

SHERIFFDOM OF GRAMPIAN, HIGHLAND AND ISLANDS AT STORNOWAY

**Under the Fatal Accident and Sudden Deaths Inquiry (Scotland) Act 1976
Section 6**

2014FAI34

Case No. B38/14

DETERMINATION

by

SHERIFF DAVID OMAN SUTHERLAND

**Following an Inquiry into the circumstances
of the death of the late
LORNA MACDONALD**

STORNOWAY, 13 November 2014

The Sheriff, having resumed consideration of all the evidence adduced and submissions thereon, Finds and Determines in terms of Section 6 of the Fatal Accident and Sudden Deaths Inquiry (Scotland) Act 1976 that:

1. In terms of section 6(1)(a) that the late Lorna MacDonald, born 21 May 1985, died at approximately 1600 hours on 24 November 2011 as a result of drowning in the waters of Loch Nan Uidhean, Isle of Harris, at a point close to the A859 Leverburgh to Stornoway road. At the time of her death the deceased was in the course of her employment with the Western Isles Health Board as a speech and language therapist.

2. In terms of section 6(1)(b) the cause of death was:

(a) drowning

and

(b) road traffic incident

The incident which resulted in her death occurred when the Mazda 2 motor car registered number SY10 XSP driven by the deceased left the A859 Leverburgh to Stornoway Road on account of the deceased losing control of her vehicle as a result of the prevailing road and weather conditions.

3. In terms of section 6(1)(c) a reasonable precaution which might have prevented Miss MacDonald's death was that her employers ensured that lone working employees did not make journeys to isolated and distant areas in adverse weather conditions predicting 65 to 75mph winds and flooding.

4. In terms of section 6(1)(d) there are no defects which justify a determination that they contributed to the deceased's death.

5. In terms of section 6(1)(e) the following facts are relevant to the circumstances of death:

(a) the deceased's employers did not have a policy to assess work related driving risks being disseminated on the intranet until December 2011 although the policy "Managing Work Related Driving Risks" was approved in September 2011; and

(b) there was no system whereby lone workers in rural or isolated areas were contacted regarding deterioration in weather and travelling conditions.

Representation

6. Mr David Teal, Procurator Fiscal, appeared for the Crown in the public interest. Mr Angus MacDonald appeared for the family of the late Lorna MacDonald and Mr Fitzpatrick, Advocate, appeared for NHS Western Isles.

Legislative framework and purpose of the Inquiry

7. Fatal accident inquiries are statutory proceedings set up and governed by the Fatal Accidents and Sudden Deaths Inquiry (Scotland) Act 1976. The sheriff's duty is governed by section 6 of the said Act requiring the sheriff to produce a determination in terms of the five separate headings contained in section 6. Section 6(1) requires the sheriff to determine:

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

8. The sheriff therefore requires to produce a determination in terms of the said Act but in addition to determining the circumstances of the death, the sheriff also has regard to future public safety. He has to look to see whether any lessons might be learned whereby future accidents or deaths might be avoided. It has often been said

that the purpose of the fatal accident inquiry is not to establish fault. It is the one place where hindsight is appropriate and necessary. Indeed, section 6(3) of the 1976 Act states that the sheriff's determination shall not be admissible evidence or founded upon in any other judicial proceedings. See Lord Hope in *Black against Scott Lithgow Limited* 1990 Session Cases 322 and Lord Hamilton in *Global Santa Fe Drilling against Lord Advocate* 2009 SLT597.

9. A fatal accident inquiry is a fact finding rather than a fault finding procedure but that does not mean that a sheriff should not make critical remarks regarding various matters, merely that he is not making a statement finding fault as a basis of legal liability.

10. It is interesting to note regarding section 6(1)(c) which relates to reasonable precautions whereby the death or any accident resulting in the death might have been avoided is referred to in the case of *James MacAlpine* 1986 where Sheriff Brian Kearney states:

“The phrase ‘might have been avoided’ is a wide one which is not as far as I am aware been made the subject of judicial interpretation. It means less than on the balance of probabilities being avoided but rather directs one’s mind in the direction of the lively possibilities. We are looking at future avoidance of fatal accidents and that is the purpose of this legislation”.

Sheriff David Oman Sutherland

Note

1. I first heard from Mrs Peggy MacDonald, mother of the late Lorna MacDonald, who described how Lorna had been born on 21 August 1985 and had died on Thursday 24 November 2011. She described how she had been employed by NHS Western Isles since January 2010 and before that had worked for Argyle Health Board and prior to that for the Health Board in Hamilton. She described how Lorna had passed her driving test in 2003 and had driven a green Mazda 2 motor car.

2. She described how Lorna had left for work about 7.00am on 24 November 2011 going first to the hospital in Stornoway before driving to Ness on the north coast of Lewis before returning to Stornoway and then on to Point. She had come to her mother's house for lunch about 12 noon and had left about 1.00pm.

3. Mrs MacDonald spoke of the weather being very inclement that day with it blowing up and very wet. She indicated to Lorna that she hoped that she would be working in the office that day but Lorna had explained that she was having to travel to Leverburgh at the south end of Harris. Mrs MacDonald indicated that she had told her daughter not to go but Lorna had checked with her work to see if she should go and having phoned the hospital gave her mother the thumbs up sign which Mrs MacDonald took to mean that it was alright for her to travel.

4. Mrs MacDonald explained how Lorna had indicated to her that a previous appointment with the patient in Leverburgh had been cancelled and she felt she had to go down to fulfil the appointment.

5. Mrs MacDonald explained how she herself had travelled to Crossbost to see her mother after 2.00pm and described the driving conditions as being very difficult.

6. Mrs MacDonald explained how her daughter would always check her e-mails either on the phone or on her laptop but she was not aware of any e-mails being sent to her regarding the weather conditions. She described how her daughter was a very careful driver and that she had driven the Mazda motor car for approximately two years since she had arrived on the island. She was on the road five days per week with a resultant high mileage and was used to driving on rural roads.

7. Mrs MacDonald described how the roads were very wet that day, there having been a heavy rainfall with the wind getting stronger all the time. She described how her daughter was very conscientious regarding her work and she got the impression that her daughter felt that it was essential for her to travel that day.

8. Mrs MacDonald stated to the court how she felt that the NHS should have prevented her daughter from making the journey that day. She felt that employers had a responsibility for the welfare of their workers and when the health board had realised that the weather was getting worse and that they were going to have to close some departments they should have thought about the people who were out travelling to rural appointments. She felt that the NHS should have got in touch with her daughter given that there was a forecast of 70mph winds. She said that she was aware of some policies coming into force after her daughter's accident and wished that they had been in place at the time of her daughter's death.

9. Mrs MacDonald explained how Lorna always had her mobile phone with her together with her laptop and was constantly checking for e-mails. She understood

that some departments at the hospital were closed at 2.30pm and she felt that her daughter should have been contacted and told not to proceed until further notice. She felt that certain people were in more danger than others and certainly felt that her daughter would have been safer sitting in a parked car in Leverburgh than having to make her way back to Stornoway in the weather pertaining that day.

Kayreen MacMillan

10. I then heard from Kayreen MacMillan, aged 43, who described how her daughter was receiving help from the speech therapy department. She described how on 24 November 2011 the late Lorna MacDonald had visited her. She had visited on three previous occasions but there had been two cancellations, one by the NHS and one when Mrs MacMillan had cancelled herself.

11. She described how Lorna had arrived between 2.00pm and 2.30pm and had left about 3.15pm. The weather she described as simply awful, wet, windy and gusty and they had spoken about the weather during the visit. She said that she had said to Lorna that she had half expected the session to be cancelled because of the weather.

12. Mrs MacMillan described how Lorna had been dealing with her daughter because Lorna had a qualification in makaton and work required to be done on that before the case was handed on to another therapist. She described how she would contact the therapist directly regarding any changes in the appointments.

13. Mrs MacMillan described, in cross-examination, how the weather was particularly wild that day, even for the Western Isles, and she had been concerned regarding Lorna travelling back to Stornoway given the deterioration in the

conditions even in the time since she arrived. She confirmed that no-one from NHS had tried to contact herself or Lorna regarding the weather conditions.

Douglas Smith

14. I then heard from Douglas Smith, aged 62, and an NHS Electrician. He described how he had been driving on 24 November 2011 from Leverburgh back up to Stornoway, having worked that day in Leverburgh. He described how, given that the weather was worsening, they decided to call a halt to the work they were doing on the outside of the nurse's cottage in Leverburgh and head back home. He was driving a Ford Transit Connect van and had concerns travelling back from Leverburgh given the strength of the wind and the fact that they had a roof-rack with a double extension ladder on top. He described how they had a few close encounters on the way back up from Leverburgh, mentioning particularly a gutter to the left hand side of the road and being concerned about being blown into the gutter.

15. He described how he noticed a vehicle coming up behind him with headlights on and described how the vehicle eventually overtook him. He described how the vehicle had overtaken him quite slowly. He had been doing about 35 to 40mph but slowed down to possibly 25mph to allow the vehicle to pass. He confirmed that he had indicated to the vehicle that it should overtake him.

16. In describing the weather conditions, Mr Smith indicated that although it had been not too bad when they had set off from Leverburgh, he encountered a couple of bad gusts which required him to counter his steering and indicated that he had never experienced that before. He described how the wind was catching the whole van and physically moving it. He also described how the rain was coming down in

sheets and described it like blankets of rain coming across the hills. At certain points water was flowing across the road and when it was put to him that there were gusts between 60 and 70mph he agreed and felt that they were probably even more than that.

17. In describing the overtaking manoeuvre, Mr Smith indicated that although there was an oncoming vehicle he regarded the manoeuvre as safe and the overtaking vehicle got back onto its own side of the road without incident.

Jeffrey Peterson

18. I then heard from Jeffrey Peterson, aged 44, Ambulance Technician, who described how on 24 November he received a call about 16.20 from Ambulance Control in Inverness asking him to attend at an incident in the waters of Loch Nan Uidhean. He arrived at approximately 16.30 and stated that the fire brigade was already in attendance. He described how at 17.05 a female casualty was carried out of the car in the loch by the coastguards and he put her onto a stretcher and into the back of an ambulance. Dr MacKellar was in attendance but there was no sign of life in the occupant of the car. He described how the patient was hooked up to the defibrillator and CPR was carried out on the patient all the way up to Stornoway in the ambulance. He described how they had arrived at Stornoway hospital at 18.05 whereupon the patient was taken to the resuscitation room and further CPR was carried out. Life was pronounced extinct at 1900 hours. He indicated that during all the time that he was involved with the patient he saw no signs of life.

19. Cross-examined by Mr MacDonald for the family, Mr Peterson confirmed that he had spoken to Dr MacKellar regarding the possibility of the use of a

helicopter given that they did not know how many casualties were in the car and they could only accompany one patient in the ambulance. His evidence was that the patient's chances of survival if she had been removed by helicopter from the locus would not have been helped because he did not consider that there was anything else that could have been done.

Samuel Cameron

20. I then heard from Samuel Cameron, aged 66, a Maintenance Assistance with Western Isles NHS who described how he had been working in Leverburgh with his colleague Douglas Smith on 24 November 2011. He described how the weather conditions when travelling back to Stornoway were horrendous. He indicated that he had been living in the Western Isles for 40 years and he had never seen conditions like that on the roads. He described the conditions as severe gale, storm and torrential rain which caused their van to be blown from one side of the road to the other. Further torrential rain was coming down the hillsides causing the water to backup blowing like a fountain. He described how the wind was blowing the water on the loch on the top of Ardhasaig and the water was blowing across the road, describing it as circles as if it was a tornado.

21. He described how they left Leverburgh about 2.50pm. If the weather conditions had been better they might have stayed longer in Leverburgh but they noticed that the weather conditions were deteriorating and decided to leave early.

22. When driving from Leverburgh towards Tarbert they became aware of a vehicle coming up behind them and he indicated to his driver that they should slow down and let the car pass. He described how they had been driving in the middle of

the road and were doing 20 to 30mph when they slowed down to let the car pass. He described that a lorry was coming in the opposite direction but there was no difficulty with the car passing them.

23. He described the conditions as being the worst he had seen in his 45 years on the island and said that he was concerned for his own safety and just wanted to get home.

24. He described how, when the car overtook their van, it was safe for that manoeuvre to take place and there was no lights showing when the car started overtaking but immediately the car had passed the van lights appeared from the oncoming vehicle. He did not consider that there was any danger to anyone in the overtaking manoeuvre.

25. He described how there was approximately one to two inches of water on the road, describing it in terms of rivers of water.

PC Scott Wordie

26. Police Constable Scott Wordie, aged 37 with 16 years police service, had come on duty at 7.00am on 25 November 2011. He had been informed by his nightshift of a road traffic accident and was tasked to go down to the locus and secure the area for the road policing unit. He arrived at Loch Nan Uidhean at approximately 7.45am and the road policing unit arrived at approximately 11.00am. The road policing unit requested that he travel to Leverburgh and take a statement from Kayreen MacMillan at 17 Dunmore Crescent in Leverburgh. He advised the court that it was some 16.9 miles from the locus to Leverburgh and the journey took him approximately 21 minutes.

27. Cross-examined by Mr MacDonald for the family, PC Wordie advised the court that when he arrived at the locus at 7.45am there was no police presence although there were physical blocks on the road. He understood, however, that a constable from Tarbert had been there earlier.

Finlay MacLennan

28. The court then heard from Mr Finlay MacLennan, aged 50 and employed as a lorry driver. He confirmed that on Thursday 24 November 2011 he was working for a company called John MacKay, Haulage Contractors, and was travelling towards Leverburgh carrying a load of aggregate. He described that on the A859 just south of Grosebay Road End, he saw a green car overtaking a white van. He considered that the vehicle was going too fast given the very bad road conditions.

29. He described how he had lived in the islands for 50 years and described the 24th November 2011 as one of the worst days he had ever seen in terms of weather conditions.

30. Cross-examined by Mr MacDonald for the family, he indicated that he was not concerned when he saw the car passing him although he thought it was going too fast. He thought it was probably doing more than 40mph but he could not put an exact figure on it and conceded that it was probably easier for the people in the white van to give an indication of the speed given that they were being overtaken and would have known what kind of speed they were doing whereas he merely saw a car coming towards him overtaking.

31. His concern related to the road conditions and indicted that the overtaking manoeuvre would have been fine on a good clear day and he confirmed that he did not think that there would be a collision and that the car had moved onto its correct side of the road after overtaking safely.

32. He estimated that the rivers of water seen on the road were some two to three inches in depth.

PC John Forsyth

33. The court then heard from PC John Christie Forsyth, aged 46 and a constable with Police Scotland's Road Policing Unit in Dingwall. He advised the court that he had been a Collision Investigator since April 2009 holding a standard certificate in Collision Investigation and a SCOTVEC certificate in Vehicle Examination. He had been trained in the use of Leica Total Station Surveying Equipment and also the use of AITSC damage software.

34. He submitted a report (document No. 3) into a fatal road accident which took place on the A859 Leverburgh to Stornoway road at Loch Nan Uidhean on the Isle of Harris. He stated that the accident related to a Mazda 2 motor car SY10 XSP. He advised the court that he attended on 25 November 2011 to carry out a collision investigation. He photographed the locus from both ends and plotted the locus using the Leica surveying equipment. He took measurements of the points of the tyre marks on the verge down to the shoreline on the loch.

35. He described how he found tyre marks on the grass verge and the bumper from the vehicle going down towards the water's edge. He then used an approximate position of where the vehicle would have been because the vehicle had

been recovered the night before and he had relied on officers at the scene telling him roughly where the vehicle had been in the water.

36. He spoke of information being obtained from the council about data from the weather station, the information being given to him that between 15.20 and 15.40 on Thursday 24 November 2011 there had been wind speed at the wind station, some 134 Metres south of the locus, of 42.3mph to 46.8mph in a southerly direction. Gusts at that time were between 59.5mph and 64.4mph. He was advised that the rain sensor was not in operation at the time and he understood it to have been 10° Celsius.

37. Although he had not examined the vehicle personally, vehicle examination had been carried out by Sergeant Murray and PC Mowat and he understood that no defects had been found in the vehicle which would have been a contributory factor in the accident. It was ascertained that the driver and passenger front airbags had been activated and there was indication that the seatbelt had been worn.

38. He advised the court that they were unable to establish a speed for the vehicle, although he understood from a witness statement of the witness Smith that the speed of the Mazda when overtaking the white van was in excess of 40 to 45mph.

39. His conclusion, based on statements of the witness Smith and other witnesses on the road, was that the cause of the accident rested with the driver of the Mazda 2 motor car in that she lost control of the motor car, crossed the carriageway and into the grass verge before coming to rest upside-down in the waters of Loch Nan Uidhean. He stated that the reason why the driver had lost control was not known but the probability was due to excessive speed for the prevailing road and weather conditions.

40. He confirmed in his report that weather conditions at the time of the incident were reported as having been torrential rain with storm force gales. The road was affected by surface water.

41. Cross-examined by Mr MacDonald, solicitor for the family, Police Constable Forsyth said that he assumed that the locus had been protected from the time of the accident until he carried out his examination. He said it was not normal for a vehicle to be removed from the scene prior to his arrival but that had not been his decision. He confirmed that in order for his investigation to be carried out it would have been normal for the vehicle to remain in situ until he arrived and completed his investigation.

William Bell

42. The court then heard from William Bell, aged 62, Telephone Engineer, who described how, on 24 November 2011, he had been travelling from Tarbert heading back to Leverburgh when he came across the accident at approximately 4.00pm. He stated how he saw the rear wheels and the bumper in a small loch just past Horsacleit Lodge, Loch Nan Uidhean. He saw the rear wheels, rear bumper and number plate of the vehicle upside-down in the loch. As a result he called 999 from his mobile phone asking for police and the fire service. He did not see anyone in the vehicle.

43. Cross-examined by Mr Fitzpatrick for NHS Western Isles, he described the weather conditions as horrendous with atrocious rain covering the road in up to half an inch of water. In addition there was a very strong gusting wind. When asked to

compare with other episodes of severe weather he indicated that it was pretty high up the scale.

44. Cross-examined by Mr MacDonald for the family, he indicated that he probably drove more slowly because of the conditions, estimating possibly 40 to 45mph.

Chris Sutton

45. Christopher Sutton, aged 53, Painter and Decorator and Retained Fire Fighter, described how on 24 November 2011 he received a call at 16.13 to attend the scene of an accident, arriving at the accident at 16.23. They were the first emergency service to arrive although other people were in attendance, including the previous witness William Bell.

46. He described how he saw the vehicle in the loch with the rear wheel and bumper exposed.

47. He explained how the fire brigade were not personally allowed to go into the water as they were not trained for such rescue but were able to throw a rope onto the back axle and pulled the car in towards the shore. As they pulled the car in a girl fell out of the front window and the coastguard, who had arrived by this time, cut her seatbelt and removed her fully out of the car and onto the shore. She was then taken to the ambulance by the ambulance crew.

Tom Lavery

48. Mr Lavery, Emergency and Planning Facilitator for NHS Western Isles, described how he had been in post since 2007 and he would advise Angela Grant,

Administrative Manager for Public Health, of any information that had to be given to managers and staff. He described how on 23 November 2011 he started to monitor the situation regarding the impending storm and spoke to Andy MacDonald, the Western Isles Council's Emergency Officer. He described how Ross Melville from the Met Office would give them a general weather bulletin and he stated that the greatest area of concern was for Thursday evening and Friday morning, although the worst of the weather should be over by the weekend. He described how a yellow warning issued by the Met Office was that people should be aware.

49. The first e-mail which he received he sent out to senior managers and directors with an e-mail going out at 13.47 on 23 November to all mail users in the health board which would include Lorna MacDonald.

50. As he started to monitor the situation, he spoke to Andy MacDonald, Western Isles Council Emergency Officer, and also to Ross Melville from the Met Office. He described how a yellow alert which had been given from the Met Office went to senior managers. This would mean a low or very low risk of disruptive events. He described how the limit was lower in the Western Isles than in the central belt in that there were fewer trees and less people. The Met Office would not issue weather warnings below 65 to 70mph for the Western Isles.

51. As far as he was concerned, Mr Laverty felt that a yellow warning meant that people should expect it to be outwith the normal winds but that there was a low likelihood of anything happening. An amber warning was an increased likelihood of something happening and one should expect roads not to be suitable for normal driving. A red warning meant that one should take action.

52. As far as the health board action was concerned, a yellow warning was simply highlighted to all mail users but an amber warning would necessitate senior managers being asked what steps they were going to take. For instance, at that stage they would look at the travelling requirements for staff members.

53. Mr Lavery stressed the importance of proportionality and stated that it was highly unlikely that a yellow warning would affect travel. He reckoned that the Western Isles received 20 to 30 yellow warnings per year but only two or three times would the weather go beyond a yellow warning.

54. He described the principal effects of issuing warnings was that people would miss appointments, even although no severe weather actually transpired and there was always the worry that the public might consider the health board to be, as he described, "crying wolf".

55. He described how senior managers had responsibilities for their staff and that was why a yellow alert was sent to senior managers. The flood alert which had also been issued was sent to the same senior managers.

56. Cross-examined by Mr MacDonald for the family, Mr Lavery felt that when there was a yellow alert staff members could continue to travel but it would be based on their own judgement. He accepted that the weather might actually be worse than the forecast.

57. Cross-examined by Mr Fitzpatrick for the health board, Mr Lavery described how, on 24 November 2011 at 10.23, a yellow warning had been sent to him. He sent it on to Angela Grant, Administrative Manager for Public Health, who forwarded it on to the relevant managers. He confirmed that there had been no further issue of

this to general members of staff although the warning of 23 November had been forwarded to them. He described how, on 24 November at 12.10, he sent information regarding the flood alert which had been received to Angela Grant and she had sent this on at 12.16 to the relevant managers. At 15.41 on the same date, managers had been advised of the flood alert.

Christine Lapsley

58. Christine Lapsley, Manager of Speech Therapy, described how she had come to work for Western Isles NHS 21 years ago and had been manager of the speech therapy department for 15 years. She described how Western Isles Health Board employed eight speech therapists, three support workers and two administrative staff. Four of the therapists were based in Stornoway and four in Benbecula in the Southern Isles. Lorna MacDonald, she stated, was a band 6 speech therapist and was described as a specialist. She stated that the therapists' work was normally divided geographically and stated that, as manager, she did not have day-to-day control of the workload unless someone was off on long term sickness. She described how on Monday morning she would communicate with the therapists and would meet up with them in Stornoway once per month. She described how the individual therapist would manage their own time and caseloads and they would write on a white board in the speech therapy department where they were going and what time they expected to return.

59. She described how the late Lorna MacDonald had an average caseload amounting to probably 40 patients. She had never raised any concerns regarding her caseload and would have been able to contact Mrs Lapsley at any time.

60. She described how if Lorna had phoned her when in Leverburgh she would have stated that she could either travel home or stay in Leverburgh or Tarbert. She understood that the speech therapy department in Stornoway had closed that day at 2.30pm. She had phoned Stornoway to tell them that her department in the Sothern Isles was closing and that they should go home and be careful.

61. She described that no-one had been in the department when she had phoned Stornoway so she left a message on voice mail in the department. She described how the administrator in the department only worked until lunchtime and she assumed that everyone had gone home.

62. She felt that her staff were responsible people and should take control of the risks about them. She described how she considered that health and safety was the individual member of staff's responsibility. She described how she had never had had to contact a member of staff when they had been out in the community.

63. Cross-examined by Mr MacDonald for the family, Mrs Lapsley said that she considered that she had a duty of care to her employees. She was aware of the Wednesday e-mail but did not speak to her members of staff as she assumed that they would all have received that particular e-mail. She stated that she considered her staff to be autonomous people who had responsibility for their actions and she did not feel responsible for Lorna MacDonald's death that day.

64. She stated that she was aware of the NHS Lone Workers Policy. She stated that the only system that the NHS Board had for tracking their employees was the white board in the department. She did not know that Lorna was in Leverburgh but indicated that she could have contacted her on her mobile phone. She described how, in the Western Isles, they are often told to expect bad weather but it does not

actually happen. She described how Lewis and Harris could be totally different from the Sothern Isles and therefore the individual members of staff had to take responsibility.

65. She conceded that there had been no formal risk assessment carried out regarding any journeys although she did concede that Lorna had come within paragraph 3 of the Western Isles NHS Lone Working Policy. There had been no formal risk assessment carried out as per paragraph 4 of the Lone Working Policy paper with only verbal assessment being made. She described her staff as being professional and there were regular verbal discussions relating to any perceived problems. Much of this was done at the induction training and would have been carried out by the Health and Safety department.

66. She agreed that senior line managers and heads of department were responsible for making sure that risk assessments were carried out and reviewed regularly and stated that this was done verbally. She was not aware that they had to be done in writing and certainly there was no written procedure regarding driving in adverse weather conditions. She was not aware of the Chief Executive ever having contacted her as to whether written assessments had been done and certainly she had no requests for such assessment.

67. She explained how, since Lorna's death, she had put into place a verbal agreement that if staff were concerned and that the wind had risen to over 40mph, they should not go to far-flung places but that they should contact her directly. She accepted that she might be overcompensating to ensure that something like this never happened again but she felt that it was her responsibility to implement that procedure.

68. As far as home visits and travelling while at work was concerned, as per paragraph 7 of the Lone Working Policy was concerned, she did not consider that paragraph 7.2 was practical. No-one was identified to communicate with the department as there might not be anyone in the office at any particular time. In any event, it would make no difference to the outcome in that someone might not be returning until it is too late. She felt that it was the responsibility of the employees to contact her as the line manager. At every supervisory meeting she had, health and safety was on the agenda but she felt that individual employees were autonomous and had to take responsibility.

69. Cross-examined by Mr Fitzpatrick, she conceded that her decision to introduce a system whereby staff would contact her if the wind went to over 40mph was possibly an over-reaction. However, she felt that some system like what she had introduced should have been in force before Lorna's death. She indicated that contacting members of staff in outlying areas might be problematic in that they might not be able to get a mobile phone reception. She did not consider that there was any defect in the department's office system which had contributed to Lorna's death, although she did indicate that she did now have a risk assessment for driving related matters.

Jennifer Porteous

70. Mrs Porteous, H R Director with NHS Western Isles, described how the Managing Work Related Driving Risks Policy had been approved in September 2011 but had not been put onto the staff intranet until December 2011. She described how paragraph 5, relating to responsibilities, had come from the Scottish Department and paragraph 6, regarding assessing risk, had come about as a result of discussion with

staff and unions. She referred to the Attendance at Work During Adverse Conditions Policy and Procedures, which stated that the policy should be followed in adverse weather conditions. She described how, where weather conditions showed signs of worsening, managers should take a decision as to whether to allow staff to leave early. It was the managers' responsibility to make such a decision. She described how every four to six weeks line managers would have meetings with senior managers and would have written records of risk assessments being carried out. Where weather conditions showed signs of worsening then local managers should take a decision as to whether to allow staff to return home early.

71. She felt that "inclement weather" was always open to interpretation and while individual members of staff were responsible for their own safety, nonetheless managers should take action to minimise risk to their staff.

72. She described how managers were responsible for performance management of staff and stated that every four to six weeks she would have a performance review meeting in which managers would confirm that they had done certain things, including providing details of written records of risk assessment.

Ruraidh Nicolson

73. Finally the court heard from Ruraidh Nicolson, uncle of the late Lorna MacDonald and former Police Constable. He described how he had dealt with many fatal accidents in his role as police officer and had compiled reports when in the Northern Constabulary Traffic Department. He described how he was concerned regarding the conclusions of the police report given that the locus had not been secured and the vehicle had been removed before the officers conducting the road

policing inquiry had arrived. They were relying on other witnesses to say where the vehicle had been, whether gouge marks and scrapings were actually related to the vehicle in its trajectory towards the loch and also with relation to damage to the vehicle.

74. He described how he went to the locus of the accident the following day and the wind was still fierce but dropping from what it had been the day before. Water was still flowing across the road and he described how the drains simply were not coping with the level of water. He described how he saw approximately 1½ inches of water cascading across the road and he indicated that in his experience the tread on an ordinary car would simply not cope with that body of water resulting in lack of steering.

75. He described how Lorna had driven approximately 10,000 miles per annum in her work but did not use her car socially. He had helped her when she was learning to drive and found her to be a most cautious driver. She had a clean licence and he described her as an extremely competent driver.

76. Having looked at the police report and listened to what the witnesses had said (Mr Nicolson had the benefit of having heard the witnesses give their evidence in court) he simply did not know why Lorna had lost control of the vehicle. Although there had been extremely inclement weather there was no indication that she had done anything wrong as far as her driving was concerned.

77. He described how he had driven home that day from Stornoway to Lochs at approximately 4.00pm. He had been driving a Honda CRV and even in a vehicle like that he felt that the wind was catching his car.

78. Cross-examined by the procurator fiscal Mr Nicolson agreed that he would never know what had caused his niece to come off the road that afternoon.

Submissions

79. Agents helpfully lodged written submissions on the evidence adduced and I first heard from the Procurator Fiscal, Mr David Teal. He asked me to find in terms of section 6(1)(a) that Lorna MacDonald had died at approximately 1600 hours on 24 November 2011 as a result of drowning. In terms of section 6(1)(b) he suggested that the cause of death was drowning and a road traffic incident. He stated that the cause of the motor car leaving the road was not known. He maintained that there was insufficient evidence to justify any inference as to why the deceased's car had left the carriageway and felt that it would be unsafe to proffer any explanation as to why the accident occurred. He did not consider that there was any defects in any system of working contributing to the death and did not ask me to make any finding in that regard nor did he suggest that there should be any finding in terms of section 6(1)(e).

80. Mr Teal did not consider that the weather could be considered as a cause of the accident given the Crown's position that there was no reliable explanation for the accident having occurred. If, however, the court was to consider that the weather was a cause then he asked me to remember that the wind speed was insufficient to bring it above the threshold of a Met Office yellow warning. This meant that people were simply to "be aware" rather than to take any action.

81. He felt that the health board had an obligation to balance duties of safety with proportionality and stated that a basic tenet of health and safety is that each person has to be conscious of their safety and responsible for their own actions. He maintained that the weather warning issued on the Wednesday was sufficient in its terms to provide sufficient warning to users in the health board of the predicted weather and such warning had been issued to all users. He accepted that the yellow warning from the Met Office issued on the Thursday had not been issued to all users but had contained the same information as that available the previous day.

82. For the family of the late Lorna MacDonald, Mr MacDonald asked me to make the same determination as the Crown in terms of section 6(1)(a). In terms of section 6(1)(b) he suggested that the cause of death was:

(a) drowning

and

(b) a road traffic incident which occurred when the deceased lost control of her motor vehicle as a result of the prevailing road and weather conditions.

83. He suggested that in terms of section 6(1)(c) steps should have been taken to ascertain which lone working employees were travelling to an isolated work area so to ensure that any journey be cancelled during the period of violent weather predicted for Thursday 24 November 2011.

84. He argued that in terms of section 6(1)(d) the defects at the time of the deceased's death which contributed to her death were that her employers did not have:

(1) a policy which specifically assessed work related driving risks;

- (2) a system whereby a check was made on the return of lone workers having completed their task within the community;
and
- (3) a system whereby each lone worker was contacted individually to discuss and assess the need for them to travel in weather conditions such as those prevailing.

85. In terms of section 6(1)(e) Mr MacDonald considered the police's failure to secure the location of the fatal accident to allow the road policing unit to complete their investigation meant that the family were unable to be provided with any certainty specific reasons why her vehicle left the road. He felt that the road policing report was based on inaccurate information together with evidence which could not be relied upon because of the insecurity of the locus.

86. Mr MacDonald felt that the deceased had a right to expect that her employers would exercise a duty of care towards her and given the location and weather in the Western Isles, particularly the weather pertaining on that day, that a specific policy should have been in place to ensure the safety of the employees, particularly lone workers. He felt that it was not sufficient for steps to be taken by the employers only when a "yellow" alert changed to "amber". He felt that any reasonable employer should have ensured that the deceased did not have to travel to remote locations such as Leverburgh in the weather forecast.

87. Mr MacDonald was critical of the attitude of the health board. In particular he felt the family had been let down and referred to the deceased's line manager, Christine Lapsley, stating that the decision to drive on the 24th November was a matter entirely left to the judgment of each employee. Mr MacDonald felt that the

health board, as the employer, had a duty of care and in particular Mrs Lapsley as the deceased's line manager should have ensured that all staff under her control were protected from weather associated risks. Whilst the health board's "Lone Working" Policy stated that the health board "takes extremely seriously the health, safety and welfare of its staff" he felt that the events of the 24th November 2011 did not reflect this and although it was accepted by Mrs Lapsley that this policy applied to Lorna MacDonald, nonetheless no evidence was forthcoming suggesting that the health board was fulfilling its duties as described in the Lone Working Policy document.

88. For the health board, Mr Fitzpatrick concurred in the suggestion of Mr Teal and Mr MacDonald relating to a determination in terms of section 6(1)(a). In terms of 6(1)(b) he suggested that the cause of death was drowning and road traffic incident. The incident which resulted in Lorna MacDonald's death was caused by her having lost control of the vehicle, probably in consequence of:

- (1) driving at excessive speed for the prevailing road and weather conditions;
- or
- (2) failing in some other unknown respect to adjust her driving sufficiently to address those conditions.

89. He did not consider that there were any reasonable precautions whereby the death might have been avoided other than for the deceased to have driven with more care for the prevailing road and weather conditions.

90. He did not consider that there were any defects in any system of working which contributed to her death.

91. In terms of section 6(1)(e) he considered that the deceased being likely to have been driving with insufficient care for the prevailing weather conditions and probably involving excess speed having regard to these conditions, were factors which were relevant to the circumstances of her death.

92. Mr Fitzpatrick considered that although the witnesses to the deceased's driving did not give evidence consistent with the statements held by the police, nonetheless their evidence taken as a whole was capable of supporting Constable Forsyth's conclusion that the deceased's loss of control of her vehicle was probably on account of excessive speed for the prevailing road and weather conditions. Mr Fitzpatrick conceded that while he understood the Crown's position that the loss of control was unexplained, nonetheless he felt that the evidence given was potentially supportive of Constable Forsyth's conclusion.

93. As Mr Fitzpatrick stated the health board's principal interest in the inquiry was whether there were any precautions whereby Lorna MacDonald's death might have been prevented and whether there was any defects in any relevant system of working. He maintained that the question was whether any of the weather information available to NHS Western Isles should reasonably have prompted any precaution which was not taken. Whilst it was agreed that the yellow warning was not given to all users on the 24th, that yellow warning did not convey any further or better information than had already been conveyed by dissemination on the e-mails of Wednesday 23rd. Many yellow warnings are put out each year but the specific action in response to that is rare and they do not result in avoidance of driving. Even if the yellow warning of 24th November had been sent to all employees it would not have conveyed to them that they should cancel plans to travel by road that day.

94. As far as Lorna MacDonald not having been made aware of the decision of Christine Lapsley that employees could go home, it was Mrs Lapsley's view that such action was not reasonably called for as her employees might well not be contactable by reason of being in a school or in an area where there was no phone signal. Winds of 60-70mph were not unusual in the Western Isles and she would only take action in more extreme conditions such as a hurricane.

95. He felt that it could not be concluded that there was a failure to take any reasonable precaution which might have prevented the death and there was no failure in a system of work contributing to the death.

Conclusion

96. This case is an inquiry into a tragic accident causing the untimely death of a young Speech Therapist serving her local community in the Western Isles. As I have stated earlier, the purpose of the inquiry is fact finding rather than fault finding. It is not the function of this inquiry to make a statement finding fault as a basis of legal liability.

97. However, in determining the circumstances of a death I require to have regard to future public safety and to look to see whether any lessons might be learned whereby future accidents or deaths might be avoided.

98. It is clear that on the day Lorna MacDonald died the Western Isles were subject to severe weather conditions with gales and torrential rain. A warning had been sent to all NHS e-mail users on 23 November 2011 of strong winds for 24 November and 25 November.

99. On 24 November 2011, Tom Lavery, Emergency and Planning Facilitator for NHS Western Isles, received a Met Office yellow alert and information regarding flooding. He forwarded this information by e-mail to Angela Grant, Administrative Manager for Public Health NHS Western Isles at 11.58 on 24 November stating “please forward this message containing Met Office alerts and flooding information to all members of EPPHIG as a matter of urgency”.

100. This information was forwarded to the members of the Emergency Planning Public Health Incident Group (EPPHIG) at 12.02 on 24 November tagged “Importance: High”. This stated that for Thursday 24 November “the strongest winds, gusts up to 65 to 75 mph will occur across the Outer Hebrides and north-west mainland during this afternoon”.

101. Mr Lavery felt that a yellow warning meant that people should expect weather to be outwith the normal winds but there was a low likelihood of anything happening. He felt that a yellow warning was unlikely to affect travel, indicating that the Western Isles received 20 to 30 yellow warnings per year but only two or three times would the weather go beyond a yellow warning.

102. Nonetheless, Mr Lavery described how senior managers had responsibilities for their staff and that was why a yellow alert was sent to senior managers together with the flood alert.

103. Regrettably, although this information was sent to EPPHIG marked “Importance: High” its information does not seem to have been given to employees

by their relevant managers. There seems to have been a view taken that a yellow warning on the mainland was of higher significance than on the Western Isles, there being fewer trees and less people.

104. Mr Laverty stressed the importance of proportionality and said that it was highly unlikely that a yellow warning would affect travel, although he did accept that the weather could turn out to be worse than that forecast.

105. Although Christine Lapsley, Manager of Speech Therapy, could not recall whether she had received any information on 24 November 2011 regarding a weather warning, she decided that because of the worsening weather that she would close her department in the Southern Isles and phoned Stornoway at 2.30pm to tell them to go home and be careful. Unfortunately, the administrator in the Stornoway department of Speech and Therapy only worked until lunchtime and Mrs Lapsley therefore left a message on the department's voice mail assuming that everybody had gone home. She did not try to contact any of her employees working in the community.

106. She did not consider it necessary to contact individual speech therapists stating that they were responsible people and should take control of the risks about them. She considered that health and safety was the individual member of staff's responsibility.

107. NHS Western Isles had in place a Home Working Policy revised in December 2007. One of its policy aims was to:

“make sure that the risk of working alone is assessed in a systematic and ongoing way and that safe systems and methods of work are put in place to reduce the risk so far as is reasonably practicable”.

108. Paragraph 7.2 of this policy stated:

“All employees undertaking home visits should ensure that there is a designated responsible person who will initiate communications with the person undertaking the home visits when that person does not report or communicate back when expected. The responsibility to identify that person is that of the line manager”.

109. In addition, 7.17 stated:

“A diary should be kept by the line manager outlaying all of the visits in which lone working is going to occur”.

110. None of these parts of the policy were implemented. The only notification of where a lone worker had an appointment was on a white board in the speech therapy department in Stornoway which only had an administrator working in the mornings.

111. Paragraph 8.1 of this policy states:

“Community or line managers will put in place procedures for checking on staff regularly if they work alone with patients”.

112. None of these measures were implemented and are relevant to the circumstances of death.

113. Clearly the weather in the Western Isles was worsening that day and a decision could have been taken by management after the e-mail forwarded to EPPHIG to cancel Lorna MacDonald's journey to Leverburgh. By 2.30pm Mrs Lapsley had left a telephone message in the speech therapy department in Stornoway telling them to close and go home but had still not spoken to Lorna MacDonald or, as far as we are aware, anyone else in the community.

114. These failures while not justifying a determination that they contributed to the deceased's death certainly might have prevented her death if her journey had not been undertaken. While every employee has a duty to look after their own health and safety, this does not remove the responsibility of employers.

115. Young professionals with a sense of responsibility for their clients and patients will always endeavour to do their best for them. Management has a duty to protect employees from risks resulting from this sense of duty.

116. The health Board's Policy for Managing Work Related Driving Risks states, in appendix 2:

"In the event of inclement weather managers should take action to minimise risk to staff, for example prioritising home visits".

This had been agreed in September 2011 although not placed on the staff intranet until December 2011. It does not appear to have been implemented by the time of Lorna MacDonald's death on 24 November 2011.

117. We are used to stormy weather in the Western Isles and there is always the danger that people become complacent, especially with the number of weather warnings, many of which do not turn out to be as bad as feared. As Mrs Porteous, HR Director with NHS Western Isles, said “inclement weather” will always be open to interpretation but she confirmed that managers should take action to minimise risk to their staff. Individual members of staff will always have responsibility for their own health and safety but this does not remove the responsibility of managers. In particular, managers must implement fully the health board’s Lone Working Policy and Policy for Managing Work Related Driving Risks.

118. Finally, Mr MacDonald, for the family, was critical of the police in preparing the collision investigation report. The authors of the report relied on statements obtained from witnesses by other officers. It is hardly the officers’ fault that evidence different to the statements provided was given in court. Nonetheless it did appear that the locus was not secured before the arrival of investigators and the vehicle had been removed prior to their arrival on the scene. While that omission does not have any bearing on this inquiry, it could be relevant in future accidents and consideration should be given to ensuring that such sites are preserved in future.

119. It only remains for me to thank Mr Teal, Mr MacDonald and Mr Fitzpatrick for their professionalism and courtesy in the conduct of this Fatal Accident Inquiry.

120. Meanwhile the court extends its sympathy to the family of the late Lorna MacDonald in their tragic loss.