SHERIFFDOM OF GRAMPIAN, HIGHLAND AND ISLANDS AT INVERNESS

[2020] FAI 23

INV-B343-19

DETERMINATION

BY

SHERIFF MARGARET M NEILSON

UNDER THE INQUIRIES INTO FATAL ACCIDENTS AND SUDDEN DEATHS ETC (SCOTLAND) ACT 2016

into the death of

MOHAMED BAKARI CHACHE

Inverness, 30 April 2020

The Sheriff, having resumed consideration of the Fatal Accident Inquiry into the death of Mohamed Bakari Chache, determines in terms of section 26 of the Inquiries into Fatal Accidents and Sudden Deaths etc (Scotland) Act 2016 ("the Act") as follows:-

In terms of section 26(2)(a) (when and where the death occurred)

The late Mohamed Bakari Chache, born on 8 November 1968, died on 11 January 2019 between 17.38 and 19.06 whilst driving the number 26C Stagecoach bus at Littlemill Bridge on the B9161 road.

In terms of section 26(2)(b) (when and where any accident resulting in the death occurred)

The accident resulting in the death of said Mohamed Bakari Chache took place at Littlemill Bridge on the B9161 road at 17.38 on 11 January 2019.

In terms of section 26(2)(c) (the cause or causes of the death)

The cause of the death of said Mohamed Bakari Chache was 1 (a) head and cervical spine injuries with positional asphyxia due to (or as a consequence of) (b) bus collision with bridge parapet.

In terms of section 26(2)(d) (the cause or causes of any accident resulting in the death)

The cause of the accident resulting in the death of said Mohamed Bakari Chache, was the bus being driven at excessive speed on the approach to the bend at Littlemill Bridge on the B9161 road at Littlemill Bridge.

In terms of section 26(2)(e) (any precautions which (i) could reasonably have been taken and (ii) had they been taken, might realistically have resulted in the death, or any accident resulting in the death, being avoided)

There are no precautions which had they been taken might have avoided the accident or the death. The available evidence indicates that the fatal injuries could have occurred whether or not a seat belt restraint was provided, and at any point during the initial impact with the bridge and the final resting place of the deceased and the vehicle.

In terms of section 26(2)(f) (any defects in any system of working which contributed to the death or the accident resulting in the death)

There were no defects in any system of working which contributed to the death of Mohamed Bakari Chache.

In terms of section 26(2)(g) (any other facts which are relevant to the circumstances of the death)

There are no other facts which are relevant to the circumstances of the death of Mohamed Bakari Chache.

It is not appropriate to make any recommendations in terms of section 26(1)(b) and (4) of the Act.

NOTE

Introduction

[1] This inquiry was held in terms of section 1 of the Inquiries into Fatal Accidents and Sudden Deaths etc (Scotland) Act 2016 and was governed by the Act of Sederunt (Fatal Accident Inquiry Rules) 2017. This was a mandatory inquiry in terms of section 2 of the Act as the deceased died as a result of an accident in the course of his employment or occupation.

[2] The purpose of the inquiry is set out in section 1(3) of the Act as being to establish the circumstances of the death and to consider what steps, if any, might be taken to prevent other deaths in similar circumstances. It is not intended to establish liability, either criminal or civil. It is an inquisitorial process. The Crown, in the form of the Procurator Fiscal represents the public interest.

[3] In terms of section 26 of the Act the inquiry must determine certain matters, namely where and when the death occurred, when any accident resulting in the death occurred, the cause or causes of the death, the cause or causes of any accident resulting in the death, any precautions which could reasonably have been taken and might realistically have avoided the death or any accident resulting in the death, any defects in any system of working which contributed to the death, and any other factors relevant to the circumstances of the death. It is open to the Sheriff to make recommendations in relation to matters set out in subsection 4 of section 1 of the Act.

[4] At this inquiry, parties were represented as follows:- for the Crown, Ms C Whyte, Procurator Fiscal Depute and Mr M Donaldson, solicitor, representing Stagecoach, the deceased's employers.

[5] I was grateful to both representatives for their conduct of the inquiry, in particular the fact that they had agreed some evidence in advance which allowed a joint minute to be lodged and some witnesses to be countermanded. I also appreciated their concise submissions. The joint minute contained a number of facts relating to the cause of death and to the "mandatory findings".

[6] A preliminary hearing took place on 5 February 2020 and the inquiry itself took place on 9 March 2020.

[7] The Crown lodged an inventory of productions as follows:-

1. Pronunciation of Life Extinct Form
2. Post mortem report
3. CCTV disc
4. Collision investigation report
5. Contract of Employment
6. Road Vehicles (Construction and Use Regulations) 1986 Regulations 46 and 47
7. Information from DVSA – Fitments of seat belts to vehicles in service
8. Notes – Stagecoach National Liaison Committee Vehicle Cab Design Meeting 19 April 2007
9. Route Risk Assessment Service 26 – Inverness - Fortrose

[8] Stagecoach lodged an inventory of productions as follows:-

1. CV of David Beaton

2. GreenRoad Guide

3. GreenRoad Performance Statistics for Mr Chache.

[9] I heard oral evidence from Crown witnesses Jean Eilidh Evans, Murray George Marshall, Lynn Cooper and Police Constable Christopher Eric Donaldson and from David Beaton, Managing Director of Stagecoach Highland who was led by Mr Donaldson.

[10] Other witnesses on the Crown list of witnesses did not require to be called because of the joint minute which included the evidence of those witnesses.

[11] An affidavit was lodged containing the evidence of Robert Stewart.

[12] I found all witnesses who gave oral evidence to be credible and generally reliable. I had the impression that they were all trying to assist the inquiry as much as possible. It was clear that the two witnesses who had been passengers in the bus at the time of the accident had understandably found the accident to be a traumatic experience and at times found it difficult to give evidence. Both had sustained injuries. Despite this both gave their evidence in a clear way although their recollection of certain parts of the incident was affected to an extent by the injuries they sustained at the time. I hope that they found the experience of giving evidence to the inquiry gave them some closure.

The facts

[13] Mohamed Bakari Chache was born on 8 November 1968. As at the date of his death he resided in the Inverness area with his wife.

[14] He had been employed by Stagecoach since 25 September 2006. He had passed a renewal of his PCV licence which included a medical on 7 August 2018. He had an excellent attendance record with only 2 days absence in the previous 4 years.

[15] On 11 January 2019 he started work at 11.56 and was due to finish at 20.42. During this shift he drove several different types of bus on different routes. He took a scheduled break between 15.26 and 17.11. He left Inverness at 17.20 to travel to Cromarty via Munlochy on the 26C route. He had driven the same route on a regular basis.

[16] During said break the deceased was spoken to by the operations manager at Stagecoach about failing to pick up passengers on a previous run that day. He stated that he had been running late and was asked to pay more attention next time. He said that was not a problem and seemed happy.

[17] Mr Chache died on Friday 11 January 2019 between 17.38 and 19.06 whilst driving a Stagecoach bus in the course of his employment on route 26C between Farraline Bus Station Inverness and Cromarty at Littlemill Bridge, Munlochy on the B9161 road.

[18] At the time of the accident there were 9 passengers on the bus. All sustained injuries.

[19] As a result of the collision Mr Chache was propelled through a bus window onto the ground. The bus came to rest partially on top of him and trapping him under it.

[20] A post mortem examination was carried out on 15 January 2019 by Dr Mark A Ashton and Dr Natasha Inglis. The cause of death was established as 1(a) head and cervical spine injuries with positional asphyxia due to and as a consequence of 1(b) buss collision with bridge parapet. The report (CP2) showed a joint conclusion that there was evidence of a significant blow to the head together with an undisplaced but unstable fracture of the cervical spine. In addition there were several rib fractures. These injuries were severe but not necessarily fatal. It was likely that entrapment beneath the vehicle had led to positional asphyxia.

[21] Dr Ashton later clarified that had a seat belt been fitted and used by Mr Chache he could have remained in the vehicle. However the head and neck injuries sustained by Mr Chache could have been present before he was ejected from the vehicle. Head and neck injuries of that type were likely to be fatal.

[22] CCTV footage from inside the bus timed at between 17.30 and 17.36 on 11 January 2019 records Mr Chache driving at 52 mph at 17.36.

[23] Scott Ironside, Paramedic, Scottish Ambulance Service pronounced life extinct at 19.06 on 11 January 2019.

[24] Crown Production 4 is a collision Investigation Report prepared by Police Constables Malcolm Ross Cameron and Christopher Eric Donaldson. It contains *inter alia* narrative, maps of the locus, photographs of the locus and conclusions.

[25] The bus was examined by both Police Constable Angus Macleod and Michael Howden, DVSA vehicle inspector and found to have no mechanical defects which could have caused or contributed to the accident on 11 January 2019. The bus was fitted with full passenger seatbelts and signs on each passenger seat directing that they should be used.

[26] The bus Mr Chache was driving was an Enviro 200, an "urban bus", which was an appropriate type of bus to be used on the route in question.

[27] At a Stagecoach National Liaison Committee Vehicle Cab Design meeting it was agreed that drivers' seat belts should not be fitted on Enviro 200s and 400s as they would be too restrictive for the drivers in the operation of the vehicle and when dealing with passengers.

[28] The route risk assessment for the 26 route had been last reviewed on 18 October 2018. Page 7 of the document (CP 9) details the hazard as "Narrow bridge. Reduced speed limit" and the action required to be taken as "Use caution in this area. 40 mph speed limit. Be aware of priorities at bridge."

[29] The GreenRoad Explanation Manual (Stagecoach production 2) contains information about the safety performance system used by Stagecoach to assess their drivers' safety ratings.

[30] Stagecoach production 3 contains the GreenRoad information for Mr Chache between 14 October 2018 and 11 January 2019. Mr Chache was consistently amongst the top performing drivers for Stagecoach nationally in terms of safety performance.

[31] Stagecoach have 1588 ADL200 vehicles in service and last year these vehicles travelled a total of 66,983,027 miles.

[32] Stagecoach employ 18,363 drivers in the UK and records disclose only one previous driver fatality arising from a collision, which was in 2013.

[33] PC Robert Stewart has 6 years' experience in the road policing unit. On 11 January he started duty at 17.30 and at 17.40 heard a radio transmission relating to the accident on the B9161 road at Munlochy. There were numerous ambulances in attendance already. He saw a Stagecoach bus lying on its side in a field to the North of the bridge. He met with PC Donaldson, was advised that it was a fatal accident and dealt with the formalities arising from that with the family of the deceased. As reporting officer he had investigated many aspects of the case on the instructions of the Procurator Fiscal, including the legality of the non-provision of driver seat belts and the deceased's contract of employment and training and disciplinary records. There was nothing of significance in the previous 12 months of his employment. There had been two minor mistakes earlier on the same day as the accident, on a different bus which was not fitted with GreenRoad telematics system. It was suggested that on the route 25 he did not wait for a connecting bus at Alness and also went into North Kessock which was not on the route in question.

[34] Jean Evans was a passenger on the number 26C bus driven by the deceased on 11 January 2019. She was travelling to Avoch from Inverness. It was normally a 25 minute journey. She used the route quite often. She had travelled with the same driver previously. She was with her 8 year old grandson. She sat near the front on the

same side as the driver. During the journey she felt concerned that the driver was travelling too fast. Coming off the A9 onto the B9161 she noticed he did not stop but just slowed down. As the bus approached the bridge she became so concerned about the speed that she shouted at her grandson to hold on. The driver did not slow down at all on the approach to the bridge. Her grandson turned to look at her. The lights went out and she felt like she was on a merry go round and floating in the air. She ended up sitting on the grass on broken glass where the window had been, facing in the opposite direction. It was pitch black. She shouted to her grandson. He shouted back. She could not see anything. The bus had turned over. Passers-by stopped to help. Someone broke a window at the back of the bus and she got out through there. Fire engines and ambulances were already there. She was taken to hospital and was kept in overnight. She had cuts and bruises and swelling to her neck. Her grandson had a bump to his head.

[35] Murray Marshall had been travelling in his car from Fortrose to Inverness along the B9161 road on 11 January 2019. He often travelled on that road and was familiar with it. He had just passed the Littlemill Bridge and was approximately 100 – 150 metres past it on the straight. A Stagecoach bus was travelling in the opposite direction and he noticed that it was going much faster than he had expected. It was travelling faster than he had ever seen a bus travelling there. There was nothing erratic about the driving, it was just the excessive speed that he had noticed. He did not think much about it at the time but later on, when he heard about the accident he had called the police.

[36] Lynn Cooper was a passenger on the bus. She was a regular user and travelled on the route almost every week. She recognised the driver. She thought he was nice and friendly and a good driver. She did not notice anything wrong at first. She sat about 3 rows behind the driver on the same side as him. There was a lady with a small boy in front of her [witness Evans]. Just before the bridge she realised the bus was going far too fast and she had shouted at the driver to slow down. She wondered what was happening. The accident itself was a complete blank. She came round in the foetal position lying on a window between the seats. Someone helped her out through the back window. The emergency services were already there. She had a number of injuries including concussion and a number of fractures. She still has flashbacks about the accident.

[37] PC Christopher Donaldson has some 5 ½ years' experience in the road policing unit. He has prepared many road collision reports. He and his colleague prepared one in relation to the incident (CP 4). They were the first police officers to arrive on the scene. The fire service and ambulance service were already in attendance. They found the bus on its side. There were a number of casualties from the bus. There was no ice on the road. They inspected the road surface. There was nothing about it which could have contributed to the accident. The road was 5.6 metres wide which would be just wide enough for two cars to pass but it would be very tight. The bridge is set up for one vehicle to cross it at a time. He had included photographs from the scene in his report. They show, for example, where the bus ended up, the damage to the bridge and the damage to the bus. The bus was examined in detail. There were no mechanical defects.

[38] There was CCTV from inside the bus. It was mentioned in the report and played at the inquiry. It was spoken to by PC Donaldson. It clearly showed that the bus was travelling at 52 mph as it approached the bridge and started veering off the road. The report also contained images of the road signs leading up to the bridge. These included "give way", "40 mph" and "road narrows" signs. The speed limit on the bridge was 40 mph but PC Donaldson agreed most bus drivers would cross it at between 20-30 mph. The bus sustained significant damage having gone from 52 mph to rest very quickly.

[39] David Malcolm Beaton is the Managing Director of Stagecoach Highland. He has extensive experience in the industry. The bus used on the route is the Enviro 200. Route 26 is a typical town to rural route. It is the core business of the company. A driver of a coach may need to stop 4 or 5 times on the route. A bus driver is constantly having to stop and start and change body position. Because this is designed as an urban bus there is no requirement for a driver to have seat belts. The whole issue of seat belts had been considered and discussed at length in the past with the Unite union. The union and drivers in general felt that seat belts would prevent them helping disabled passengers and passengers with buggies and would also prevent them from protecting themselves and their takings. There is no requirement for passenger seat belts on an urban bus but in fact this bus had them. The route risk assessment (CP 9) is done to help drivers identify hazards on the route. It is reviewed annually and if there are any changes to the route. When a driver starts covering a particular route they will initially

be mentored by an experienced driver. Mr Chache was an experienced driver and a "happy go lucky" individual.

[40] The GreenRoad system monitors routes in real time for "hot spots". It is monitored by someone in the bus station. When it was first introduced the drivers thought it was a sort of "spy in the cab" but after only 6 months or so all the drivers accepted it and indeed liked it. Each driver has performance statistics prepared for them which are colour coded. Green means "excellent". Yellow means "needs looking at". Red means "something needs addressed". If, for example, Mr Chache had gone into a 40 mph limit at 52 mph in the past this would have shown up and he would have been spoken to about it. All Mr Chache's records on GreenRoad were "green". There are 204 drivers based in Inverness. There are numerous ways to feed back any issues or requests to management. The company health and safety committee considered this accident and found it very difficult to see how it could have occurred.

The evidence

[41] Two of the witnesses (Jean Evans and Lynn Cooper) were caught up in the accident themselves. They were clearly, and understandably, still upset by the events that they had witnessed. Each gave their evidence in a clear and straightforward manner. Each spoke of the accident happening suddenly and of the bus being driven at excessive speed. They had each experienced the accident from a different place and perspective and unsurprisingly there were slight differences in their accounts. On all

material aspects, however, their evidence was consistent and I had no reason to doubt it. Mr Marshall's evidence of the bus being driven at speed supported this view.

[42] One police officer gave oral evidence. Police Constable Christopher Donaldson, based at the Road Policing Unit at Dingwall, was the co-author of the Collision Investigation Report which was lodged in process. He was taken through his report and gave a clear explanation of his findings. I found him to be a credible and reliable witness.

[43] Mr Beaton from Stagecoach was also a credible and reliable witness. He was very experienced in his area of work and had been with the company for years. He was clearly fully conversant with all the matters he was asked to give evidence on and I had no reason to doubt anything he said.

Submissions

[44] Ms Whyte invited me to make findings in relation to the date, place, time of death and the accident resulting in the death and the cause of death, all in line with the joint minute, affidavit and the oral evidence. None of this appeared to me to be in any way controversial. In terms of section 26(2)(d) she asked me to find that the cause of the accident was Mr Chache driving too fast as he approached the Littlemill Bridge. She asked me to find that there were no defects in the system of working in terms of s26(2)(f) and to make no findings in terms of s26(2)(g).

[45] Mr Donaldson adopted the Crown submissions in their entirety.

Discussion

[46] Mohamed Bakari Chache was born on 8 November 1968 and at the time of his death was a driver with Stagecoach He was a long standing employee who was valued by management, colleagues and passengers.

[47] On the day of the accident he was tasked to drive the number 26C bus from Inverness to Cromarty, a route he was very familiar with. He had an excellent safety record. There is no doubt whatsoever that (for reasons that are not clear) on 11 January at around 17.36 he drove on the B9161 at Littlemill Bridge at an excessive speed. The speed limit was 40 mph but most drivers would cross the bridge at 20 – 30 mph. Mr Chache was driving at 52 mph.

[48] As a consequence of driving at excessive speed Mr Chache was unable to safely complete the manoeuvre and the bus failed to take the corner, crashing through the parapet of the bridge and landing in the adjoining field having rolled over before coming to rest. All the passengers were injured to some extent, some worse than others. Mr Chache sadly died as a result of the accident.

[49] In this case the inquiry had the benefit of direct eyewitness evidence from two passengers on the bus who were caught up in the accident. In addition it heard oral evidence from a Police Officer who arrived at the scene shortly after the accident and there was other agreed evidence contained in a joint minute. I concluded that all of these witnesses were entirely credible.

[50] The locus of the accident was spoken to by the two passenger eye witnesses and the Police Officer who attended and prepared the report and is in no doubt.

[51] The cause of death is outlined in the post-mortem report and agreed in the joint minute as is the time and place of death.

[52] There were no mechanical defects on the vehicle. There was no ice on the road. The post mortem ruled out any medical condition having caused the accident.

[53] From the evidence before me there can be no doubt that Mr Chache was driving his bus at excessive speed on the approach to the Littlemill Bridge on the B9161. Both passengers on the bus (Jean Evans and Lynn Cooper) spoke to realising he was going too fast before the vehicle swerved off the road. The car driver who passed the bus (Murray Marshall) noticed that it was travelling much faster than he had ever seen a bus travelling there before. The CCTV on the bus itself showed the speed on the approach to the bridge to have been 52 mph in a 40 mph limit at the bridge which other drivers tended to cross at somewhere between 20 and 30 mph. Travelling at 52 mph the bus would not be able to safely cross the bridge and the bus going off the road was virtually inevitable.

[54] What is less clear is why he was travelling so fast. He was well regarded by both his passengers and management. His record on the GreenRoad telemetric scheme was excellent. Driving at excessive speed, as he undoubtedly did on 11 January 2019, appeared to be totally out of character. Any further discussion as to why he was, indisputably, driving too fast would involve speculation on my part. Accordingly I will limit my findings on that basis.

[55] At the start of the inquiry and at the end I extended my condolences to Mr Chache's family. I was joined in so doing by the procurator fiscal depute and the

solicitor representing Mr Chache's employers. I would wish formally to repeat those condolences in this determination. Mr Chache was clearly a much valued and respected employee who was well liked by both his employers and passengers.