of Appendix A of the Crash Investigation Report (Crown production 3) dated 4 June 2012 that the police officer author formed a clear opinion regarding responsibility for the accident which resulted in Mr Lochrie's death. In my experience, these reports take time to prepare because detailed inquiries are carried out and careful skilled consideration is given to them. Such reports are often an important consideration in the police report of the accident to the procurator fiscal. This report was prepared within a reasonable time after 31 March 2012.

[191] PS Dawn Miller (then of Strathclyde Police) deponed in her affidavit that shortly after the accident occurred in the morning of 31 March 2012, she assumed the role of Senior Investigating Officer. This was shortly after Mr Lochrie had been pronounced dead. She appointed PC David Murdoch as the investigating officer. On 31 March 2012 PC Murdoch saw Mr Logue very briefly and described him as being "in complete shock, pale and frightened". He explained that he did not interview Mr Logue or take a statement from him. He explained that he had been told not to have any interaction with Mr Logue. I accept PC Murdoch's unchallenged evidence in this regard.

[192] PS Miller deponed in her affidavit that: " At about 9.15am, Logue was taken by ambulance to Glasgow Victoria Hospital and I instructed Constable Lorna Breen to stay with him and provide me with a medical update".

[193] PC Breen was at the scene of the accident and knew from her own involvement that Mr Lochrie was trapped under the bus and was unresponsive. She then spoke to Mr Logue and formed the view that he could answer questions. She noted that he was pale, shaken and appeared upset. She stated that she did not get any information about him from a paramedic.

[194] PC Breen stated that she remained with him when other officers came. She said that Mr Logue said that he was the driver of the bus. She also stated that Mr Logue said he did not remember anything about how the accident had happened. She stated that she went to the Victoria Infirmary and was present when Dr Buchanan spoke to Mr Logue in the Accident & Emergency Department. She stated that Mr Logue had stated that he did not know how the accident happened and that he thought he had blacked out. PC Breen stated that later, after Mr Logue had been seen by a doctor, she was instructed by a traffic sergeant to tell Mr Logue that Mr Lochrie had died. She did so and "he was visibly upset and shaking". She stated that although she had had conversation with him at the Infirmary, she did not consider cautioning him. When pressed about this by the court, she was unable to give any explanation for not giving this matter any consideration.

[195] PC Roger Millar, a traffic officer, gave evidence that along with PC Parker he saw the bus driver and that, when required to do so in terms of section 172 of the Road Traffic Act 1988, Mr Logue identified himself as the driver of the bus involved in the accident. A breath test was administered with negative result. PC Millar stated that Mr Logue did not volunteer "anything to me".

[196] It is both surprising and of concern that PC Murdoch was told not to have any interaction with Mr Logue but that no such instruction was given to PC Breen. This inconsistency of approach suggests a failure to properly consider the position of Mr Logue, his legal and human rights, the evidential position and the direction of police inquiries. At that time, Mr Logue was, at the very least, a potential suspect in the commission of a crime or a road traffic offence. Put another way, he was clearly the driver of the bus which had left the road and collided with the bus stop shelter, struck Mr Lochrie and resulted in him sustaining fatal injuries. If any crime or offence had been committed by the bus driver, clearly the perpetrator was Mr Logue. The instruction given to PC Murdoch was appropriate and coincided with his own view. It is also a matter of concern that at no stage did PC Breen ever consider whether to caution Mr Logue. She felt able to engage in conversation with him. The occasion when PC Breen advised Mr Logue of Mr Lochrie's death was one which was likely to induce a response from Mr Logue. I do not suggest that there was any calculated approach to induce an incriminating response but throughout the period when PC Breen was involved, it was going too far too fast to conclude that no crime or road traffic offence had been committed by Mr Logue.

[197] The third finding is not contentious. It was accepted by Mr Logue that he did not report the incident on 3 August 2004. I was satisfied that it was established that he lost consciousness on this occasion, as discussed above. It is of significance because on my finding he should have notified the DVLA, who as a result were unaware of the incident at all material times prior to Mr Lochrie's death.

[198] The fourth finding is based upon the acceptable opinion evidence of Dr Wyn Parry. It is of relevance to Mr Lochrie's death for obvious reasons.

[199] So far as the fifth finding is concerned, it is in four parts. Parts (i) (ii) and (iii) are facts established by acceptable evidence, which have been discussed earlier. Mr Logue should have advised the DVLA of the episode of loss of consciousness on 3 August 2004. Mr Logue should have given Dr Byrne full and complete information on 17 June 2008. Dr Byrne should have advised the DVLA in August 2008 that Mr Logue was a bus driver and that the incident on 6 June 2008 in which Mr Logue lost consciousness occurred unusually whilst he was sitting driving a bus.

[200] Dr Wyn Parry made it clear that the personal responsibility of the licence holder to report any relevant matter to the DVLA was very important. He pointed to the availability of the DVLA website and telephone helplines to assist any licence holder. He drew attention to the At a Glance Guide for Medical Practitioners at the section relating to loss of consciousness: "A full history is imperative to include pre-morbid history, prodromal symptoms, period of time unconscious, degree of amnesia and confusion on recovery." He drew attention of the efforts being made by The General Medical Council to raise the level of awareness of requirements of the Guidelines amongst the medical profession. The evidence established that as full information as could possibly be obtained was necessary to assist the medical advisers at DVLA reach an informed decision on a licence holder's continued fitness to drive.

[201] The acceptable evidence of the medical practitioners who gave evidence at this Inquiry established that diagnosis and advice has to be given upon the basis of the

available information. It is established that at all material times prior to 31 March 2012 relevant medical records were not always available and that general medical practitioners and consultants had to proceed very much upon the basis of what a patient told them, which account would be accepted and proceeded upon unless there was some contrary factor. It was upon this basis that diagnosis and advice was given.

[202] Where a medical report was subsequently requested by the DVLA it was established that that report would be provided on the basis of the information obtained in the manner described in the preceding paragraph. Since Mr Lochrie's death there have been information technology improvements whereby consultants can easily gain access online to a patient's previous hospital records within the Greater Glasgow and Clyde NHS Health Board but not elsewhere. So problems gaining access to relevant medical records persist.

[203] Turning to part (iii) of the fifth finding, I was satisfied on the evidence that one of the reasons the DVLA was not aware of the full circumstances in respect of Mr Logue's episodes of loss of consciousness was due to the inadequacy of the forms then in use by the DVLA to obtain information from the licence holder and from medical practitioners. The essential problem was that the forms then in use were of a tick box type and did not require the provision of sufficient evidence to enable an informed and sound decision to be made regarding a licence holder's continuing fitness to drive where loss of consciousness and a syncope vasovagal episode was under consideration.

[204] Turning to the sixth and seventh findings, which can be taken together, Dr Wyn Parry considered that had the further information put to him in the course of his

examination as a witness at this Inquiry been known to the DVLA at the material time Mr Logue's licence would have been revoked in 2008 with the likely result that Mr Lochrie's death would have been avoided. It is with that very much in mind, and taking full account of the respective submissions made to me, that I have accepted most of the helpful suggestions made as to how the forms might be improved. The questions in the DVLA forms must seek full information on all relevant matters. As the DVLA medical advisers have to proceed to make decisions on licence holders' continuing fitness to drive, it is essential that the fullest possible information be available to them. It was established that in the past this has not always been so: see paragraph 78 above. In some complex cases, this may mean that the information ingathered for consideration will be considerable. But I am conscious and readily accept that advising on which questions should be asked in forms is no easy matter. I have set out for consideration my findings as to how the forms might be improved and am content to leave to the DVLA the matter of detailed consideration of the questions which should now be asked and how these questions should be framed. I have no doubt that they will appropriately consult before reaching a final decision.

[205] It appears to me in the light of the findings made at this inquiry that I should respectfully recommend that consideration be given by The Secretary of State for Transport as to whether appropriate legislation is required to change the law in certain respects. The obvious plain fact is that if a licence holder does not answer fully and candidly the questions asked or avoids reporting notifiable matters to the DVLA, the system of self-notification is undermined and brought into disrepute. It is essential that

the DVLA has all necessary and relevant information to determine a licence holder's continuing fitness to drive. Accordingly, the DVLA must have appropriate powers to obtain necessary and relevant information to discharge its responsibilities. This is the purpose of the first recommendation. Rather than have the DVLA have to get the licence holder's consent to seeing medical records in each case, it may be better to have deemed consent as a condition of being a licence-holder. The matter of requiring the licence holder to attend for medical examination might merit fresh consideration so that in an appropriate case it can be invoked in the interests of public safety.

[206] So far as the second and third recommendations are concerned, whether it is appropriate to continue to seek reports from specialists who have dealt with the licence holder but may not have full information about him may be ripe for consideration.

There was some discussion in the course of Dr Wyn Parry's evidence regarding the instruction of independent medical examiners in appropriate cases. The introduction, use, duties and responsibilities of medical practitioner examiners may merit consideration in view of increasing case numbers and complicated cases. In an appropriate case, it may be better to use an independent medical practitioner examiner, being a suitably qualified and experienced doctor or surgeon chosen by the DVLA. It may now be appropriate to consider setting up a panel of medical practitioner examiners throughout the country to give detailed consideration to and opinion on difficult or sensitive cases. It is important that medical practitioner examiners should have access to all relevant medical and general practitioner records. It respectfully appears to me that such medical practitioner examiners would have to report to the

DVLA fully and in writing to the DVLA on the matters set out in recommendation (3) within a reasonable time.

[207] So far as the fourth recommendation is concerned, the matter of whether DVLA should be given the power to impose interim revocation pending a decision on the licence holder's continuing fitness also arises for consideration. This could not be for an unlimited time but the present system does appear to lack any effective power to revoke a driving licence on an interim basis in an appropriate case.

[208] So far as the fifth recommendation is concerned, the need for medical advisers to give written reasons was focussed at this Inquiry because the absence of written reasons occasionally made it difficult and well nigh impossible to be certain as to the reason for a particular decision in respect of Mr Logue. I respectfully recommend that consideration be given to making it a statutory obligation for a medical adviser to give written reasons for a decision. These reasons need not be long but should clearly and sufficiently set out why the decision was made.

[209] So far as the sixth recommendation is concerned, the current penalties for breach by licence holders of existing legislation was a matter of concern to Mr Lochrie's family. But they were more particularly concerned about what they considered to be "woefully inadequate enforcement" of sections 92(10), 94(3) and section 94(3A) of the Road Traffic Act 1988, as amended. Dr Wyn Parry stated in evidence that he would not expect members of the public to know if they were suffering from a relevant disability unless they were told by a doctor: see paragraph [74] above. I respectfully recommend that consideration be given to specifying in plain straightforward language all the relevant

disabilities which require to be declared to the DVLA. The corollary of the maxim “ignorance of the law is no excuse” must be that the law can be easily found without the necessity of seeking medical advice. The second part of this recommendation is a technical matter: if all relevant disabilities are specified then section 94(2) appears to be otiose.

[210] So far as the seventh recommendation is concerned, I respectfully recommend that consideration be given to whether it should be made explicit that the onus of proof of reasonable excuse rests upon the licence holder, it being a matter peculiarly within his knowledge and therefore for him to establish on the balance of probabilities.

[211] So far as the eighth recommendation is concerned, I respectfully recommend that consideration be given as to whether the existing penalties for current offences are sufficient to promote compliance with current requirements on licence holders to report matters to the DVLA. The system of self notification is brought into disrepute if the penalties for failure to comply with a statutory requirement to report a disability to the DVLA are not significant and proportionate with the consequences of compliance, which can be revocation of the licence holder’s driving licence. Moreover, certain cases of alleged breach of section 94(1) and (3) or section 94(3A) may merit prosecution upon indictment, where penalties which can be imposed upon conviction are greater, and I respectfully recommend that consideration be given to extending the mode of prosecution in respect of these sub-sections.

[212] So far as the ninth recommendation is concerned, it may now be appropriate to consider introducing a new indictable offence of driving whilst unfit to do so by reason

of the driver not having followed medical advice to maintain fitness to drive. Whilst there should not necessarily be difficulties of proving such an offence if the general medical practitioner sees the licence holder subsequent to specialist advice and a letter is sent confirming the medical advice, I appreciate the creation of such an offence requires careful consideration because of its wide ranging implications. I envisage it being used in exceptional cases of blatant disregard of medical advice regarding maintenance of fitness to drive.

[213] So far as the tenth and eleventh recommendations are concerned, the acceptable evidence led at this Inquiry established a gap which many right thinking members of the public may consider to be unacceptable. At present, bus companies do not appear to be obliged to report to the DVLA any information which they acquire regarding any of its employees who hold the necessary licence to drive a bus having an episode of loss of consciousness. The licence holder is obliged to report the episode to the DVLA but if he does not do so, then the DVLA will not necessarily be advised of the episode. I recommend that consideration be given to placing a statutory obligation to report upon bus companies within a short time limit, with appropriate penalties upon conviction for failure to do so.

[214] Each and all of these matters appear to me to merit consideration as a result of the evidence led at this Inquiry but each would require legislation. Accordingly, I respectfully recommend that consideration be given by The Secretary of State for Transport as to whether appropriate legislation is required on any or all of the matters I have specified.

[215] There is one final matter with which I must deal. Attention was drawn by Dr Wyn Parry to the changes which have taken place at the DVLA since Mr Lochrie's death. The now current Medical Standards of Fitness to Drive (November 2014) comprise Crown production 30. Counsel for the Lochrie family accepted that these Guidelines contained suitable and sufficient measures for dealing with Mr Lochrie's case. I did not accept his submission that all previous Guidelines were inadequate. As both Dr Wyn Parry and counsel for the DVLA during his closing submission made clear the Guidelines have evolved in the light of experience and cases which have been considered by the relevant Honorary Medical Advisory Panels. Those medical practitioners who sit on the Honorary Medical Advisory Panels are highly qualified and have extensive experience. There is input from lay members. Nothing in the acceptable evidence led at this Inquiry would justify any criticism being made by me of this system or the content of any previous Guidelines which were in force at any material time relevant to the circumstances of Mr Lochrie's death.

[216] I should like to record my thanks to the procurator fiscal depute and to counsel for the Lochrie family, the solicitors for Mr Logue, First Glasgow (No 1) Limited and Greater Glasgow Health Board and counsel for the DVLA for their considerable assistance during the Inquiry and for their carefully focussed submissions.

APPENDIX

SUBMISSIONS FOR THE FAMILY OF THE DECEASED in the FATAL ACCIDENT INQUIRY into the death of JAMES LOCHRIE

1. *Synopsis*

David Logue has a medical condition of recurrent syncope episodes (blackouts). Prior to the fatal accident on 31 March 2012, he had two of these episodes whilst driving a bus in the employment of First Bus. Evidence was led of another fainting episode at work in 2004.

Once is happenstance, twice might be coincidence, three times is a pattern.

By 2008 at the latest, it ought to have been apparent to Mr Logue and anyone with access to his medical or occupational health records that this was a recurrent problem. The episodes in 1998 and 2008 were particularly significant because he was at the wheel of a PCV. It is more difficult to faint when sitting or driving.

First Bus say that the DVLA were responsible for certifying him fit to drive a PCV, but they employed Mr Logue and put the keys to a bus in his hand. Their medical officer, Dr Lyons, said that it was for Mr Logue's GP to provide information to the DVLA. He abdicated any responsibility for the safety of employees or the public. First Bus failed to bring the 2004 incident to the attention of any medical practitioner or the DVLA. The DVLA decisions were based on information provided to them which was materially deficient. It is not possible to be too critical of the DVLA decisions because their records are hopelessly incomplete. Mr Logue's GPs, Dr Burman and Dr Kennedy did not correspond at all with the DVLA. Dr Kennedy said that it was primarily the responsibility of First Bus and their medical officer to provide information to the DVLA; and for First Bus to make decisions about Mr Logue's fitness to drive.

The months after the episode on 6 June 2008 were effectively the last best opportunity for First Bus, Dr Lyons, the GPs or the DVLA to examine Mr Logue's case and make a decision which would have prevented him from driving on 31 March 2012. Each of them failed in their responsibilities in different ways and each contributed to Mr Logue driving a bus on 31 March 2012. Primary responsibility for the death rests with Mr Logue.

2. Determination

I invite the court to make the following determinations, under s. 6(1) of the Fatal Accidents and Sudden Deaths Inquiries (Scotland) Act 1976:

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

James Lochrie died on 31 March 2012 at around 0801 hours at Cathcart Road, near Aitkenhead Road in Glasgow.

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

James Lochrie died when he was struck by a southbound white coloured Volvo Olympian double deck PCV bus, registration R153 EHS ('the bus'). The bus was travelling route number 31 East Kilbride Bus Station. The bus was driven by David Logue, an employee of First Glasgow (No. 1) Limited, 197 Victoria Road, Glasgow, G42 7AD. Mr Logue began route 31 at around 0627 hours. At around 0800 hours, he approached the junction of Cathcart Road and Aitkenhead Road. At the lights, he lost consciousness. The bus continued along Cathcart Road. At a point around 20 metres from the lights, the bus mounted the offside kerb. The bus struck a bus stop around 50 metres from the junction. James Lochrie was waiting in the bus stop as the relief driver on the route 31. The bus struck the bus stop and James Lochrie. It continued along the pavement, coming to rest approximately 70.5 metres from the junction. James Lochrie was trapped under the bus. He was completely unresponsive to witnesses moments after the accident. It is likely that he died, or at least was rendered completely unconscious, instantly.

Moments before the collision, David Logue lost consciousness as a result of a syncope vasovagal attack. He had experienced two previous syncope vasovagal attacks with loss of consciousness whilst driving at work, on 20 January 1998 and 6 June 2008. Both previous attacks resulted in collisions. He also lost consciousness as a result of syncope attacks in 1996 and 2004. On the latter occasion, he fainted at work and required medical treatment for a minor head injury. There were no defects in the bus which caused or contributed to the accident.

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

- (i) David Logue could have, on any number of occasions, informed his GP, histreating physicians, his employer and/or the DVLA, of episodes of dizziness and loss of consciousness. As his evidence is unreliable and incredible, it cannot

- be known how many episodes were not reported. There is evidence of a failure to report 2 or 3 episodes in 1995 and 1996 and one episode in 2004. Had Mr Logue been candid about his (known) medical history, he would not have held a PCV licence on 31 March 2012.
- (ii) Mr Logue could have relinquished his PCV licence prior to 31 March 2012.
 - (iii) Professor Brodie could have made a referral to cardiology in March 1998. On his own evidence, had there been more than one syncopal episode, he would have made that referral. He was aware of two previous episodes.
 - (iv) Professor Brodie could have properly documented a previous syncopal episode in his correspondence. He failed to record the “identical episode” on jury duty 2 years previously. That failure resulted in the creation of an inaccurate medical history.
 - (v) First Bus could have provided their medical officer with a copy of the accident report dated 3 August 2004. Had a detailed referral been made, or had the GP been given the accident report, Mr Logue’s false report of the accident might have been investigated. First Bus did not let its left hand know what its right hand was doing.
 - (vi) First Bus had no routine assessment of an employee driver’s fitness to drive. Had the First Bus medical officer routinely examined Mr Logue, the medical condition of recurrent syncope episodes might have been identified.
 - (vii) The First Bus medical officer did not carry out a critical review of the occupational health records in assessing Mr Logue’s fitness to drive. A pattern of syncopal episodes could have been identified earlier.
 - (viii) The First Bus medical officer could have corresponded with the DVLA regarding Mr Logue’s fitness to drive (in 1998, 2004 and/ or 2008). Dr Lyons said only the DVLA could take a driver off the road, but he had no idea what information had been submitted to the DVLA or the basis of their decisions.
 - (ix) First Bus could have spoken to Mr Logue or instituted disciplinary action in respect of his reporting for driving duties on 20 January 1998 and 6 June 2008 after experiencing dizzy spells. Mr Logue was apparently in breach of their Driver’s Handbook rule on reporting for work.
 - (x) Mr Logue’s GP (Both Dr Burman and Dr Kennedy) could have corresponded with the DVLA. Dr Kennedy in particular ought to have been alert to Mr Logue’s

tendency to mislead others about his medical history. Had Dr Kennedy recognised that, on his own evidence, he would have reported it to the DVLA.

- (xi) The notification to the DVLA by Mr Logue and/or by Dr Byrne could have stated that the episode on 6 June 2008 occurred at the wheel of a PCV and resulted in a crash. That information, material to the DVLA decision, was omitted.

(d) The defects, if any, in any system of working which contributed to the death or any accident resulting in the death

- (i) The failure of First Bus to send the accident report of 3 August 2004 to their medical officer resulted in him recording an inaccurate medical history. An accurate medical history would have resulted in the DVLA reaching a different decision following the episode of 6 June 2008.
- (ii) If Mr Logue's evidence that he did not drink much because of a perceived lack of toilet facilities whilst driving is accepted, there is either a lack of toilet facilities for drivers, or Mr Logue did not know what toilet facilities were available for drivers.
- (iii) The failure of First Bus to correspond with the DVLA concerning the fitness of their employees to hold a PCV licence. First Bus appear to proceed on the assumption that it is the responsibility of the employee and their GP to provide information to the DVLA. First Bus ought to recognise that they share responsibility for the fitness of their employee PCV drivers, in particular because they may have information not known to the GP.
- (iv) The DVLA do not give information about driver licencing to employers. Had such a system of notifying the employer of a PCV licence holder of medical unfitness to drive or their entitlement to drive a PCV, First Bus may have become more involved in monitoring their employee's fitness to drive.
- (v) The failure of Mr Logue's GP to correspond with the DVLA. Dr Kennedy said that primary responsibility lay with First Bus and their medical officer. He said that he shared some of that responsibility, but could not identify any act by the GP practice discharging that responsibility.

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

- (i) First Bus failed to monitor their employee's entitlement to drive. Mr Logue did not hold a PCV licence between 20 June 1999 and 7 July 1999. That was following expiry of a 1---year licence, which was subject to review on medical grounds. First Bus appear to have had no system in place to check the fitness of Mr Logue on expiry of that period or confirm that he was entitled to drive thereafter.
- (ii) Dr Burman wrote a letter to DVLA on 25 May 1999, advising them that Mr Logue was "absolutely free from symptoms including black---outs" and "there is no concern about his state of health and he is physically and mentally fit". Dr Burman had not examined Mr Logue in 11 months. He was in no position to make those statements in relation to Mr Logue's fitness to drive. Those statements resulted in the grant of a new licence to Mr Logue, commencing 7 July 1999.
- (iii) Mr Logue was prescribed Ramipril from 5 November 2010 to the date of the accident. It was known that a side effect of Ramipril is syncope. In the opinion of Professor McKay, the ingestion of Ramipril may have contributed to the syncope episode on 31 March 2012.
- (iv) An opportunity was missed by the investigating police officers to take a contemporaneous statement from Mr Logue. A statement taken shortly after the accident might have shed light on his apparent statement to Dr Buchanan in A&E that he had experienced "dizzy spells".
- (v) The absence of a robust system of identifying and prosecuting those who give false information to the DVLA. There has never been a prosecution for giving the DVLA false information. Drivers, such as Mr Logue, are able to give misleading accounts to the DVLA with impunity.

3. Witnesses

(1) David Logue

It is submitted that David Logue gave largely incredible and unreliable evidence in relation to his medical history. His account of events on 31 March 2012 is not challenged.

Mr Logue had been a PCV driver for 23 1/2 years prior to the accident. 1995--6
In cross-examination, Mr Logue denied having dizzy spells at any time other than the episodes in 1998 and 2008. He said that he could not remember any episode in 1996

(which his wife reported) of going into a dream---like state [p. 140]. He said that the episode he consulted his GP about on 14 June 1996 was different from any episode reported by his wife [p. 655]. In cross--examination, Mr Logue said that he could not remember anything about episodes of dizziness prior to the episode on 20 January 1998. He accepted that he had been given an oral warning about his absence from work on 1 July 1996 [p. 795].

Mr Logue's evidence was inconsistent with his apparent report that he had "an identical episode" while on a jury in around 1996. It is simply not credible that a person who has a faint on jury duty would forget it. Taking part in a jury is a memorable experience for anyone. It is inconceivable that anyone would forget they had fainted. When the report of fainting on jury duty was put to Mr Logue when recalled, he minimised its significance. His description did not sound like an "identical episode".

From an early stage in the reporting of dizziness, Mr Logue had a motive to conceal the extent of any medical problems. He had been warned about absence from work.

1998

On 20 January 1998, he crashed a bus after he felt light-headed and became dizzy. He lost consciousness. His employers, possibly Strathclyde Buses knew of the accident and Mr Logue informed his GP. In cross-examination, Mr Logue did not recall having several dizzy spells earlier that day [GP letter, p. 103]. When speaking to his employer's investigator, Mr Logue made no mention of the previous dizziness [p. 669]. When Mr Logue saw Dr Lyons, he downplayed the dizziness, saying that it was "just prior" to the accident [p. 91]. In cross, he said he couldn't remember, no-one was injured.

Mr Logue was not consistent or candid in reporting his symptoms of dizziness prior to the accident on 20 January 1998. It is likely that his account to his GP was the truthful and accurate one. When he spoke to either representative of his employer, he either omitted reference to the several dizzy spells or substantially downplayed it. That indicates a consistent intent to mislead his employer about the nature of symptoms of dizziness in the context of crashing a bus.

In March or April 1998, Mr Logue informed Dr Lyons that he had the "all clear" from Professor Brodie to return to driving [p. 98]. That was false. He also did not tell Dr Lyons about any dizziness in 1995 or 1996. He did not tell the DVLA about previous episodes of dizziness.

The first notification to DVLA was by Mr Logue, telephoning on 20 April 1998 (DVLA acknowledged in a letter, dated 30 April 1998 [p. 122]). *It is not clear why Mr Logue*

delayed 3 months before contacting DVLA. He was either unaware that he had to report the incident to DVLA or did not want to. Either possibility is concerning from a public safety perspective. After medical enquiries, Mr Logue was permitted to drive under a new PCV licence on 11 June 1998 [p. 93].

Mr Logue could not say what led to the granting of the new licence. He thought that it might have been after a medical with the company doctor. He described the cause of the episode on 20 January as cardio-vascular.

In response to questions from the bench, Mr Logue said that he did not drive from the date of the episode until the 1---year licence was granted on 1 July 1998. He was clearly concerned about losing his job and told the DVLA so [Crown Production 29, p. 8].

2004

Mr Logue was asked about the incident on 3 August 2004 in the bus depot. He said in chief that there was a railing outside the snooker hall which was loose. He knocked it back and forth. Someone came out of the hall and he fell back and cracked his head on the wall. He felt dazed and sick as a result. When he was asked further questions about the report of the accident in chief, he said that he didn't remember. He said that the form was not in his handwriting [p. 755]. The signature was his, but he probably did not read it before signing. He said he was pretty sure it was an accident rather than a faint. When the report of Stephen O'Reilly was put to him in chief, he denied that he had fainted [p. 717].

In cross-examination, Mr Logue could offer no explanation for why Mr O'Reilly would make up a false accident report. He accepted Mr O'Reilly was there at the time of the incident. He ventured that pressure might have been put on Mr O'Reilly (that he was "badgered" into writing it).

Mr Logue's denial of a loss of consciousness on 3 August 2004 is not credible. His position is contradicted by two contemporaneous records, one of which he signed.

Mr Logue did not report a loss of consciousness when seen at Victoria Infirmary later than day [p. 602]. Mr Logue was later seen by Dr Lyons [p. 756]. Mr Logue did not inform the DVLA of the incident on 3 August 2004 because he didn't think it was necessary.

Mr Logue had received a formal oral warning about his attendance level at work some 2 months previously [p. 752].

Mr Logue's cover---up of the fainting episode on 2 August 2004 began as soon as he was taken to hospital. He concealed the faint from Dr Lyons and was certified by Dr Lyons as fit to work on 9 August 2004. The motive for Mr Logue to conceal the faint was his concern about being off work due to illness and the formal oral warning he had received recently.

Mr Logue subsequently told Dr Byrne that he had not experienced any fainting or blackout between 1998 and 2008 [p. 313]. Dr Byrne's assessment was made on that basis.

2008

Mr Logue had another loss of consciousness at the wheel of a bus on 6 June 2008. He explained in chief that he had driven into the back of the garage. A trainee was reversing and he stopped, waiting to park his bus. I felt dizzy and lost consciousness. When he regained consciousness, he had crashed into another bus.

When Mr Logue was cross---examined about his statements that he felt dizzy going into work [p. 315] and before he got on the bus [p. 313], he said they had been misinterpreted. In response to a query from the bench, Mr Logue said that he was not dizzy when he got onto the bus. Mr Logue could not remember telling his GP about dizzy spells [p. 663].

That attempt to explain away the contemporaneous notes is not credible. On p. 315, there is a careful long---hand note of "coming into work feeling slightly dizzy, increase on bus". Mr Logue's evidence that he would not have come into work if he had felt dizzy was self---serving and rang false. The GP records note "dizzy spells" contemporaneously (albeit Dr Burman is not available to speak to them). That note is likely to be accurate because it was an important symptom in the context of loss of consciousness at the wheel of a bus.

Mr Logue informed the DVLA on 20 June 2008 [p. 205]. He thought he could not drive for around 6 months and accepted the suggestion that might have been until October 2008. When he was asked whether anyone had suggested his driving days were over, he said that he thought that himself. He couldn't remember what the doctor had said. On the DVLA form, Mr Logue made no reference to the episode in 2004 [p. 160]. *It is unlikely that Mr Logue told DVLA that he had lost consciousness at the wheel of a bus and crashed it on 6 June 2008. That information is not recorded anywhere in the DVLA papers and on the evidence of Dr Parry, it would have resulted in revocation of Mr Logue's PCV licence.*

2012

On 31 March 2012, Mr Logue started work at 6.17 am and drove a route from Larkfield to East Kilbride, returning to Glasgow City Centre. He was due to have a meal break at 8.01 am. At the time of signing on, he had a cup of Klix tea, later described in cross as a

small cup of tea. He had nothing to eat since the previous day. Mr Logue said that he did not feel different that morning. On Cathcart Road, at the junction with Butterbiggin road, Mr Logue he lost consciousness.

Mr Logue said in chief that he did not have a lot to drink while driving a bus because there was nowhere to go to the toilet. In cross, he confirmed this position and said there were no public toilets which he knew of on the route.

Mr Logue accepted in cross that he had told Dr Buchanan at Victoria Infirmary A&E that he had dizzy spells. *Since the accident on 31 March 2012, this is a unique admission by Mr Logue that he had a history of dizzy spells. There was no reference to a history of dizzy spells given to Dr Cree (see computer notes [p. 535] and her referral, [p. 500]).*

Mr Logue said he could not remember telling Dr Mackay about palpitations the night before. He did not tell Dr Mackay about the episode in 2004.

Mr Logue appealed the decision to remove his car and PCV licence, although he appears only to have sought return of his car licence. They were both restored to him.

Mr Logue continues to drive. He is an IT engineer and drives a van very occasionally at work. His licence was removed by DVLA on 4 August 2015. He is appealing against that decision. *In the circumstances Mr Logue's evidence on 14 August 2015 shows, at best, a totally cavalier attitude to public safety. His grotesque question of why it was relevant to the enquiry is a clear demonstration of his impudent failure to take any responsibility for the accident on 31 March 2012. It clearly shows the reason why it is necessary for employers and the DVLA to take a more robust approach to medical conditions affecting fitness to drive.*

(2) John Reilly, Richard Duguid, Jason Perry, Stuart Purvis, Malcolm Dippie, James Findlay, Lorna Breen, Lynn Caldwell, Roger Miller and David Murdoch

These witnesses all spoke to the scene of the accident. Their evidence is not challenged. It supports the narrative at 2(b) above.

The evidence of Stuart Purvis that Mr Logue stated he was on water tablets is curious. The medical records and evidence of Dr Cree does not support a finding that Mr Logue was prescribed water tablets. He was either mistaken about the nature of the medication he was on, or was taking unprescribed medication.

No statement was taken from David Logue at any time after the accident, nor was he interviewed under caution. Sergeant Dawn Miller was the Senior Investigating Officer; David Murdoch was the Investigating Officer. Mr Murdoch said in evidence that he took the decision not to interview Mr Logue, but he had been instructed to have no contact

with Mr Logue. His senior officer, Sgt Miller makes no mention of that instruction in her affidavit, or the reasons for it.

(3) George Courtney, VOSA

Mr Courtney's evidence is not challenged. There were no defects in the bus which could have caused or contributed to the accident.

(4) Professor Martin Brodie

Prof Brodie made clear that his role was to exclude epilepsy as the cause of Mr Logue's episode on 20 January 1998. He described the difference between epileptic seizures and other sorts of attacks, including syncope. There was nothing in the notes or Prof Brodie's examination to suggest that Mr Logue had an epileptic seizure. He said in cross-examination that his role was to diagnose or exclude the diagnosis of epilepsy. It was clear that he did not consider his role went any further.

Mr Logue had been seen at A&E, then referred to Level 8 Medicine. A note of that examination was produced by Prof Brodie. Dr Hunter, the consultant there, noted "Identical episode 2 years ago while on jury duty". *It is sheer happenstance that record was available to the Inquiry. The report of the previous identical episode was not recorded in Prof Brodie's correspondence or anywhere else in any of the medical records. That is a significant omission. All of the medical practitioners subsequently based their opinions on the (in)frequency of syncopal episodes. A documented identical episode was material to their opinions.*

Prof Brodie said that the jury episode could have been typical of a syncopal episode. *It is clear that he made no further enquiry about the jury room episode because it was not indicative of epilepsy.*

Similarly, Prof Brodie did not attach any significance to the previous episodes of altered consciousness noted by his assistant, Dr Elaine Wilson [p. 615]. He thought they were vasovagal episodes and so was unconcerned by them. Prof Brodie went on to say that everyone who has an episode of collapse has to tell the DVLA and Mr Logue was informed of that. He then said that "fainters faint".

There is no challenge to the opinion evidence of Prof Brodie on the exclusion of epilepsy, or the working diagnosis of previous syncopal episodes, or the proposition that "fainters faint". However, it is clear that an opportunity to question Mr Logue about his history of fainting was missed and what was covered was poorly documented. Prof Brodie's certainty about reporting to DVLA was not matched by his general attitude towards syncopal attacks. As he could exclude epilepsy, his view was the episode on 20 January 1998 was consequent on an "unusual sequence

of events". That does not stand up to logical scrutiny, since it appears Prof Brodie was aware of 2, possibly 3 other similar episodes within the preceding 2 years.

Prof Brodie said he did not refer to cardiology because he was dealing with one episode of collapse, although he said if there was more than one episode, that is the referral he would have made. *On his own evidence, that is not correct. He was completely preoccupied with the issue of epilepsy.* He said that if he knew the nature of the problem, he would refer the patient, otherwise the patient would be sent back to the GP: "If I referred every patient with syncope, there would be too many referrals ... He did not have an epileptic seizure, it is not my responsibility, it is for the GP and him. I think it was done through the bus company." *That is what happened here, with the apparent approval of a return to driving and no reference to the previous episodes he was aware of.*

(5) Dr Lyons

Dr Lyons began by explaining his duties: PCV licence renewals, health surveillance, fitness to drive and sick list management. In cross-examination, he accepted that there was little in the way of health surveillance. It also became clear that once a driver was referred to the DVLA, he took no active part in deciding whether that employee was fit to drive for First Bus.

Dr Lyons would not contact the DVLA in relation to a driver – that was for the driver to do. *This is a curious view of his responsibilities, since Dr Lyons was a GP employed by First Bus, rather than a treating GP. One of his roles was assessing fitness to drive. There was no suggestion by Dr Lyons that he had any remit to remove a driver from driving duties or that he could or should inform DVLA of anything concerning a driver's medical circumstances. Dr Lyons seems to have seen his role as a 'post box'.*

On 31 March 1998, Mr Logue told Dr Lyons that Prof Brodie had given him the "all clear". Dr Lyons was not happy to go on "verbal information" from Mr Logue and subsequently received the emphatic answer that Prof Brodie "certainly did not". *There was no indication by Dr Lyons that he subsequently challenged Mr Logue about his inaccurate statement, or drew the conclusion that Mr Logue's truthfulness was in doubt.*

Dr Lyons advised Mr Logue to contact the DVLA in relation to the episode on 20 January 1998. There was no way he could check whether that had been done (DVLA records subsequently showed the contact was not made by Mr Logue until 30 April 1998). After DVLA decided Mr Logue was fit to drive on 11 June 1998, Dr Lyons said he was fit to drive.

Following the episode in 2004, Mr Logue was seen by Dr Lyons' colleague on 9 August 2004 [p. 84]. The notes record that Mr Logue told the GP that he had been knocked out

when he fell against a wall. Dr Lyons and his colleague had no access to the notes in the personnel file which stated that Mr Logue had fainted. *That is a prima facie failure of a system of monitoring employee's health.* In cross, Dr Lyons accepted this failure allowed an employee to tell the doctor something different from what the company knew. *It allowed Mr Logue to mislead the GP about his medical history and create a false impression that he was fit for work. Dr Lyons could not explain why he was not sent the accident report. First Bus did not call any witness to explain this failure.*

Dr Lyons' report of 10 June 2008 contains inaccuracies [p. 72]. Mr Logue lost consciousness on 6 June 2008, not as he states in the report "became weak and drowsy". Mr Logue also lost consciousness during the episode in 1998, but is reported here as an "episode of impaired consciousness". There is no mention of crashing the bus on a public road in 1998. The loss of consciousness and crash are clearly recorded in Dr Lyons' own records [p. 91, 98, 102, and 103]. Dr Lyons accepted the report was inaccurate and sought to explain that his statement of "impaired consciousness" probably meant loss of consciousness. *Dr Lyons' report of 10 June 2008 was sloppy and inaccurate. Had a manager at First Bus been considering Mr Logue's fitness to resume duties, this report would have given a misleading impression of the seriousness of the incidents.*

Dr Lyons made clear in cross that his role was to pass on the diagnosis to First Bus. He could not make referrals and did not contact the DVLA himself (except on one occasion to help Mr Logue get his licence back (2008)). He relied on the employee's GP and DVLA to investigate fitness to drive. Only the DVLA could take Mr Logue off the road. Dr Lyons did not even know what information DVLA were proceeding upon.

Dr Lyons said that First Bus do not carry out any routine medical examinations of their drivers. The 'health surveillance' he referred to was hearing tests.

Dr Lyons' statement that he assessed drivers for their safety is wholly meaningless. He could not conduct any enquiries or investigations, his only apparent source of information was the driver himself, and he did not even know the basis upon which the DVLA made their decisions. Dr Lyons and First Bus took no practical responsibility for assessing driver safety.

Dr Lyons was referred to the DVLA guidance current in June 2008 (p. 1160). He accepted that Mr Logue would have fit Box 3, indicating a high risk of recurrence. *That conclusion ought to have been obvious to Dr Lyons on the information available to him at that time. It is not expressed in any of the reports he prepared.*

(6) Dr Wynn Parry

Dr Parry was an impressive witness. He was knowledgeable and reasonable. He made appropriate concessions.

The DVLA consider around 680,000 medical cases each year. There are 21 doctors and 200 non---medically qualified staff who consider these cases. Medically qualified staff on average have to consider 26 cases per day; the other staff consider 100 cases per day. Assuming 8---hour working days, that equates to an average of 181/2 minutes per case for a doctor and just under 5 minutes per case for other staff.

Dr Parry accepted that the DVLA system for medical conditions of drivers was a 'notification---based system'. There are some European countries and other territories (including Ontario) which operate a statutory reporting system.

The DVLA records were in some disarray. There were missing copy letters. Some chronological sense was provided by the CASP records [Crown Production 29], although the information recorded was very limited.

Mr Logue notified the DVLA of a vasovagal attack on 20 January 1998. The notification was made by telephone on 30 April 1998 and confirmed in a form [p. 119]. Dr Parry indicated it was no part of the form to provide information on whether the episode occurred at the wheel of a vehicle. *That information would be medically significant to the question of whether there was likely to be a recurrence.*

In 1998, the prevailing guidelines contained separate provisions on loss of consciousness and syncope; slightly different decisions could result. The DVLA had received notification about the episode in January and 3 months had elapsed. A medical advisor made the decision to issue a 1---year licence, but the offer was not contained in the DVLA files. Some of the decision---making was admittedly difficult to follow because the records were incomplete. In cross, Dr Parry said it was not possible to say who made the decision or how the guidelines were applied. *This would have made it very difficult for staff at a later date to have proper regard to the driver's medical history.*

In cross, Dr Parry accepted that the DVLA were not aware of the "identical episode" on jury duty or the reference in the GP records to dizziness. He said the additional information meant there was a recurrence, and that meant an increased risk of occurrence. The decision made then would have been different.

Mr Logue did not hold a licence to drive a PCV between 20 June 1999 and 7 July 1999. He should not have been driving between those dates.

The DVLA were unaware of the episode in 2004 (they were first informed by the police on 25 April 2012 [p. 185]). It sounded like a vaso---vagal attack to Dr Parry. Mr Logue was under a duty to report it to DVLA. Had that episode and the previous episodes been reported, it is likely that a caseworker would have removed Mr Logue's licence.

In 2008, Dr Byrne submitted the report [p. 167]. It did not inform the DVLA that the loss of consciousness reported on 6 June 2008 was at the wheel of a PCV. In Dr Parry's view, that would be relevant (applying the "3 P's": prodrome, provocation and postural). The CASP records also made no mention of the accident circumstances. *The DVLA did not know the episode in 2008 occurred whilst sitting at the wheel of a PCV or that it crashed.*

In 2008, Dr Parry would not initially placed Mr Logue in box 3 of the DVLA guidelines [p. 1163], but if the DVLA had been informed that Mr Logue was driving the bus, they possibly would have made a different decision. Mr Logue did not inform the DVLA of dizzy turns [p. 663]. He was under a duty to do so.

The DVLA issued two letters dated 5 April 2012 [p. 172] and [p. 182] which contained different advice on driving: one suggested surrender of the driving licence, the other advised Mr Logue to speak to a doctor about his fitness to drive. *This reinforced the impression from the records that the DVLA were in disarray.*

Dr Parry concluded in cross that had the DVLA known about the episodes in 1995, 1996 and 2004 in addition to those in 1998 and 2008, the decision about Mr Logue's licence would have been different; it would have been revoked. As a result of the information in the records coming to the attention of the DVLA in these proceedings, they would review Mr Logue's entitlement to drive.

Dr Parry said that he did not expect members of the public to know if they had a relevant disability. *There is no challenge to that general observation. However, the evidence supports the inference that Mr Logue knew that an inaccurate report to the DVLA of the nature and circumstances of his episodes could endanger his licence.*

It was not mandatory for the reasons for decisions to be documented within DVLA records, although Dr Parry encourages that as good practice. *Proper record keeping and noting the reasons for decisions is likely to enhance the accuracy of future decisions on drivers with recurrent conditions.*

Dr Parry gave clear and unchallenged evidence that there has never been a prosecution in the UK for providing false information to the DVLA.

(7) Dr Byrne

Dr Byrne spoke to his examination of Mr Logue on 9 June 2008 [p. 315]. Mr Logue had explained that he felt dizzy when he came into work on 6 June 2008 and it got worse. Dr Byrne said that if a driver felt any sort of incapacity, he should not be driving. In cross, Dr Byrne said he had no concerns about Mr Logue's reliability when he completed the

DVLA form. When shown the entry stating Mr Logue had no previous medical history, Dr Byrne stated that Mr Logue had not been accurate.

Dr Byrne completed the DVLA form, noting that this episode was a simple faint [p. 167]. He went on to say that after a 3 episode of collapse, he would assume the patient had a tendency to faint. It was unusual for a faint to take place whilst sitting down and particularly when driving (due to the movement of feet on the pedals). He would want to know the detailed circumstances. If the cause was not identified, he would be concerned.

Dr Byrne was asked whether 2 faints at the wheel indicated a driver who would put others at risk. He replied “absolutely”.

Dr Byrne was taken through Mr Logue’s previous medical history in cross-examination. He was not aware of entries relating to dizziness and similar or identical episodes. He said they would have altered his view in 2008 and increased the risk of recurrence. The number of events increased, so did the risk of recurrence. He would have had some concern.

Dr Byrne’s report to DVLA appears to have been the basis of the decision to allow Mr Logue to retain his licence. The report omitted the key information that the loss of consciousness was while sitting at the wheel of a bus, causing a crash. That was known to Dr Byrne and ought to have been included in his report.

Knowing then what he does now, Dr Byrne would not want his children on a bus driven to the continent by Mr Logue. *That is a good indication of the level of risk to public safety posed by Mr Logue.*

(8) Prof Mackay and Dr Rae

Professor Mackay and Dr Rae were not informed of the episode in 2004. Professor Mackay said he was only aware of 2 previous episodes. Mr Logue did not tell him that he had suffered from dizzy spells, because he would have documented it, had he been told. Mr Logue told him that he did not drink much when driving because of a lack of toilet facilities.

Dr Rae said it was very important to know the patient’s medical history. It was important to know whether it was a repetitive condition. Dr Rae did not know that the episodes in 1998 and 2008 occurred at the wheel of the bus, when Mr Logue was sitting. He said that was significant because vasovagal episodes are less common when sitting. He did not know the episode on 31 March 2012 was the third at the wheel, despite

asking Mr Logue about the incidents. Mr Logue's report to Dr Buchanan of dizzy spells was not consistent with what he told Dr Rae.

Dr Rae said the report of the 'dream---like state' noted by Dr Wilson was consistent with a vasovagal episode. The note of the identical episode on jury duty was also consistent with a vasovagal episode. The episode in 2004 was also consistent with a vasovagal episode.

Dr Rae said the more episodes, the more chance there is of recurrence. In light of the information about other episodes, he said Mr Logue was more prone to recurrent episodes. Had he been asked in 2008, he would have said it would have been surprising if Mr Logue did not have another episode.

That is strong evidence that had information about all the previous episodes been available to a cardiologist in 2008, the medical opinion would have been that it was very likely Mr Logue would have further syncopal episodes.

In light of the new information, in 2012, Dr Rae would have placed Mr Logue in box 3 of the DVLA Guidelines [p. 1213]. He was at high risk of recurrent episodes of vasovagal syncope whilst sitting or driving. Dr Rae would have ticked box 3 and sent a letter setting out his concerns. He would have advised a management plan.

When recalled, Professor McKay said that any hypotensive drug, such as Ramipril, would increase the likelihood of a syncopal episode in a person predisposed to that condition. The ingestion of Ramipril could have contributed to Mr Logue's syncopal vasovagal episode on 31 March 2012.

(9) David Phillips

Mr Phillips confirmed in cross that the company GP did not have access to the personnel files. He said that where a referral was made, they would be given an account of any incident. *That did not happen here. Either there was a system failure, or that was an ad hoc system which did not operate on this occasion.*

Mr Phillips said that employees were under a duty to inform the management team if they were not fit for work. He later referred to the handbook's reference to reporting to work in a fit state. *The focus on driver fitness appears to have been on the fitness to drive on a particular day, not a more general importance of health.*

(10) Steven Neilson

Mr Neilson said he could not understand why someone would be badgered into giving a false account of an incident at work. He would find that unacceptable. If he learned of a false report, disciplinary procedures would be followed. He and the company rely on the honesty of their drivers.

Mr Neilson's evidence undermines Mr Logue's position that the accident report and witness statement concerning the 2004 loss of consciousness was made up.

(11) Dr Cree

Dr Cree's involvement was largely after the accident on 31 March 2012. When examined on 6 April 2012, Mr Logue did not give her the same information about "dizzy spells" which he had given to Dr Buchanan at Victoria Infirmary A&E.

Dr Cree confirmed that when Dr Burman wrote to DVLA on 25 May 1999, certifying Mr Logue was fit to drive and had no further episodes, he had not seen Mr Logue for 11 months.

Dr Cree retreated from her apparent position in correspondence that she supported Mr Logue's appeal of the DVLA decision to revoke his licence. Mr Logue had not told her that the incidents in 1998 and 2008 involved crashing a bus.

Dr Cree applies the DVLA guidelines in advising patients. Had she been applying today's guidelines in June 2008, she would have applied box 6, meaning Mr Logue's PCV licence would have been revoked for 10 years.

(12) Dr Kennedy

Dr Kennedy was not an impressive witness. He continually sought to give character references for his patient, David Logue. His description of David Logue, for what it is worth, is in contrast to the evidence that Mr Logue concealed information about his medical condition from his employer and various doctors. Dr Kennedy's approach to giving evidence, combined with incomplete medical records, caused a considerable waste of court time.

Dr Kennedy accepted that he had some responsibility to report to DVLA in relation to patients who had medical conditions which affected their safety as drivers. If a patient

was dishonest about their medical condition, he had a duty to report that to DVLA. He thought that an occupational health advisor to an employer bore greater responsibility because they had more information about the patient and had greater specialism in driver safety. *In these respects, Dr Kennedy was candid and helpful. It is clear from his evidence that the role of the GP is to some extent as advocate for the patient. That sits uneasily with the duties on the GP in reporting to the DVLA.*

(13) Dr Cormack

Dr Cormack gave evidence in a clear and confident manner. She prescribed Ramipril to Mr Logue at the initial dose of 2.5 mg and increased it to 5 mg.

She took blood pressure readings, arranged for blood tests and asked Mr Logue about side effects.

Dr Cormack may not have reviewed the reports of previous syncopal episodes in 1998 and 2008, as contained in the correspondence section of the GP records. However, had she read them, she would still have prescribed Ramipril. It was clear that her focus was treating hypertension in the patient, not the potential recurrence of syncopal episodes.

Dr Cormack's evidence raises an issue of awareness of syncope and responsibility for driver safety. She is a diligent GP. She conducted investigations and queried the previous prescription of Bisoprolol. Her notes are detailed. However, the medical history of syncope would not have prevented her prescribing Ramipril. Neither would she have given any particular warning about syncope. *This raises the question of whether when Mr Logue's high blood pressure was initially seen, he should have been advised that medication to reduce it would also have the effect of increasing the likelihood of further syncope episodes.*

Submissions on the principal issues

The standard of proof of fact in general is on balance of probabilities. The standard of proof under 6(1)(c) is something less than balance of probabilities (Kyle Brown, FA I 1 October 2007, Sheriff Lothian; Carmichael, p. 174). The provision poses the question of what was a real or lively possibility of the death being avoided. Hindsight can and should be applied in establishing what precautions might have avoided the accident. Sheriff Principal Lockhart has said: *"A Fatal Accident Inquiry is very much an exercise in applying the wisdom of hindsight ... It is for the sheriff to identify the reasonable precautions, if any, whereby the death or any accident resulting in the death might have been avoided ... The sheriff is required to proceed on the basis of the evidence produced without regard to any question of the state of knowledge at the time of the accident. The statutory provisions are concerned with*

the existence of reasonable precautions ... at the time of the accident or death and are not concerned with whether they could and should have been recognised. They do not relate to the question of foreseeability of risk at the time of the accident."

(1) Syncopal episodes

Episode 1

Mr Logue was examined at Professor Brodie's Seizure Clinic on 20 January 1998. His wife reported that 3 years previously he had an attack in which he "felt dizzy for a few seconds and nauseated and then seemed to go into a dream---like state for a minute or two". That attack probably took place in 1995 or 1996. Mr Logue said he could not remember it, but there is no reason to doubt the accuracy of the report by his wife, or the record of it taken by Dr Wilson. Dr Rae said it sounded like a syncope episode. It is significant that Mr Logue's wife reported the attack, rather than Mr Logue himself.

On 14 June 1996, Mr Logue was examined by his GP, Dr Burman. He reported dizziness and appears to have been observed to have spontaneous nystagmus. Precisely what was or was not observed by Dr Burman is not known. He gave a tentative diagnosis of viral labyrinthitis. Spontaneous nystagmus is usually indicative/ diagnostic of an inner ear problem. That might tend to suggest this was not syncope---related, but the diagnosis was tentative.

Episode 2

When examined by Dr Hunter on 20 January 1998, Mr Logue described an "identical" syncopal episode 2 years previously. The note which preceded that is detailed and clearly identifies a syncopal episode. There can be no doubt that in or around 1996, Mr Logue experienced a syncopal episode on jury duty in around 1996. That was episode number 2. Mr Logue accepted this was not the same as episode number 1.

Episode 3

Mr Logue lost consciousness at the wheel of a bus on 20 January 1998. He was admitted to A&E by ambulance at 6.03 pm. The Western General Hospital records are not available, nor is any note or report from the Ambulance Service. Mr Logue was examined by Dr Denison in A&E, where the tentative diagnosis was of a "fit" [p. 618]. Dr Hunter in Level 8 Medicine noted a detailed account of the incident [Production 28]. That was episode number 3. Mr Logue told Dr Hunter that he had felt light---headed earlier in the day. On 20 January 1998, Mr Logue told Dr Wilson in the Seizure Clinic

that he had several dizzy attacks prior to going to work [p. 251]. On 10 March 1998, Mr Logue later told Dr Lyons that he felt dizzy just prior to the blackout [p. 91; p. 102].

Episode 4

On 3 August 2004, Mr Logue lost consciousness at work when he was speaking to a colleague, Stephen O'Reilly [p. 717; 755]. He did not tell the doctor at Victoria Infirmary that he had fainted, or that he had been feeling unwell for 30 minutes prior to the accident [p. 755]. That was episode number 4. Mr Logue subsequently gave a false account to Dr Lyons.

Episode 5

On 6 June 2008, Mr Logue again lost consciousness at the wheel of a bus and crashed [p. 595]. That was episode number 5. On 16 June 2008, Mr Logue described dizzy turn or turns to his GP [p. 663]. On 17 June 2008, Mr Logue was examined by Dr Byrne in the Syncope Clinic. He told Dr Byrne that on 6 June 2008, he came into work feeling dizzy and that dizziness increased when he was on the bus [p. 315].

Episode 6

On 31 March 2012, Mr Logue had a third syncopal episode at the wheel of a bus, causing a collision and the death of James Lochrie. That is episode number 6. He reported dizzy spells to Dr Buchanan in A&E [p. 326]. It is not known whether Mr Logue was referring to dizzy spells prior to the accident on 31 March 2012, general and intermittent dizzy spells or only the episodes 1 to 6 referred to above.

In 1998 and 2008, Mr Logue experienced dizzy spells on his way into work. In 1998, he had experienced two documented episodes (one loss of consciousness and one impaired consciousness), yet he reported for work. On 6 June 2008, Mr Logue had experienced four documented syncopal episodes, including one causing a collision, yet he reported for work despite the dizzy spells.

By 6 June 2008 at the very latest, it ought to have been apparent to Mr Logue that dizzy spells could precede a syncopal episode and that it was not safe for him to drive. It ought to have been apparent to him by that time at the very latest, that he had a tendency to syncopal episodes.

(2) The medication taken by David Logue at the time of the accident

Mr Logue was taking Ramipril (5mg tablets, one per day) on 31 March 2012. A known side---effect of Ramipril is syncope. That was known to Dr Cormack when Ramipril was first prescribed on 5 November 2010 (2.5 mg dose), and when it was increased. The prescription was a contributing factor to the syncopal episode on 31 March 2012.

(3) The counterfactual in 2008:

(a) What advice doctors would have given David Logue

All of the doctors who gave evidence would have given different advice to Mr Logue had they known the extent of his history of syncopal episodes.

(b) What decision would have been made by DVLA

The unchallenged evidence of Dr Parry is that the DVLA would have reached a different decision in 2008 had they known the extent of Mr Logue's history of syncopal episodes.

(4) The role of First Bus in monitoring the health of their drivers

First Bus elected not to bring a witness to their decision---making process (if any) in 1998 and 2008. Nor did they lead any evidence as to why the reports of the 2004 incident were not sent to Dr Lyons. Evidence on either of those matters would have been of assistance to the Inquiry. Where appropriate, I invite the court to draw an adverse (as opposed to a neutral or favourable) inference.

Mr Logue was seen by Dr Lyons on 10 March 1998. He was unfit to drive [p. 102]. On 31 March 1998, he was seen again by Dr Lyons and said that he had been "given the all clear to go back to work". That was misleading. Dr Lyons' approach demonstrates a lack of rigour.

Dr Lyons wrote to Professor Brodie before advising First Bus of Mr Logue's fitness to drive. However, it was clear from his evidence that Dr Lyons made no decision about Mr Logue's fitness to drive; he considered that to be the role of the DVLA. Dr Lyons and by extension, First Bus abdicated responsibility for driver safety.

When Dr Lyons reported to First Bus, he noted Mr Logue's description of feeling dizzy just before the blackout. He omitted information contained in Dr Wilson's letter that Mr Logue had several dizzy attacks before going into work. It appears that no advice or disciplinary action was taken against Mr Logue for reporting to work after experiencing

several dizzy spells. An opportunity to reinforce Mr Logue's responsibility to report illness, or even discipline him for (an apparent) breach of the Driver's Handbook was missed.

Dr Lyons stated in his report to First Bus that he referred the case to DVLA in response to Professor Brodie's letter of 3 April 1998. However, the DVLA records [Crown Production 29] show that it was Mr Logue who contacted them on 30 April 1998. There is no correspondence between First Bus (including Dr Lyons) and DVLA in relation to the incident on 20 January 1998. First Bus and Dr Lyons did not know what information was considered by DVLA prior to granting a 1-year licence.

First Bus failed to provide a copy of the accident report of 3 August 2004 to Dr Lyons when they referred Mr Logue to him. There is no copy of the referral to Dr Lyons. The omission of the accident report allowed Mr Logue to give a false report to Dr Lyons of the incident.

Dr Lyons considered Mr Logue fit to return to work on 9 August 2004. There is no record of how or when he conveyed that to First Bus. Had Dr Lyons given a written report detailing Mr Logue's account of the incident on 9 August 2004, it might have given First Bus an opportunity to see the discrepancy in accounts.

Mr Logue was seen by Dr Lyons on 10 June 2008 [p. 73]. Dr Lyons took blood pressure and conducted the Romberg's test (for balance and dizziness). Dr Lyons requested a medical report from Dr Burman [p. 67].

In each of Dr Lyons' reports to First Bus (10 June, 3 July and 20 July 2008), he states that Mr Logue became weak and drowsy while driving a bus. There is no reference to Mr Logue feeling dizzy before going to work. That might explain why there is no apparent record of any advice or disciplinary action against Mr Logue for reporting to work with dizziness (and with a known history of dizziness and fainting).

There is no correspondence between First Bus (including Dr Lyons) and DVLA in relation to the incident on 6 June 2008. First Bus and Dr Lyons did not know what information was considered by DVLA prior to their decision that Mr Logue could retain his licence. An opportunity was missed by First Bus and Dr Lyons to inform DVLA of the material information that the syncopal episode on 6 June 2008 occurred at the wheel of a bus and resulted in a crash.

Dr Lyons took very few proactive steps to investigate Mr Logue's health or fitness to drive. There was no correspondence with DVLA. Dr Lyons completely abdicated any responsibility for the safety of the public and employees. His approach to reporting was sloppy and inaccurate.

Evidence was led from David Phillips of the First Bus Driver Handbook [First Production 1, para 4.9.3]. No evidence has been led that anyone spoke to Mr Logue about his responsibility to only report for work when fit, or sought to emphasise that after the episodes in 1998, 2004 and 2008.

(5) The role of the GP in advising Mr Logue

(6)

Dr Burman's letter to DVLA on 25 May 1999 [p. 604] was not based on any examination of Mr Logue. His conclusions and advice to DVLA are completely unsupportable. Dr Kennedy clearly adopted the role of advocate for Mr Logue. He candidly said that he had a degree of responsibility for assessing and reporting Mr Logue's safety as a driver, but could not point to a single instance in which he discharged that responsibility. It appears Mr Logue was not advised that hypotensive drugs could increase the likelihood of syncope episodes. However, given Mr Logue's cavalier attitude, it is doubtful whether advice would have made any difference to his conduct.

(7) The decision---making process of the DVLA

The decision---making process of the DVLA is largely opaque, due to missing records and a failure to record the basis upon which decisions were made. It is not even possible to say how the DVLA Guidelines were applied to the decisions made in 1998 or 2008.

(8) The evolution of the DVLA Guidelines

Since March 1996, the DVLA Guidelines have dealt ever more specifically with syncopal episodes. In March 1996, if a syncopal attack was neither sudden nor disabling, they need not have been notified [p. 1061]. However, that applies where the attack is physiologically provoked and the result of postural hypotension. The evidence indicates that postural hypotension does not occur when sitting. The 1996 Guidelines do not deal specifically with the range of syncopal episodes referred to in later Guidelines. Retrospectively, they fall far short of adequate.

By February 2008, the DVLA Guidelines on loss of consciousness clearly states: "A full history is imperative to include pre---morbidity history, prodromal symptoms, period of time unconscious, degree of amnesia and confusion on recovery". This appears to have been done very little by any of the medical practitioners. It underlines the importance of full and detailed reporting of previous episodes (compare the reports of Dr Lyons, for instance, or Dr Byrne's omission of loss of consciousness at the wheel of a bus). The February 2008 Guidelines have a far more detailed set of definitions. It appears that there was a tendency to report Mr Logue's 2008 episode (and indeed the 1998) episode

as a “simple faint” (box 1). However, that overlooks the exclusion of “unlikely to occur whilst sitting” and the requirement to consider (if recurrent) the 3 P’s. A proper construction of the February 2008 guidelines leads to the conclusion that box 3 was applicable to Mr Logue in June 2008.

In October 2008 [p. 170], it appears that because 3 months had passed from the date of the accident to the DVLA decision, Mr Logue was allowed to retain his PCV licence (box 3, Group 2 entitlement).

Under the current Guidelines, box 6 has been introduced. If there are two or more episodes of loss of consciousness without reliable prodromal symptoms within the last 10 years, the PCV licence is revoked (until such time as the risk has reduced to less than 2% per year).

It is submitted that the current Guidelines contain suitable and sufficient measures for dealing with Mr Logue’s case. By necessary implication, and applying retrospection, all previous Guidelines are inadequate. Had the Guidelines in 2008 have been in the form they are now (and the 2004 episode known to DVLA), his PCV licence would have been revoked. Even if the 2004 episode was not known to DVLA, they could have exercised discretion to revoke Mr Logue’s licence.

The Guidelines demonstrate that medical advice to the DVLA has evolved over time. Syncopal episodes do not appear to have been given much prominence in early guidance. The risk to the public from recurrent syncopal episodes has only been properly recognised in the current Guidelines.

(8) Offences

Section 92 of the Road Traffic Act 1988 provides:

“92. — Requirements as to physical fitness of drivers.

(1) An application for the grant of a licence must include a declaration by the applicant, in such form as the Secretary of State may require, stating whether he is suffering or has at any time (or, if a period is prescribed for the purposes of this subsection, has during that period) suffered from any relevant disability or any prospective disability.

...

(10) A person who holds a licence authorising him to drive a motor vehicle of any class and who drives a motor vehicle of that class on a road is guilty of an offence if the declaration included in accordance with subsection (1) above in the application on which the licence was granted was one which he knew to be false.”

A “relevant disability” is defined in regulation 71 of the Motor Vehicles (Driving Licences) Regulations 1999/ 2864 as including *inter alia*:

“71.— Disabilities prescribed in respect of Group 1 and 2 licences

(1) The following disabilities are prescribed for the purposes of section 92(2) of the Traffic Act as relevant disabilities in relation to an applicant for, or a person who holds, a Group 1 or Group 2 licence—

...

(c) liability to sudden attacks of disabling giddiness or fainting which are caused by any disorder or defect of the heart as a result of which the applicant for the licence or, as the case may be, the holder of the licence has a device implanted in his body, being a device which, by operating on the heart so as to regulate its action, is designed to correct the disorder or defect;

(d) liability to sudden attacks of disabling giddiness or fainting, other than attacks falling within paragraph (1)(c)...

Section 94 of the 1988 Act provides:

“94.— Provision of information, etc. relating to disabilities.

(1) If at any time during the period for which his licence remains in force, a licence holder becomes aware—

(a) that he is suffering from a relevant or prospective disability which he has not previously disclosed to the Secretary of State, or

(b) that a relevant or prospective disability from which he has at any time suffered (and which has been previously so disclosed) has become more acute since the licence was granted,
the licence holder must forthwith notify the Secretary of State in writing of the nature and extent of his disability.

...

(3) A person who fails without reasonable excuse to notify the Secretary of State as required by subsection (1) above is guilty of an offence.

(3A) A person who holds a licence authorising him to drive a motor vehicle of any class and who drives a motor vehicle of that class on a road is guilty of an offence if at any earlier time while the licence was in force he was required by subsection (1) above to notify the Secretary of State but has failed without reasonable excuse to do so.”

Under Schedule 1 to the Road Traffic Offenders’ Act 1988:

A contravention of s. 92(10) is triable only summarily, with a penalty of a fine at Level 4 on the standard scale [£2,500], discretionary disqualification and obligatory endorsement of the holder's licence with 3 to 6 penalty points.

A contravention of s. 94(3) is triable only summarily, with a penalty of Level 3 on the standard scale [£1,000]. There is no power to disqualify the driver or endorse the holder's licence.

A contravention of s. 94(3A) is triable only summarily, with a penalty of a fine at Level 3 on the standard scale, discretionary disqualification and obligatory endorsement of the holder's licence with 3 to 6 penalty points.

It is objectively unlikely that a person facing the loss of livelihood because of a medical condition affecting their fitness to drive would be deterred by a fine of up to £1,000, with no possibility of imprisonment and discretionary disqualification. There is a factual analogy between driving whilst medically unfit to do so and driving whilst unfit through drink or drugs. In the latter situation, disqualification is obligatory (ss. 4(1) and 5(1)(a) of 1988 Act; Road Traffic Offenders Act 1988, Schedule 1).

Preventing medically unfit persons from driving by enactment of the provisions of s. 94(3) and (3A) is but a pious aspiration if there are never any prosecutions for contravention. The current system of self-reporting is inadequate if it is not backed by sufficiently robust enforcement and penalties for those, like Mr Logue, who serially mislead doctors and the DVLA.

Concluding remarks

It is submitted that it is proved David Logue experienced syncopal episodes in 1996, 1998, 2004 and 2008.

This was an accident waiting to happen. It may not have taken place on 31 March 2012. James Lochrie may not have lost his life. But at some point – be it the third, fourth, fifth loss of consciousness by David Logue at the wheel of a PCV – his medical condition was ultimately going to result in injury or death.

Mr Logue was not fit to hold a PCV licence after the accident on 6 June 2008. By that time, at the very latest, Mr Logue, his GP, Dr Lyons, First Bus and the DVLA ought to have taken him off the road. Each of them contributed to a failure to recognise the danger Mr Logue posed to himself, his colleagues and to members of the public. Mr Logue, however, bears primary responsibility for the death of Mr Lochrie.

Those instructing me wish to state publically that they have no criticism of the Crown for their decision at the outset of this Inquiry not to prosecute David Logue in respect of matters before this Inquiry. However, they consider the enforcement of ss. 92(10), 94(3), and 94(3A) by the DVLA and prosecuting authorities to be woefully inadequate.

The family of James Lochrie gratefully acknowledge that this Inquiry has allowed them to hear detailed evidence of all the circumstances surrounding James Lochrie's death; evidence which they may very well not have heard in a criminal trial or a civil proof.

Edinburgh
17 August 2015